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Iain Kerr Bowden. Twaddle

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CLINICAL PSYCHOLOGISTS' ENDORSEMENT OF
MENTAL DISORDER IDEOLOGY AS A FUNCTION OF
PERSONAL SOCIOPOLITICAL VALUES

by

Iain K. B. Twaddle

B.A. (Hons.) University of Winnipeg, 1987
M.A. University of Windsor, 1989

A Dissertation
Submitted to the Faculty of Graduate Studies
through the Department of Psychology
in Partial Fulfillment of the Requirements for the Degree
of Doctor of Philosophy at the
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Windsor, Ontario, Canada
1994
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ABSTRACT

The sociopolitical underpinnings of psychiatric theory are examined both theoretically and empirically. In the theoretical analysis, the view of mental disorder as a value-free conception is shown to be rooted in logical-positivism, an epistemology which has been strongly criticized for positing a realm of science beyond values. It is argued that psychiatric theory, like all knowledge, contains values which promote particular sociopolitical interests. Traditional mental disorder conceptions are outlined as supporting the interests of dominant sectors of society by focusing on the intra-individual concomitants of psychiatric distress and minimizing the importance of the social context in which human suffering arises. By directing attention away from adverse societal factors, such as inequality and powerlessness, these asocial models protect the sociopolitical system from criticism and reform. An empirical investigation was conducted in order to investigate the relationship between mental health clinicians' personal sociopolitical values and their endorsement of asocial theoretical formulations. Research questionnaires were mailed to 810 clinical psychologists throughout the United States. Participants were required to complete three measures of sociopolitical values, read four clinical case vignettes, assess whether the case descriptions indicated evidence of a mental disorder, and rate the extent to which each of Biological, Psychological, Interpersonal/Situational, and Societal factors were relevant to the vignette subjects' problems. One hundred and thirty useable questionnaires were
returned. Results indicated that the Societal factor was assigned less
importance than all other mental health factors, supporting the contention that
clinicians minimize socio-contextual variables in their theoretical models.
Higher mental disorder ratings were somewhat associated with greater
endorsement of Biological and Psychological mental health factors, providing
some support for the thesis that mental disorder conceptions are asocially
based. Overall the mental health frameworks of psychologists with differing
sociopolitical values were quite similar. However, endorsement of the Societal
factor was moderately associated with liberalism and endorsement of the
Psychological factor was somewhat associated with conservativism, suggesting
that the more conservative practitioners employed more asocial models.
Recommendations for clinical practice are outlined from a socio-cultural
perspective.
ACKNOWLEDGEMENTS

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I would like to thank Lisa Keith for her critiques of the many drafts of this paper and for her support throughout "the dissertation years." I also wish to convey my thanks to Peter Cobrin and Jonathan Douglas, with whom I have shared an interest in the philosophy and theory which underlie this work. My interactions with these three friends and many others in graduate school
contributed greatly to my understanding of the ideas I have grappled with in this project.

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# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABSTRACT</td>
<td>iv</td>
</tr>
<tr>
<td>ACKNOWLEDGEMENTS</td>
<td>vi</td>
</tr>
<tr>
<td>LIST OF TABLES</td>
<td>xii</td>
</tr>
<tr>
<td>LIST OF FIGURES</td>
<td>xiii</td>
</tr>
<tr>
<td><strong>Chapter</strong></td>
<td></td>
</tr>
<tr>
<td>I INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>Literature Review</td>
<td>2</td>
</tr>
<tr>
<td>The Scientific Basis of Mental Disorder</td>
<td>4</td>
</tr>
<tr>
<td>Mental and Medical Disorders</td>
<td>5</td>
</tr>
<tr>
<td>The DSM-III-R Model</td>
<td>9</td>
</tr>
<tr>
<td>The Evolutionary Model</td>
<td>16</td>
</tr>
<tr>
<td>Psychiatric Epistemology</td>
<td>21</td>
</tr>
<tr>
<td>The Sociopolitical Basis of Mental Disorder</td>
<td>24</td>
</tr>
<tr>
<td>The Antipsychiatry Movements</td>
<td>25</td>
</tr>
<tr>
<td>Szasz</td>
<td>26</td>
</tr>
<tr>
<td>Laing</td>
<td>29</td>
</tr>
<tr>
<td>Goffman</td>
<td>34</td>
</tr>
<tr>
<td>Scheff</td>
<td>38</td>
</tr>
<tr>
<td>Rosenhan</td>
<td>42</td>
</tr>
<tr>
<td>Critique</td>
<td>44</td>
</tr>
<tr>
<td>The Postmodern Movements</td>
<td>46</td>
</tr>
<tr>
<td>The social construction of mental disorder</td>
<td>47</td>
</tr>
<tr>
<td>Ideology critique</td>
<td>51</td>
</tr>
<tr>
<td>Mental disorder as the medicalization of</td>
<td></td>
</tr>
<tr>
<td>social deviance</td>
<td>55</td>
</tr>
<tr>
<td>Mental disorder as victim-blaming</td>
<td>62</td>
</tr>
<tr>
<td>Comparison of two ideology critiques</td>
<td>67</td>
</tr>
<tr>
<td>The role of mental health professionals in</td>
<td></td>
</tr>
<tr>
<td>the dissemination of mental disorder ideology</td>
<td>69</td>
</tr>
</tbody>
</table>
Mental health frameworks and sociopolitical values .................................. 72

Empirical Research ................................................................................. 75

Overview of the Present Study .............................................................. 83
  Statement of the Problem ................................................................. 83
  Research Design .............................................................................. 83
  Research Hypotheses ........................................................................ 85

II  METHOD .......................................................................................... 88
  Participants ....................................................................................... 88
  Materials ........................................................................................ 88
    Demographics Questionnaire .......................................................... 88
    Vignette Questionnaires .................................................................. 89
    Social Attitudes Scale .................................................................... 89
  Procedure ......................................................................................... 91

III  RESULTS ...................................................................................... 93
  Preliminary Analyses ........................................................................ 94
    Development of the Final Data Set and Treatment of
    Missing Values .............................................................................. 94
    Description of the Participant Sample ............................................ 95
    Examination of the Sociopolitical Values Measures ....................... 99
      Reliability ................................................................................... 99
      Relationships between sociopolitical values
      and the demographic variables .................................................... 99
      Creation of subsamples of participants with
      differing sociopolitical values ..................................................... 100
    Creation of Composite Variables .................................................... 104

  Principal Analyses .......................................................................... 106
    Hierarchical Regression Analysis: Prediction of
    Mental Disorder Ratings .................................................................. 106
    Zero-order correlations .................................................................. 107
    Creation of interaction terms ......................................................... 109
    Regression analyses ....................................................................... 109
    MD regression results summary ..................................................... 111
Hierarchical Regression Analysis: Prediction of
Mental Health Frameworks .................. 112
Zero-order correlations .................... 113
Creation of interaction terms ............ 115
Regression analyses ...................... 115
Biological factor results .................. 116
Psychological factor results ............. 118
Interpersonal/Situational factor results 121
Societal factor results .................... 121
B, P, I/S, and S regression results summary 125
Profile Analysis: Comparison of Mental Health
Frameworks for the Comparatively Liberal
and Comparatively Conservative Subsamples 127
Profile analysis results .................... 128
MHF effect contrasts ...................... 128
SAS X MHF interaction contrasts .......... 134

IV DISCUSSION ........................................ 138

Limitations of the Empirical Study ............. 138
Generalizability of the findings .......... 138
Range of sociopolitical values .......... 140
Research design ......................... 140

Were the Hypotheses Supported? ............. 142
Mental health frameworks ............... 142
Mental disorder conceptions ............ 144
Sociopolitical values and mental health
frameworks ............. 148

Integration of the Empirical Findings and the Theoretical
Treatise ............................................. 149
Endorsement of mental disorder ideology .... 150
Sociopolitical values and endorsement of
mental disorder ideology ............... 153
Significance of the study's findings .... 154

Implications and Recommendations for
Clinical Practice: A Socio-Cultural Perspective 155

Conclusion ........................................ 159

Postscript: An Explication of the Values Underlying
this Research ................................. 160
REFERENCES ................................................. 163

Appendix

A DEMOGRAPHICS QUESTIONNAIRE ....................... 184
B VIGNETTE QUESTIONNAIRES .............................. 186
C SOCIAL ATTITUDES SCALE ............................... 195
D COVER LETTER ........................................... 198
E INSTRUCTIONS .......................................... 200
F POSTCARD ................................................ 202
G MENTAL HEALTH FACTOR INTERCORRELATION
   MATRICES ............................................... 204

VITA AUCTORIS ............................................. 209
# LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Demographic Characteristics of the Sample</td>
<td>96</td>
</tr>
<tr>
<td>2</td>
<td>Demographic Variable ANOVA Summary Statistics for SAS Scores</td>
<td>101</td>
</tr>
<tr>
<td>3</td>
<td>Cronbach's Alpha Reliability Coefficients for the Mental Health Factors</td>
<td>105</td>
</tr>
<tr>
<td>4</td>
<td>Intercorrelations among MD, HELP, and SAS</td>
<td>108</td>
</tr>
<tr>
<td>5</td>
<td>Hierarchical Regression Analyses for Mental Disorder Ratings</td>
<td>110</td>
</tr>
<tr>
<td>6</td>
<td>Mental Health Factors' Correlations with MD and SAS</td>
<td>114</td>
</tr>
<tr>
<td>7</td>
<td>Hierarchical Regression Analyses for the Biological Factor</td>
<td>117</td>
</tr>
<tr>
<td>8</td>
<td>Hierarchical Regression Analyses for the Psychological Factor</td>
<td>120</td>
</tr>
<tr>
<td>9</td>
<td>Hierarchical Regression Analyses for the Interpersonal/Situational Factor</td>
<td>123</td>
</tr>
<tr>
<td>10</td>
<td>Hierarchical Regression Analyses for the Societal Factor</td>
<td>124</td>
</tr>
<tr>
<td>11</td>
<td>Profile Analysis/ANOVA Summary Statistics</td>
<td>129</td>
</tr>
<tr>
<td>12</td>
<td>Mental Health Factor Total-Composite Means and Subsample t-Test Comparisons</td>
<td>131</td>
</tr>
<tr>
<td>13</td>
<td>Within-Participants t-Test Comparisons of Mental Health Factor Total-Composite Means</td>
<td>133</td>
</tr>
</tbody>
</table>
## LIST OF FIGURES

<table>
<thead>
<tr>
<th>Figure</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>B on MD regression lines for the Comparatively Liberal and Comparatively Conservative subsamples</td>
<td>119</td>
</tr>
<tr>
<td>2</td>
<td>P on MD regression lines for the Comparatively Liberal and Comparatively Conservative subsamples</td>
<td>122</td>
</tr>
<tr>
<td>3</td>
<td>Mental health factor total-composite means for the total sample</td>
<td>132</td>
</tr>
<tr>
<td>4</td>
<td>Mental health factor total-composite means for the Comparatively Liberal and Comparatively Conservative subsamples</td>
<td>135</td>
</tr>
</tbody>
</table>
CHAPTER I
INTRODUCTION

Civilizations throughout history have witnessed members whose behaviors were considered unusual, bizarre, or irrational. The societal response to individuals exhibiting these aberrant forms of conduct has varied greatly between cultures and over different historical periods, ranging from acceptance and social integration to inhumane treatment such as incarceration, torture, and banishment from the community. With Western civilization's scientific revolution in the seventeenth and eighteenth centuries came an increase in medico-scientific explanations of human functioning and the use of medical technology as a solution to human problems. As people embraced advancing medical treatments to cure their physical ailments, aberrant behavior too came to be understood within a medical framework. Thus, what was once known as lunacy or madness became recognized as a form of mental illness or disorder. The hegemony of science and medicine in the twentieth century has solidified the use of these medically based conceptions and recent years have seen an increasing number of behavioral and emotional problems defined as evidence of mental disorder. Despite the hope brought by the medical profession to many people suffering with these afflictions, numerous theorists and clinical practitioners have expressed concern about the increasing
medicalization of daily life and have pointed to the political aims this process may serve. The purpose of the present study was to examine the relationship between mental health practitioners' sociopolitical values and their endorsement of traditional mental disorder formulations. This research was based upon a review of literature spanning the fields of medicine, psychology, sociology, philosophy and related disciplines.

Literature Review

Few issues in medicine have been as controversial as those concerning the concept of mental disorder.\(^1\) This is largely due to the elusive nature of the phenomena to which this term refers. Unlike other medical disorders for which presenting symptoms are manifest in the physical body, mental disorders involve symptoms which are primarily psychological or behavioral in nature (Spitzer & Endicott, 1978). Moreover, with the exception of the organic mental disorders, they are not clearly associated with physiological

\(^1\) To refer to psychiatric conditions which are the focus of mental health treatment, the term "mental disorder" will be employed throughout this review. This is consistent with the predominant phraseology found in the literature and with the American Psychiatric Association's (APA) official terminology (APA, 1987). The word "disorder" is utilized in terms such as "mental disorder" and "medical disorder" because it reflects the totality of a medical condition, unlike "illness" (manifest symptomatology), and does not assume a physical dysfunction, as does "disease" (pathophysiology), (Spitzer & Endicott, 1978). However, despite their somewhat divergent connotations, terms such as "mental illness," "madness," and "insanity," will be used in place of "mental disorder" in reference to texts which use these alternative labels.
pathology; in cases where a biological abnormality is suspected, it is viewed as one of many etiological components (Spitzer & Endicott). With no physical referent by which to identify mental disorder, it has been referred to as a functional illness, that is, "psychological impairment, often resulting in maladaptation, without physiological or structural pathology" (Klein, 1978, p. 49). The difficulty in formulating models which unequivocally differentiate disordered from normal functioning within the psychological realm has lead to contention over the objective status of mental disorder.

In accordance with the established tenets of psychiatry, many mental health professionals have maintained that mental disorder is an objective, scientifically grounded conception. Recent attempts to demonstrate this position are presented in the first section of this review. Critics from various sectors, however, have argued that mental disorder conceptions are far from objective. These theorists suggest, instead, that mental disorder diagnoses incorporate social values and have significant political implications. Their

---

2 The term scientific is used here and throughout the paper in the traditional sense in which scientific theory is viewed as a direct reflection of reality, uninfluenced by the values of the observer or theorist (Gergen, 1985). This usage corresponds to that found in the literature considered in the first section of this review. For example, Kendell (1986) states that "the most fundamental issue is whether disease and illness are normative concepts based on value judgments, or whether they are value-free scientific terms" (p. 25). Similarly, Wakefield (1992a) proposes that "the concept of disorder combines value and scientific components" (p. 373). The assumptions underlying this value-free philosophy of science will be examined later in this review. It is acknowledged that science in general incorporates a wide variety of paradigms, many of which do not pose a strict division between values and scientific theory. For a recent discussion of contrasting scientific paradigms, see Savage (1990).
ideas will be outlined in the second section of this review. Finally, in the third section, relevant empirical studies will be examined.

The Scientific Basis of Mental Disorder

Traditionally, mental disorder has been viewed as a scientifically based concept rooted in objective criteria (Kendell, 1986). The role of social values in psychiatric diagnosis, if recognized at all, is usually seen as secondary to scientific components (e.g., Klein, 1978; Wakefield, 1992a). In fact, mental health professionals have been quick to condemn applications of the concept which appear to be rooted in sociopolitical judgments. For instance, Western practitioners firmly denounced their colleagues in the Soviet Union over the alleged use of psychiatric treatment as punishment for political dissidents (see Bloch & Reddaway, 1984). In addition, disorders affirmed as value-laden have been removed from the psychiatric nomenclature; examples include "dрапетомания" (the diagnosis given to slaves who attempted to run away) (Cartwright, 1981), "childhood masturbation disorder" (Engelhardt, 1981), and "homosexuality" (Spitzer & Williams, 1982). The disharmony between social values and mental disorder is clearly outlined by Spitzer and Williams (1982): "An individual whose behavior brings him or her into conflict with society should not be regarded as having a mental disorder unless there is strong evidence supporting the inference of a behavioral, psychological, or biological dysfunction" (p. 21).
This section of the paper reviews literature supporting this scientific conception of psychiatric disorders. It begins with an examination of the relationship between mental disorder and the larger class "medical disorder." This is followed by an analysis of two models embodying attempts to define mental disorder within an objective framework. The first is the definition formulated by Spitzer and his colleagues (Spitzer & Endicott, 1978; Spitzer & Williams, 1982) which is presented formally in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders: Third Edition - Revised (DSM-III-R; APA, 1987), the standard reference for the classification of mental disorders in North America. The second consolidates the work of numerous theorists, all of whom incorporate evolutionary theory in their formulations (e.g., Kendell, 1975; Klein, 1978; Wakefield, 1992a). Finally, the epistemological roots of these theories will be discussed.

Mental and Medical Disorders

Although not stated in DSM-III-R, many theorists consider mental disorder to be a subset of medical disorder and on this basis justify the application of the medical model to the treatment of these conditions (e.g., Klein, 1978; Spitzer & Endicott, 1978; Spitzer & Williams, 1982). This view is corroborated by the inclusion of mental disorders in The International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM; Commission on Professional and Hospital Activities, 1978). However, with the
exception of the organic mental disorders, there is no assumption that mental conditions are biologically based. Where biological abnormalities are suspected, they are seen as forming a complex etiology along with psychological and environmental components (Spitzer & Williams, 1982). Without a clear physical cause, a myriad of theoretical models (e.g., psychodynamic, behavioral, existential) have been formulated to explain mental disorders, each outlining putative etiologies, underlying mechanisms, and associated treatments. In order to remain theoretically neutral, the classification and definition of disorders in the DSM-III-R is based solely on clinical features (symptomatology) rather than etiology (APA, 1987).

It is the specific nature of these clinical symptoms which differentiates mental conditions from other medical problems: "A mental disorder is a medical disorder whose manifestations are primarily signs or symptoms of a psychological (behavioral) nature, or if physical, can be understood only using psychological concepts" (Spitzer & Endicott, 1978, p. 18). According to Spitzer and Endicott, "psychological manifestations" include "disturbances in subjective feelings (other than physical pain), ideation, reality testing and purposeful behavior" (p. 30). Exceptions to the pairing of psychological symptoms and mental disorders occur in two categories. The first includes conditions which, though manifest physically, are considered mental disorders as they can only be understood using psychological concepts. These are the somatoform disorders and some sexual dysfunctions. Most physically manifest conditions,
however, are considered nonmental (physical) disorders even when psychological components are relevant to their etiology (e.g., asthma). The second group of exceptions consists of focal neurological impairments, such as temporal lobe epilepsy, which, though manifest psychologically, are not considered mental disorders. However, more generalized neurological deficits such as mental retardation are classified as mental disorders.

Theorists attempting to define mental disorder have tended to concentrate on defining its parent term, "medical disorder," first (e.g., Kendell, 1975, 1986; Klein, 1978; Spitzer & Endicott, 1978). Spitzer and Endicott outline three concepts they considered fundamental to the definition of medical disorder: "negative consequences", "organismic dysfunction", and an implicit "call for action" (Spitzer & Endicott, 1978). Basically, a disorder is seen as any dysfunction in the human organism leading to negative consequences which warrant the person to seek treatment and assume the "sick role." Klein (1978) suggests a remarkably similar approach: "Illness' can ... be recognized as a hybrid concept, with two necessary components; something has gone wrong involuntarily, and the results are sufficiently major to justify the sick, exempt role by a particular society" (p. 46). The involvement of social values in these conceptions has been clearly outlined by the authors. Both Spitzer and Klein acknowledge that terms such as illness and disorder are developed by humans to justify certain social practices such as the sick role and medical treatment. They also recognize that the designation of disorder is dependent upon social
and cultural values related to the desirability of a particular condition. However, they deny accusations that the concept of disorder is fundamentally rooted in social evaluations (see e.g., Sedgwick, 1982b). Both assert that only in cases where something has gone wrong with the human organism (i.e., an organismic dysfunction) is the term disorder applied. This position has been succinctly stated by Wakefield (1992a) who defines disorder as a "harmful dysfunction," wherein "harmful" is based in social values and "dysfunction" is a scientific designation.

The conceptualization of disorder as an undesirable dysfunction which invokes medical action seems relatively straightforward when applied to most physical disorders. For example, in "myocardial infarction" the heart stops pumping blood (dysfunction) causing the cessation of the blood flow and the experience of pain (undesirable negative consequences or harm), a condition which is deemed in need of medical attention by society (call for action). However, the inference of dysfunction is based on prior knowledge of correct functioning. As Moore (1978) points out, there is more widespread agreement regarding the appropriate functions of the body's physical structures than of its mental or psychological processes. It is for this reason that diagnoses of mental disorder are frequently implicated as moral value-judgments (e.g., Szasz, 1961). Numerous theorists have nevertheless argued that mental disorders are the result of organismic dysfunction, and thus, conclude that there is a scientific basis to psychiatric diagnosis (e.g., Kendell, 1975;
Klein, 1978; Liggio, 1980; Spitzer & Endicott, 1978; Spitzer & Williams, 1982; Wakefield, 1992a). According to these theorists, the dysfunction component not only provides a value-free criterion for mental disorder but also forms the basis for differentiating these conditions from nondisordered negative reactions such as bereavement. However, diverging attempts to demonstrate evidence of dysfunction in psychiatric disorders have given rise to significant debate. In the following two sections, two models are outlined in which theorists have attempted to define mental disorder objectively on the basis of a value-free conception of psychiatric dysfunction.

The DSM-III-R Model

Surprisingly, an official definition of mental disorder was not formulated until 1980 when the APA published the third edition of the Diagnostic and Statistical Manual of Mental Disorders, commonly referred to as DSM-III. Earlier compendiums of mental disorders, such as the DSM-II (APA, 1968) and the World Health Organization’s Glossary of Mental Disorders (WHO, 1978), did not defined the phenomena included within their classification systems. It has been suggested, therefore, that psychiatric nomenclature represents the classification of "problems psychiatrists treat" rather than of theoretically derived disorder entities (Kendell, 1986; Klein, 1978). Yet, not all human problems attended to by psychiatrists are considered mental disorders (Wakefield, 1992a). Conditions meriting psychiatric attention
but not attributable to a mental disorder, such as "uncomplicated bereavement" and "occupational problem," are listed under "V codes" in DSM-III and its revised edition DSM-III-R (APA, 1987). It seems that, although formal conceptions of mental disorder did not guide the development of initial psychiatric classification systems, an implicit understanding of the nature of these disorders played an important role.

Attempts to provide an official definition of mental disorder for the APA arose due to controversy over the inclusion of homosexuality in the DSM-II (Spitzer & Endicott, 1978; Spitzer & Williams, 1982; see also Bayer, 1981). In order to determine if homosexuality was a mental disorder, members of the APA's Task Force on Nomenclature and Statistics were forced to consider the meaning of the term "mental disorder" itself and to delineate its boundaries. Robert Spitzer, a junior member of the Task Force, proposed that "subjective distress or generalized impairment in social effectiveness" (Spitzer & Williams, 1982, p.16) be considered as inclusionary criteria. On the basis of this guideline, homosexuality was replaced by "sexual orientation disturbance," a category for individuals who are dissatisfied with their homosexuality\(^3\), for the seventh printing of DSM-II. As work on the creation of DSM-III began,

\(^3\) Spitzer and Williams (1982) reserve the diagnosis sexual orientation disturbance for "individuals whose sexual interests are directed primarily toward people of the same sex and who are either disturbed by, in conflict with, or wish to change their sexual orientation" (p. 17). Interestingly, they do not consider the possibility that an individual may be dissatisfied with his or her heterosexuality or bisexuality.
these criteria proved insufficient for guiding decisions regarding the appropriateness of conditions for inclusion in the nomenclature (Spitzer & Endicott, 1978; Spitzer & Williams, 1982). Spitzer, who chaired the work groups formed to develop both DSM-III and DSM-III-R, strived to establish a comprehensive yet precise definition of mental disorder that would be accepted as a standard by the psychiatric profession. He and his colleagues were largely responsible for the development of the definition introduced as a formal part of DSM-III and the updated version presented in DSM-III-R. The most current definition states:

In DSM-III-R each of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in a person and that is associated with present distress (a painful symptom) or disability (impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable response to a particular event, e.g., the death of a loved one. Whatever its original cause, it must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the person. Neither deviant behavior, e.g., political, religious, or sexual, nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the person, as described above. (p. xxii)

Spitzer’s three components of medical disorder discussed above (i.e., "negative consequences," "organismic dysfunction," and "call for action"; Spitzer & Endicott, 1978), form the basis of the DSM-III-R definition presented here. The potential negative consequences are listed as: "distress," "disability," and "risk of suffering death, pain, disability, or an important loss of freedom." The
phrase "clinically significant" indicates that these consequences must be serious enough that they require clinical attention (Spitzer & Williams, 1982), capturing the notion that a "call for action" must be invoked. That the consequences must be due to an organismic dysfunction in order for the problem to constitute a mental disorder is plainly stated: "Whatever its original cause, it must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the person." Finally, "behavioral or psychological syndrome or pattern" distinguishes mental disorders from nonmental medical conditions. The remaining parts of the definition merely clarify these key elements by limiting their application. The phrase "in a person" restricts mental disorder to disordered functioning occurring within individuals rather than within interpersonal systems such as families (Spitzer & Williams, 1982). The second sentence ("must not be an expectable response to a particular event") represents an attempt to ensure that the undesirable consequences are the result of a dysfunction, by ruling out normal responses to external stimuli (Wakefield, 1992b). The final sentence ("neither deviant behavior ... nor conflicts that are primarily between the individual and society are mental disorders") was included to insure that value judgments do not lead to the misrepresentation of social deviance as mental disorder (Spitzer & Williams, 1982).

As previously discussed, the key to establishing mental disorder as scientifically based is in demonstrating that it is the result of an organismic
dysfunction, thus grounding it in an objective criterion. Spitzer does this explicitly by stating that a mental disorder must be "a manifestation of a ... dysfunction in the person." But declaring that the disorder must be due to a dysfunction in a person does little to clarify how such a dysfunction can be recognized; nor does stipulating that disorders are not the result of "deviant behavior" or a "conflict ... between the individual and society" illuminate how such distinctions are to be made (Wakefield, 1992b). In a detailed critique of the DSM-III-R definition, Wakefield (1992b) suggests that its operationalization of dysfunction involves only two components: the clinical features of the disorder, or its "negative consequences," and the qualification that these consequences "must not be an expectable response to a particular event."

Thus, according to Wakefield's interpretation, the DSM-III-R indicates that dysfunction can be inferred when a psychological condition incorporates "statistically unexpectable distress or disability" (1992b, p. 238).

From Wakefield's perspective (1992b), this criterion fails to distinguish mental disorders from nondisordered psychological conditions and thus is an inadequate operational definition of dysfunction. He points to numerous nondisordered psychological reactions involving distress or disability which are unexpectable in either kind or intensity; for example, the DSM-III-R classifies unusual or extreme academic, occupational, and interpersonal problems as "conditions not attributable to a mental disorder" (APA, 1987,
p. 359). Alternatively, he highlights many conditions included as disorders in DSM-III-R which can be considered expectable responses to highly stressful circumstances (e.g., post traumatic stress disorder). Wakefield further submits that the application of this operational definition to specific disorders has led to the development of invalid diagnostic criteria. He cites the DSM-III-R classifications "adjustment disorder" and "oppositional defiant disorder" as examples. A diagnosis of adjustment disorder can be made if "a reaction to an identifiable psychosocial stressor [involves] symptoms that are in excess of a normal and expectable reaction to the stressor(s)" (APA, 1987, p. 330).

Oppositional defiant disorder is indicated in children who display five of a number of specific oppositional behaviors (e.g., "often loses temper," "often argues with adults"), but only if each "behavior is considerably more frequent than that of most people of the same mental age" (APA, 1987, p. 57). In both cases, the diagnosis of disorder is based upon the statistical frequency of symptoms or behaviors in the population. Wakefield claims that Spitzer confuses normal variation with dysfunction and in doing so misclassifies many statistically unexpected yet normal reactions as disordered.

Clearly, statistical deviance or abnormality is a poor indicator of dysfunction. There is no implication that something has gone wrong simply because psychological functioning is rare or unusual, nor is infrequency necessary for the assignment of dysfunction (Klein, 1978; Macklin, 1981). On the contrary, some epidemiological research has demonstrated that mental
disorder symptoms are, in fact, highly prevalent in the general population (see Srole et al., 1975). More to the point, the criterion of unexpectability entails the application of cultural norms regarding the frequency of particular responses to environmental phenomena (Macklin, 1981). A definition of disorder which is operationalized in terms of cultural norms rests, not upon objective scientific criteria, but rather on social values.

An alternative strategy for defining dysfunction in operational terms is presented by Spitzer in an earlier publication (Spitzer & Endicott, 1978). Here he stipulates that an organismic dysfunction can be inferred from negative consequences if the following conditions are met:

1. Simple informative or standard educational procedures do not lead to a reversal of the condition.
2. Nontechnical interventions do not bring about a quick reversal of the condition. (p. 27)

These criteria are intended to exclude cases where abnormal functioning is due to a lack of information or adverse environmental circumstances. But, as Moore (1978) explains, "simple informative or standard educational procedures" and "nontechnical interventions" essentially represent nonmedical procedures. Accordingly, Spitzer's model seems to suggest that mental disorders are those psychological conditions which can only be treated with medical (i.e., psychiatric) interventions - a worthless tautology, for the interventions themselves depend upon the disorders they treat for their definition.
In summary, Spitzer and his colleagues have failed to provide unequivocal guidelines for the recognition of mental disorder. The DSM-III-R definition defines dysfunction in terms of statistical deviance, thereby requiring the application of cultural norms. Spitzer's alternative formulation, based on the nature of the interventions required to reverse the condition, adds little to the statistical deviance model due to its circularity. It appears that the DSM-III-R definition, though explicitly rooted in the notion of dysfunction, is not unequivocally grounded in objective, value-free criteria.

The Evolutionary Model

One author notes that problems in providing an objective definition of mental disorder are fundamentally due to "the absence of an overall scientific theory on which to base conceptions of health and illness" (Macklin, 1981, p. 409). A number of theorists have proposed that evolutionary biology provides such a theory and have attempted to define disorder within an evolutionary framework. According to the theory of evolution, over the course of many generations, hereditable biological variations that enhance an organism's ability to survive and reproduce in a particular environment become more prevalent through the process of natural selection. From this view, the existing physiological and psychological mechanisms in the human species have been retained due to their specific adaptive functions. Although there has been significant contention within the mental health field over the assignment of
specific functions to psychological processes, the theory of evolution is touted by some theorists as a value-free guideline by which a mechanism's "natural function" can be determined (e.g., Wakefield, 1992a).

Scadding (1967, 1990) first advanced the idea that in order for abnormal functioning to be considered a disease, it must place the organism at a "biological disadvantage." Kendell (1975, 1986) interprets Scadding's model within a narrow conception of evolutionary theory and proposes that only those conditions which interfere with the primary functions of survival and reproduction should be diagnosed as disordered. When applied to mental disorders, these criteria identify severe psychiatric conditions (e.g., schizophrenia) as disordered but exclude many less debilitating states (e.g., anxiety disorders) which do not directly reduce life expectancy or fertility. Thus, some authors consider Kendell's approach to be too restrictive (e.g., Klein, 1978; Spitzer & Endicott, 1978; Wakefield, 1992a). Furthermore, as the ability to survive and reproduce are dependent upon circumstances in the physical and social environment, Kendell's criteria are culturally relative. Both Kendell and Scadding have been criticized for determining normal versus disordered functioning on the basis of reproductive fitness in current surroundings: "The fact that the organism's mechanisms were originally selected because they increased longevity and fertility in a past environment does not imply that some mechanism is malfunctioning when longevity and fertility decrease in the present environment" (Wakefield, 1992a, p. 379).
Klein (1978) and Wakefield (1992a) also applied evolutionary theory to the analysis of dysfunction in two highly similar formulations of mental disorder. However, unlike Scadding and Kendell, they conceptualize dysfunction as the impairment of evolved functions, rather than as interference with current reproductive fitness. According to their models, an organismic dysfunction in the mental realm is recognized when a psychological mechanism fails to perform its natural function which evolved through the process of natural selection. Their conceptions also include a value component; a disorder is not diagnosed unless society determines that the dysfunction is undesirable and sufficiently serious to require clinical attention.

Klein (1978) defines disease as "covert, objective, suboptimal part dysfunction, recognizing that functions are evolved and hierarchically organized" (p. 70). Within his formulation, illness is ascribed to disease when the clinical manifestations are judged by society to warrant the sick role. Mental illness is defined as "the subset of all illness that presents evidence in the cognitive, behavioral, affective, and motivational aspects of organismal functioning" (p. 70). Klein augments these definitions by outlining the application of evolutionary theory to the assessment of "suboptimal part dysfunction." He suggests that gross impairments in specific psychological mechanisms (e.g., perception, memory, thinking, and motivation) can be easily recognized as their functions have a clear evolutionary role. For example, the illogical thought processes characteristic of schizophrenia would constitute
evidence of a dysfunction, according to Klein's model, as they represent the failure of the naturally selected function "deductive thinking." The natural functions of more complex mechanisms, though more difficult to assign, can also be recognized by their evolutionary value. For example, the pleasure-pain mechanism (i.e., the tendency to seek pleasure and avoid pain) has an obvious adaptive function; behavior which is in opposition to this mechanism, such as self-mutilation, can be seen within Klein's formulation as constituting evidence of dysfunction. But the determination of dysfunction is not always this clear. Thus, Klein proposes numerous criteria for the recognition of "suboptimal part dysfunction" in the psychological realm, examples of which are listed below:

- Syndromal clarity.
- Endogenous course.
- Resists self-instruction.
- Resists negative consequences and cannot be markedly modified by positive rewards.
- Distress intrinsic to condition rather than secondary unhappy reaction to misfit with environment.
- Behavior markedly inflexible. (pp. 54-55)

Although these criteria may represent useful guidelines for the differentiation of dysfunction from normal functioning, they do not provide an objective, value-free basis for such discriminations. Phrases such as "syndromal clarity," "endogenous course," and "markedly inflexible" are not expressed in operational terms and thus, themselves, require judgments which may be controversial.

Wakefield's (1992a) conception of mental disorder differs from Klein's (1978) primarily in his rejection of the term "suboptimal" in reference to
dysfunction. He suggests that Klein's terminology incorrectly designates as disordered any functioning which is less than ideal. The conceptualization offered by Wakefield (1992a) is as follows:

A condition is a mental disorder if and only if (a) the condition causes some harm or deprivation of benefit to the person as judged by the standards of the person's culture ... and (b) the condition results from the inability of some mental mechanism to perform its natural function, wherein a natural function is an effect that is part of the evolutionary explanation of the existence and structure of the mental mechanism. (p. 385)

Yet, unlike Klein's formulation of mental disorder, Wakefield's definition stands on its own. His emphasis on theoretical analysis ignores the need for specific criteria by which dysfunction (impairment of evolved function), and thus mental disorder, can be recognized.

Overall, the evolutionary model, like the DSM-III-R approach, does not provide a definitive formulation of mental disorder. Kendell (1975) defines dysfunction on the basis of adaptation to the current environment, thus leaving his formulation dependent upon cultural values. Alternatively, Klein (1978) and Wakefield (1992a) define dysfunction as impairment of evolved functions; yet these authors do not furnish operationalized criteria for the recognition of such impairments. Nevertheless, these evolutionary-based mental disorder formulations represent a diligent effort to ground psychiatric diagnoses in objective, scientific terms. Theorists endorsing these conceptions acknowledge the shortcomings of their definitions, but contend that more precise criteria for the identification of dysfunction, and consequently mental disorder, will
eventually be substantiated as further research uncovers the hidden mysteries of our evolutionary history. Klein (1978) states, "As our grasp of evolutionary development deepens, more precise and detailed norms will be possible, thus modifying our specific criteria for dysfunction" (p. 69). Similarly, Wakefield (1992a) concludes, "As we learn more about the naturally selected functions of mental mechanisms, our judgments about dysfunction will become correspondingly more confident" (p. 383). Though the quest for greater objectivity continues, these authors are confident that one goal has been achieved: the scientific basis of mental disorder has been established. They offer their theoretical formulations as a testimony to radical critics who have proclaimed that sociopolitical values underlie psychiatric diagnosis. Wakefield concludes from his analysis, "Dysfunction is thus a purely factual scientific concept" (p. 383) and in reference to his own treatise, Klein declares, "I believe that the principles stipulated above are reasonably ideology-free" (p. 69).

Psychiatric Epistemology

The models presented thus far offer various theoretical rationales outlining the putative objective basis of the concept mental disorder. Although the routes they take diverge, their intentions are the same: to improve the accuracy of psychiatric classification, to discredit accusations that mental disorder conceptions are sociopolitical constructs, and to justify the continued application of medico-scientific methods to the study and treatment of
psychiatric disturbance. Theorists working toward these aims share the belief that mental disorder conceptions reflect real entities or processes which exist in humans independent of the labels we assign to them (Sedgwick, 1982b). They do not necessarily see current conceptualizations as definitive, but maintain that advances in medical science will lead to increasingly accurate approximations of mental disorder's true nature (e.g., Klein, 1978; Wakefield, 1992a).

These medical models and the beliefs upon which they are based adhere to the doctrines of a particular epistemological perspective: logical positivism. The positivist paradigm represents a set of principles or assumptions about the acquisition of knowledge which forms the basis of scientific enquiry in the human sciences. According to the positivist model: (1) The scientific method of the natural sciences can be applied to the study of human and social phenomena. The underlying assumption is that human beings are not sufficiently different from physical objects to require a unique methodology for their analysis. (2) Facts and the scientific knowledge they engender are value free. (3) The scientific investigator is a dispassionate observer, able to study phenomena objectively. (4) Theoretical contention within science can be resolved through the accumulation of facts. Therefore, shifts in scientific knowledge represent the progression toward increasingly accurate reflections of reality (Howard, 1985; Ingleby, 1980; Jones, 1986; O'Donohue, 1989;
Roffe, 1986; Sedgwick, 1982b). One of the consequences of positivism is the promotion of technological solutions to address problems that are social in nature (Roffe, 1986). This can be clearly seen in the application of psychiatric medicine and the techniques of other mental health disciplines in the treatment of psychological distress.

The positivist paradigm has been sharply criticized for denying the role of values in scientific enquiry. Selecting a particular epistemological paradigm for the investigation of knowledge is in itself a value-based decision. In addition, the principles which form the foundation of an epistemological position are not objective guidelines but rather epistemic values (Howard, 1985). Positivism, through its separation of facts and values, propagates the view that human and social problems can and should be resolved through scientific methods rather than social or political action. Furthermore, by conceptualizing human and social phenomena as facts, positivism implicitly reifies the existing social order and discourages social change (Roffe, 1986). As Jones (1986) states, "value-freedom involves a misguided theory of knowledge insofar as knowledge is always achieved within a certain world-view which has a particular interest in a problem" (p. 248).

Of course, the mental health establishment does vary in its allegiance to a positivist philosophy of science; yet its alternative paradigms, like the

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4 For more detailed considerations of positivist epistemology, see Tolman (1992) and Polkinghorne (1983).
predominant models currently employed in most of the sciences, move little beyond positivism’s fundamental tenets. In recent years, scientists have tended to acknowledge the inevitability of an interaction between themselves and the phenomena they observe, but nevertheless have continued to uphold objectivity as an ideal, which can be successfully approached through striving to remain as neutral as possible toward objects of study and by acknowledging one’s biases. Though scientific knowledge may not be seen as entirely value-free, that is, as reflecting a one-to-one relationship with reality, most scientists still subscribe to a realist doctrine suggesting that there is a reality, driven by natural laws, which exists as separate from the observer; scientific knowledge is seen as at least an approximation of such a reality (Guba, 1990).

The Sociopolitical Basis of Mental Disorder

Over the past three decades, a vast body of literature has been devoted to the critique of positivist conceptions of mental disorder. Central to the writings of most critics is the rejection of the positivist claim that mental disorder is fundamentally an objective and scientific concept. The theorists advancing this assault on positivist psychiatry come from diverse backgrounds. Some are mental health clinicians disillusioned with the practices of their profession; others are theorists and researchers from a variety of disciplines, such as psychology, sociology, and philosophy, whose approaches to the study of human functioning and social systems afford unique insight into the
understanding of psychiatric phenomena. Far from representing a unified position, this varied group of writers propose an assortment of distinct and at times conflicting perspectives. Nevertheless, some similar themes have emerged from their work, the most salient being the contention that mental disorder conceptions are ultimately based in social values and thus serve a political function. Unlike positivists who have condemned the infiltration of sociopolitical biases in psychiatric diagnosis, these authors have pointed to the sociopolitical foundations of the mental disorder concept itself. This section of the paper reviews the work of theorists who have concentrated on this highly controversial line of thought. Two areas will be examined: the highly acclaimed, yet controversial, writings of the initial protesters, commonly referred to as "antipsychiatrists," and the sophisticated critiques of theorists associated with the movements of "postmodernism."

The Antipsychiatry Movement:

The seeds of dissent against positivist psychiatry emerged in the 1960s alongside cries for widespread social change which were to mark this period as a time of significant political turbulence. The pioneers of political critique in the mental health field arose quite independently from each other, yet, due to similarities in their work, were quickly grouped together by their readership and collectively labelled "antipsychiatrists." Noted for their scathing critiques of the prejudices and injustices imposed upon mental patients, these theorists
gained a large following among both laypersons and professionals in the mental health field. Despite similarities, however, each writer offers a markedly unique contribution to this movement. The views of psychiatrists Thomas Szasz and R.D. Laing, the two most prominent antipsychiatrists, are examined first. Following, are reviews of the ideas proposed by sociologists Erving Goffman and Thomas Scheff. Lastly, a discussion of the participant-observer research conducted by psychologist David Rosenhan is presented.

Szasz. Since the publication of his paper "The Myth of Mental Illness" in 1960 and a book by the same name a year later (Szasz, 1961), Thomas Szasz has been renowned for his declaration that mental illnesses do not exist. From the sixties to the present day, Szasz has produced numerous books and hundreds of articles (e.g., Szasz, 1963, 1970, 1974, 1975, 1981, 1987, 1989; see also Miller, 1983) expounding variants of this theme. He maintains that the terms "illness" and "disease" appropriately refer to human conditions involving physical abnormalities in the body. But as no such deviations are present in mental illnesses, he proposes that application of the term "illness" to mental phenomena is merely metaphoric. Rather than representing true medical conditions, mental illnesses are simply "problems in living" and thus reflect the "economic, moral, social, and political problems" (1975, p. 220) which are a part of daily life. Hence, mental illness occurs in a social and ethical context; mental symptoms are deviations from social norms; psychiatric diagnoses are nothing more than thinly disguised value judgments imposed upon socially
undesirable behaviors. To Szasz, the psychiatric establishment is an agent of social control: deviants are diagnosed as "ill" and their unacceptable behaviors are "cured" through socially sanctioned "treatments." Drawing a parallel between religious persecution for various blasphemies and psychiatric treatment for the numerous behaviors now recognized as symptoms of mental illness, he suggests that over the past two hundred years psychiatry has come to replace religion as a justification for controlling deviant members of the population (1987).

Szasz is particularly concerned with losses of liberty, dignity, and responsibility incurred by patients as a result of mental illness diagnoses and their associated treatments. Many of his writings address the two psychiatric functions which most directly interfere with the delicate balance of these values: involuntary mental hospitalization and the insanity defense. According to Szasz, persons committed to psychiatric hospitals not only lose the right to leave the hospital but in addition lose many of their civil rights and suffer serious personal indignities:

They may be declared incompetent to manage their persons and assets; may lose the right to vote, drive a car, or practice their profession; may be subjected to the most brutal and injurious acts called psychiatric treatments - imaginable to modern man; and are permanently stigmatized as "ex-mental patients." (1975, p. 218)

He condemns compulsory psychiatric treatment even when imposed for the purposes of suicide prevention (1989) and also opposes voluntary mental hospitalization, which he maintains is still coercive due to the ever-present
threat of commitment (1975). Szasz, however, defends the legitimacy of outpatient psychiatric practices performed on a contractual basis between "consenting adults" (1987) and is himself a psychotherapist (see 1965). With respect to the insanity defense, Szasz rebukes psychiatry for using mythical diagnoses to allow criminal defendants to escape responsibility for their actions (e.g., 1980). Not only does psychiatry take away the freedom of innocent people, it also excuses the guilty.

Defenders of mainstream psychiatry dismissed these arguments as, what one writer called, "the myths of Thomas Szasz" (Kubie, 1974; see also Murphy, 1982; Pies, 1979; Schoenfeld, 1976; Stone, 1973). But to many disturbed by the practices of the mental health system, Szasz was the illustrious vanguard of an emancipatory movement pitted against the bastions of a repressive psychiatry. His glorification of individual freedom and condemnation of human rights violations earned him acclaim as a revolutionary in the anti-authoritarian, anti-establishment spirit which swept through the United States in the sixties (Clare, 1976a). Yet a detailed reading of Szasz suggests that his views, far from representing a social revolutionist position, are more reflective of extreme right-wing individualism (Sedgwick, 1982b). One critic suggests that Szasz is characteristically "American" with his "sturdy endorsement of the good capitalistic virtues of independence and self-improvement and ... stern disapproval of personal failure" (Clare, 1976a, p. 28). Beyond his attacks on psychiatry, Szasz offers no "subversive critique" of broad societal systems
(Sedgwick, 1982b). Furthermore, his advocacy on behalf of the mentally ill seems based more in his valuation of individual liberty than in any compassion for such persons. In fact, his writings reveal a contemptuous view of mental patients who he describes as "incompetent, destructive, and self destructive persons [who] wallow in their self-contempt and contempt of others" (Szasz, 1976, p. 83). Szasz’s political position is also evident in his endorsement of private psychiatric practice and rejection of socially funded care (see 1976). Clearly, Szasz’s ideas are rooted in a conservative philosophy: mental patients are not sick; they are merely irresponsible malcontents who should be left alone unless they break the law, in which case they should be punished just as any other member of society.

**Laing.** At the opposite end of the political spectrum from Szasz is the British antipsychiatrist R. D. Laing who, together with colleagues David Cooper (1967, 1970) and Aaron Esterson (1970; Laing & Esterson, 1964), developed a social phenomenological approach to the study of schizophrenia. Laing’s attempts to understand psychosis by entering the experiential world of the schizophrenic evolved through the sixties and are presented in numerous books, the most noted including *The Divided Self* (1960), *Self and Others* (1969), *Sanity, Madness, and the Family* (Laing & Esterson, 1964), *The Politics of Experience* (1967), and *The Politics of the Family and Other Essays* (1971). In these works, Laing suggests that the medical model’s view of schizophrenia as an illness denies the validity of the schizophrenic’s experience and ignores
the social context in which that experience occurs. The context to which he directs the reader is society itself, particularly the capitalist-bourgeois society of the Western world. According to Laing, the process of socialization in any society is a highly repressive form of control in which individuals are taught from birth to experience themselves and others in ways which reflect a particular view of reality, one that justifies and supports existing social structures. What we call "normality" is achieved through a series of destructive actions on experience, such as repression, denial, and projection, leaving individuals alienated from their authentic selves and thus bereft of their humanity. Furthermore, as deeds lead from experience, our current state of alienation is responsible for the inhumane actions which pervade present day society:

In the last fifty years, we human beings have slaughtered by our own hands coming on for one hundred million of our species. We all live under constant threat of total annihilation. We seem to seek death and destruction as much as life and happiness.... Only by the most outrageous violation of ourselves have we achieved our capacity to live in relative adjustment to a civilization apparently driven to its own destruction.... If we can stop destroying ourselves we may stop destroying others. (1967, p. 49)

Laing's incriminations are particularly focused on the family unit, society's primary instrument of socialization, for it is here, he believes, that the process of alienation most profoundly occurs. To Laing, the family is a repressive social institution which cleverly masquerades its assaults on experience as acts of love. However, he suggests that the families of
schizophrenics are distinguished by the highly paradoxical nature of the messages communicated between members. Thus, the disturbed communication evidenced in schizophrenia, in fact, reflects the contradictory interactional patterns of the schizophrenic's family of origin. The pre-psychotic individual is placed by the family in a "double-bind" (see Bateson, Jackson, Haley, & Weakland, 1956), an unresolvable interpersonal position, which is particularly destructive of the self and leaves the victim unable to rest in a normal, albeit alienated, state of being. Succinctly stated by Laing, "the experience and behavior that gets labelled schizophrenic is a special strategy that a person invents in order to live in an unlivable situation" (1967, pp. 78-79). Unable to maintain a sense of interpersonal identity, the schizophrenic escapes from the oppressive family system into his or her "inner" world, the realm of experience from which most members of society have been alienated. Therefore, to Laing, not only is psychosis an escape, it can also be a liberating experience leading to a more healthy, authentic self, a state of " hypersanity." He parallels the process of psychosis with the ego-shedding transcendental experiences described in most religious philosophies. The disturbing thoughts, feelings, and behaviors (or symptoms) which accompany the inward focus of schizophrenics are simply due to confusion, fear, and an inability to comprehend the loss of ego in a society from which such experiences have long since been banished.
Laing suggests that instead of submitting schizophrenics to the repressive degradations of traditional psychiatric treatment, they should be encouraged to follow the course of their psychosis: "This voyage is not what we need to be cured of, but ... is itself a natural way of healing our own appalling state of alienation called normality" (1967, p. 116). Furthermore, he hypothesized that if schizophrenics were allowed to progress freely through this experiential journey, it would eventually lead them back to a place where they could again engage in the interactions of societal life. In 1965, Laing put his theories into action with the development of Kingsley Hall, a residential centre for schizophrenics in which residents were given support to experience their psychoses without the burden of traditional forms of treatment (Mannoni, 1973). In this home, staff-patient roles were abandoned and almost no institutional rules or procedures were established. The inhabitants were left to live as they chose and no interference was imposed on even the most extreme psychotic behaviors (e.g., prolonged catatonia). Some inhabitants, such as the famed Mary Barnes, had dramatic recoveries during their residency at Kingsley Hall, though in the majority of cases the experiment's results were less striking. According to Laing:

People came and stayed there and left again, and didn’t seem to be any better or worse for not being treated in the usual way. It certainly showed it was feasible for people who are supposed not to be able to live in any other context and then are locked in a ward in a mental hospital, they [sic] lived in an ordinary neighbourhood. (Marcuse, 1989, pp. 20-21)
Despite the inconclusive outcome of the Kingsley Hall project, Laing’s work played a crucial role in opening the doors of psychiatry to the experiential world of the schizophrenic. Many clinicians have since abandoned purely objective approaches to the treatment of psychosis (e.g., biochemical, behavioral) and have come to understand the meaning of the communications they once perceived as mere symptoms.

With his condemnation of the social establishment and endorsement of esoteric religious ideals, Laing has both been hailed as a spokesperson for the Left and honoured as a spiritual guru (Antonio, 1973; Davis, 1976). But, to supporters of traditional psychiatry, his glorification of psychosis was a deplorable travesty, which disregarded the suffering experienced by schizophrenics and their families and denied the help available to them through psychiatric treatment (e.g., Clare, 1976a). Furthermore, as disconfirmation of Laing’s theories, Sedgwick (1982a) submits that the distinctiveness of schizophrenics’ familial communication patterns has not been confirmed and the “enlightening” advantages of psychotic experiences have rarely been documented. Szasz (1976), shedding the “antipsychiatrist” label which paired him with Laing, denounces the radical anti-capitalist basis of his theories, suggesting that “as the communists seek to raise the poor above the rich, so the antipsychiatrists seek to raise the ‘insane’ above the ‘sane’” (p. 49). However, other critics of positivist psychiatry have maintained that, as a revolutionary social critique, Laing’s views are not radical enough. In his
analysis of social context, for example, Laing limits his focus to the family, which he frames as a wilful social oppressor, rather than as a fellow victim of oppression in the broader social realm (Jacoby, 1973; Kanter, 1974). In addition, his idealization of some authentic or true self existing outside the context of interpersonal relationships is based in an essentially asocial, individualistic view of human nature which devalues all socialized aspects of human existence and proposes a highly suspect form of consciousness unmediated by social symbols (Kanter, 1974). Finally, in Laing’s writings the dehumanized social reality he so adeptly describes is viewed as an ahistorical, unchangeable given from which spiritual liberation is the only escape. This inherently positivistic framework denies the dynamic quality of social process and the importance of political action to bring about social change; mysticism may relieve one of psychic oppression, but does nothing to alter oppressive social structures (Jacoby, 1973).

Goffman. During the 1950s, sociologist Erving Goffman conducted several studies in which he observed the ward behavior of mental patients in psychiatric hospitals. His research led to a series of essays on the institutional life of psychiatric patients and inmates of other closed social establishments such as prisons, orphanages, boarding schools, and monasteries. In 1961, these papers were compiled in the book Asylums: Essays on the Social Situation of Mental Patients and Other Inmates, an eloquent work marking Goffman’s arrival on the antipsychiatric front. In this treatise, Goffman outlines the
process by which the mental patient’s “self” is stripped away and subsequently reconstituted by the institutional context. Psychiatry’s inhumane and degrading assaults on the self are explicated in intricate detail:

The new inpatient finds himself cleanly stripped of many of his accustomed affirmations, satisfactions, and defenses, and is subjected to a rather full set of mortifying experiences: restriction of free movement, communal living, diffuse authority of a whole echelon of people, and so on. (p. 148)

In addition, patients are subjected to personal defacement in the loss of their possessions, often including cosmetic and clothing supplies that constitute their “identity kit”; their physical integrity is threatened with shock therapy, psychosurgery, and even beatings; their private thoughts and feelings are exposed to others through interviews and therapy sessions; overall, their right to self-determination is removed through judgmental and punitive authoritarian control. Furthermore, these abasements of self are framed as necessary medical treatments. Complaints or objections from patients are not considered informative statements, but instead are interpreted as symptoms of their illnesses; submission to the hospital’s regime is viewed as a sign of health.

Goffman suggests that as the mental patient’s new self emerges, it reflects the institutional arrangement in which she or he exists: "The self in this sense is not a property of the person to whom it is attributed, but dwells rather in the pattern of social control that is exerted in connection with the person by himself and those around him" (p. 168). The "crazy" or "sick"
behaviors of mental patients are attributed by Goffman, not to mental illness, but rather to the dehumanizing context of the mental hospital itself. In addition, he sees the prehospital behaviors which lead to admission as "merely a temporary emotional upset in a stressful situation" (p. 132). Thus, even outside the hospital, symptoms of mental illness are inseparable from the interpersonal environment in which they occur. Furthermore, as the number of supposedly mentally ill individuals outside hospitals probably surpasses hospitalized mental patients, it is social contingencies, such as socioeconomic status and visibility of the offense (or symptom), not the illness per se, which leads to hospitalization. This innovative sociological analysis eventually leads Goffman to a Szaszian-like position in which the politically based concept of mental illness is contrasted with an apolitical conception of physical illness:

Ordinarily the pathology which first draws attention to the patient's condition is conduct that is "inappropriate in the situation".... Since inappropriate behavior is typically behavior that someone does not like and finds extremely troublesome, decisions concerning it tend to be political, in the sense of expressing the special interests of some particular faction or person rather than interests that can be said to be above the concerns of any particular grouping, as in the case of physical pathology. (pp. 363-364)

In a later publication, Goffman (1969) clearly implicates mental illness as a form of social deviance. Psychiatric symptoms are described as "wilful situational improprieties ... [which] constitute evidence that the individual is not prepared to keep his place" (p. 368). As expressions of opposition to one's social role, these symptoms reflect "alienation, rebellion, insolence,
untrustworthiness, hostility, apathy, importunement, intrusiveness, and so forth" (p. 386). The medical model, which frames these communications as a sign of individual malfunction, as opposed to interpersonal disturbance, misses their significant social meanings. Yet, Goffman does not specifically find fault with the psychiatric profession for the diagnosis and institutionalization of these troubled individuals, as does Szasz. Instead, he posits blame in the societal demand for psychiatric institutional care and, as he sees little chance of a shift in public opinion, offers no alternative to the system he so fiercely condemns.

Though praised for his insightful analysis of psychiatric asylums, Goffman has been sharply criticized for attributing all symptoms of mental illness to the institutional context (Davis, 1972; Sedgwick, 1982a). Moreover, his work has been denounced for its fatalistic view toward the possibility of institutional reform (Sedgwick, 1982a). Sedgwick cites shifts in social policy, such as the community mental health reforms which occurred shortly after Goffman's fieldwork, as refutations of Goffman's pessimism. These policy revisions led to greater utilization of outpatient treatment and brief hospitalization. Thus, while many of Goffman's insights into institutional life and the origins of mental illness are still relevant to hospitalized mental patients today, much of the system he once saw as unchangeable has since been drastically reformed.
Scheff. During the 1960s, the field of sociology witnessed the emergence of labelling theory as a prominent approach to the study of deviance (e.g., Becker, 1976; Erikson, 1962; Kitsuse, 1962). In opposition to theories which conceptualize deviance as a characteristic inherent in particular behaviors, this model focuses on the process by which members of the population come to be defined as deviant by society. Thomas Scheff is noted for his detailed application of labelling theory to the study of psychiatric phenomena. In his book *Being Mentally Ill: A Sociological Theory* (1966) and various articles (e.g., 1974, 1976), Scheff outlines his thesis that mental illness is a social role conferred upon individuals through the process of labelling. In Scheff's formulation, psychiatric symptoms represent violations of social norms. However, unlike offenses against explicit norms of social conduct, which lead to conventional designations such as "impolite," "sinful," or "criminal," it is abrogations of implicit social understandings which come to be regarded as signs of psychiatric disturbance. These tacit "residual rules" reflect culturally based assumptions about reality and thus are taken for granted by most individuals. Scheff outlines various examples of residual rules underlying interpersonal interactions:

A person engaged in conversation is expected to face toward his partner, rather than directly away from him; if his gaze is toward the partner he is expected to look toward the other's eyes, rather than, say, toward his forehead; to stand at a proper conversational distance, neither one inch away nor across the room, and so on. (1966, p. 32)
According to Scheff, residual rule-breaking is extremely common in society and can be explained through diverse factors, including organic pathology, psychological variables, situational stress, and volitional acts of defiance. However, it is the societal reaction to these transgressions which determines their outcome. Most incidents of residual rule-breaking are excused or ignored and thus tend to be transitory in nature. But in some cases rule infractions invoke culturally based stereotypes of mental illness which are imposed on the offender. When this "labelling" occurs, behaviors consistent with cultural conceptions of psychiatric disturbance are reinforced, thus stabilizing residual rule-breaking and sending the individual on a career of mental illness. Once in the role of mental patient, social pressure, disempowerment, and stigmatization encourage patients to acquire a deviant self-image and make it difficult for them to return to a normal status within society.

In this model, the contingencies which lead to labelling play a crucial role in determining which members of society are diagnosed as mentally ill. According to Scheff, although the nature of the societal reaction is partly dependent upon the frequency and degree of rule-breaking, it is also significantly affected by social systemic variables, such as the visibility of the offense, the power of the rule breaker (e.g., socioeconomic status) relative to observers and agents of social control, the tolerance of the community, and the availability of cultural alternatives to labelling. Thus, individuals thought to
be mentally ill are not necessarily more deviant than others, but may simply be more likely to have their offenses publicly labelled due to marginal status and limited resources. To Scheff, the diagnosis of mental illness is applied to socially disempowered individuals for transgressions against culturally based assumptions about reality. He emphatically concludes that

the concepts of mental illness ... are not neutral, value-free, scientifically precise terms but, for the most part, the leading edge of an ideology embedded in the historical and cultural present of the white middle class of western societies. The concept of illness and its associated vocabulary - symptoms, therapies, patients, and physicians - reify and legitimate the prevailing public order at the expense of other possible worlds. (1976, p. 210)

To test the hypothesis that acquiring and maintaining the mental patient role is dependent more on social contingencies than symptomatic behaviors, Scheff conducted two research studies: one examined the procedures used to commit psychiatric patients and the other investigated the factors critical to their release. In the first study, he found that despite high levels of uncertainty regarding mental impairment and dangerousness, commitment proceedings were perfunctory and almost always led to involuntary hospitalization, suggesting a strong presumption of illness by court and psychiatric officials (Scheff, 1964, 1966). Results from the second study suggested that the continued hospitalization of many psychiatric inpatients (43% of 530) could not be justified by their psychiatric condition; instead patient age, length of confinement, and type of hospital were found to be
significantly related to ineligibility for release (Scheff, 1966). Together these studies illustrated the impact of social factors on psychiatric patient status.

Nevertheless, to the psychiatric establishment, Scheff's analysis considerably exaggerated the role of societal reaction in mental illness. Although his research exposed undue influences in psychiatric decisions, it did not address the central hypothesis that labelling is the primary variable in the stabilization of deviance (Clausen & Huffine, 1975). Additional empirical tests of the labelling position have made little progress in resolving the dispute; opposing studies elicit conflicting interpretations with no decisive conclusions (see Gove, 1970a, 1970b, 1975a, 1975b; Scheff, 1974).

A number of social theorists, in contrast, have at once applauded this sociological analysis and rebuked its limitations. Scheff has been credited for illuminating the deleterious effects of labelling, drawing attention to deficiencies in social control mechanisms, and broadening individualistic models of psychopathology to the social realm (Davis, 1972; Schur, 1971). Yet, his simplified portrayal of social power and his indictment of labelling as the single cause of psychiatric deviance fails to capture the complexity of human interaction and social process (Davis, 1972). Moreover, though his work directly challenges the existing social system, his concentration on microsocial elements of the establishment, such as local officials, and his neglect of larger social institutions betrays a conservative vision of social change (Sedgwick, 1982b; Schur, 1971).
Rosenhan. In the early seventies, a further contribution to the antipsychiatry movement drove home the message which had been expounded by the likes of Goffman and Scheff. This was David Rosenhan’s controversial yet highly influential article, "On Being Sane in Insane Places" (1973a). In this and subsequent publications (Rosenhan, 1973b, 1975), Rosenhan describes the now well-known study in which 8 "pseudopatients" gained entry into 12 different psychiatric hospitals by feigning a single symptom; each reported hearing voices saying the words "empty," "hollow," and "thud." With the exception of falsifying their names and occupations, the pseudopatients provided accurate details of their life histories and current circumstances. All of them were admitted as inpatients, 11 with diagnoses of paranoid schizophrenia and 1 diagnosed with manic-depressive psychosis. Once on the ward, they ceased to fabricate symptoms and reported that they were feeling fine. Despite their normal behavior, the pseudopatients were never detected as sane and remained in hospital from 7 to 52 days. Throughout the hospitalizations, staff on the wards tended to interpret the pseudopatients’ behaviors as further evidence of their pathology. Each was eventually discharged with the diagnosis of "schizophrenia in remission"; none were ever pronounced "normal."

The inability of the psychiatrists and nursing staff in this study to differentiate "the sane from the insane" (Rosenhan, 1973a, p. 317) led Rosenhan to conclude that psychiatric diagnosis is determined more by contextual
variables (in this case, the hospital setting and staff expectations) than by characteristics intrinsic to individual patients. He suggested that psychiatric diagnostic labels represent attempts to invent knowledge in the absence of understanding and argued that these labels are neither useful nor reliable. In addition, he outlined diagnosis as merely one part of a larger process in which hospitalized psychiatric patients tend to be depersonalized by hospital staff.

Rosenhan’s article invoked a strong response from mental health professionals in defence of psychiatric diagnosis and the mental health system (e.g., Letters to the editor, 1973; Crown, 1975; Millon, 1975; Spitzer, 1975; Weiner, 1975). Some authors were quick to implicate experimenter bias, suggesting that schizophrenia, though inaccurate, may have been the most appropriate diagnosis given that the clinicians had been misled (e.g., Millon, 1975; Spitzer, 1975; see also Hunter, 1973; Lieberman, 1973). Others agreed with Rosenhan that the diagnoses were improper and consequently criticized the hospital staff for incompetent clinical practice, but defended the psychiatric classification system itself and mental health practices in general (e.g., Hoaken, 1973; Zucker, 1973). The consensus among critics was that the successful simulation of a mental disorder does not justify the conclusion that such disorders are not real. Despite these arguments, Rosenhan’s research had a tremendous impact on the mental health field, leaving many clinicians and laypersons sceptical of psychiatric diagnosis.
Critique. This review of the antipsychiatry literature is far from exhaustive. Though perhaps less well-known than the authors discussed above, other theorists, such as Foucault (1961/1965), Sarbin (1967, 1969), Leifer (1969), and Kittrie (1971), also provided insightful contributions to the critique of positivist psychiatry during the antipsychiatry era. Foucault’s *Madness and Civilization* (1961/1965) in particular stands out as a singular achievement in this area and, for this reason, will be examined in relation to more contemporary works in the next section.

The appearance of so many insurgencies against the psychiatric establishment in the sixties and early seventies was perhaps a sign that mental health practices were badly in need of reform; certainly these cries for change did not go unheard. The authority of the psychiatrist has since been supplanted by dramatic increases in patient rights so that medication, electro-convulsive therapy, and even hospitalization are considerably more difficult to impose on mental patients against their will. Furthermore, the population of psychiatric hospitals has drastically declined over the past three decades. For many patients, hospitalization has been replaced by community-based outpatient treatment, though the advent of neuroleptics in the fifties also played a crucial role in this development. Finally, weakened versions of the antipsychiatrists’ positions have since been incorporated into many traditional psychiatric frameworks, adding sociological insights to biologically based treatments (see e.g., Clare, 1976b). However, the psychiatric revolution quickly
lost momentum with a shift in the political climate. As the radicalism of the sixties became the conservativism of the eighties, biological models of mental disorder were increasingly endorsed and the public began to demand an increase in the psychiatric services once denounced as repressive (Sedgwick, 1982a). Thus, although the writings of the antipsychiatrists led to some permanent changes in mental health treatment, the main thrust of their work was soon forgotten.

Central to the antipsychiatry assaults on psychiatric practice is the thesis that mental disorders are not in fact objective medical problems, but instead represent sociopolitical value judgments reflecting the mores and beliefs of mainstream Western society. Unlike the psychiatric establishment, numerous social theorists have not forgotten this theme, but instead have submitted it to significant revision. Although the antipsychiatrists clearly illustrated the social and political implications of mental disorder concepts and the social control functions of psychiatric practice in general, they did not seem to capture the complex and subtle ways in which these sociopolitical processes occur. Furthermore, their writings focus primarily on microsocial structures to the exclusion of the larger social system; society itself is either ignored or viewed as an unchangeable entity and thus, truly subversive analyses are not offered. In general, their approaches are more reflective of an individualistic philosophy and a conservative notion of social change than a radical social revisionist position. Nonetheless, it was the insights of the antipsychiatrists
which paved the way for more complex critiques of positivist psychiatry which have appeared in the postmodern era.

The Postmodern Movements

The heightened political awareness of the 1960s spawned revolutions in the arts, humanities, and social sciences, challenging the traditional assumptions and values endemic to twentieth century Western society. These movements reflected a growing dissatisfaction with the "modernist" era's emphasis on science, technology, progress, and competitive individualism. Consequently, they came to be united under the banner of "postmodernism." By the 1970s, postmodern perspectives had become highly influential alternatives to mainstream cultural views and as we enter the mid-1990s their popularity continues to flourish. In the social sciences, supporters of these revisionist positions endorse a social epistemology in place of traditional positivist models. The central tenet of this approach is that our beliefs about the world are inseparable from the surrounding social structure. Knowledge and consciousness itself are viewed, not as reflections of objective reality, but rather as social products. Therefore, postmodern theorists are less interested in attaining truth and more concerned with understanding how alternative perspectives of reality are shaped by social practices. Accordingly, they concentrate on the social significance, rather than the validity, of various perspectives, making political and moral issues pertinent to all forms of
investigation (Collier, Minton, & Reynolds, 1991). The postmodern era has seen a proliferation of theorists applying social epistemology to the study of psychiatric phenomena. Though indebted to the antipsychiatrists, these authors have moved beyond the rudimentary critiques of the sixties to advance highly astute and penetrating analyses of mental disorder conceptions.

*The social construction of mental disorder.* In the history of philosophy and science, numerous models have been applied to the study of knowledge. An empiricist perspective gives priority to perceptual data and consequently views sensory experience as the only means to access reality. The rationalist model, on the other hand, emphasizes the innate processes, or laws of thought, which guide the analysis of information, and thus regards reason and innate ideas as the basis of true knowledge. "The rationalist fears the illusions of sense; the empiricist fears the delusions of reason" (Leahey, 1987, p. 55).

Inherent in these accounts is the dualistic notion that humans are separate from the objects they study. An alternative model incorporated in the social epistemology of postmodern social science is social constructionism. The social constructionist approach, cogently elucidated by Gergen (1985), transcends empiricist-rationalist dualism by redefining knowledge within the process of social interchange. Knowledge is simply that information which is communicated between people. Consequently, we come to understand the world through our social interactions. As our social environment and cultural background influence these interactions, our ideas about the nature of reality
reflect the social context in which we exist. Furthermore, as our understanding of reality inevitably affects how we communicate and what we do, alterations in our ideas about the world lead to social change. The result is a continual cycle of metamorphosis: change in the social environment results in new conceptions of reality which precipitate social reforms. With knowledge constantly changing, there are no constant criteria against which theories can be validated; the notion of absolute truth is, therefore, highly suspect.

Positivist accounts of mental disorder are based in the empiricist tradition. Within this framework, psychiatric diagnostic categories, though seen as representing hypothetical constructs, are believed to approximate real processes or structures within individuals which exist in and of themselves prior to their recognition and categorization. The practice of psychiatric diagnosis is directed toward accurately measuring these discernable human phenomena. Thus, to positivist theorists, mental disorders are ontological truths and mental disorder conceptions represent our current knowledge about these entities. This position, prevalent in traditional psychiatry, places psychiatric conceptions beyond the social realm and subsequently obscures their significant social meanings (Sedgwick, 1982b).

From a social constructionist perspective, mental disorder conceptions represent cultural linguistic forms mediated through human interaction and connected to the social environment - they are social constructions and as such incorporate socially relative values. Through exposing the value basis of
psychiatric diagnosis, the antipsychiatrists dramatically demonstrated this argument. However, in denouncing mental disorder conceptions as political labels, the antipsychiatrists implied, and at times explicitly stated, that physically based medical disorders are value-free apolitical conditions. According to their framework, the medical model is appropriately applied to disorders involving anatomical or physiological abnormalities, as physical phenomena properly belong to the realm of science; its employment in the treatment of psychiatric disturbance, however, erroneously conceptualizes as medical what are fundamentally moral issues (Eisenberg, 1981; Sedgwick, 1982b). Postmodern theorists, on the other hand, have argued that all forms of illness are indeed social constructions (e.g., Conrad, 1980; Eisenberg, 1981, 1988; Hoffman, 1978; Sedgwick, 1982a, 1982b; Veatch, 1973). This does not mean, of course, that events in nature do not exist, but simply recognizes that natural phenomena do not constitute illnesses or diseases prior to being assigned these meanings by humans. This position, is convincingly outlined by Sedgwick (1982b):

The fracture of a septuagenarian’s femur has, within the world of nature, no more significance than the snapping of an autumn leaf from its twig: and the invasion of a human organism by cholera germs carries with it no more the stamp of “illness” than does the souring of milk by other forms of bacteria.... Out of anthropocentric self-interest, we have chosen to consider as “illnesses” or “diseases” those natural circumstances which precipitate the death (or the failure to function according to certain values) of a limited number of biological species: ourselves, our pets and other cherished livestock, and the plant varieties we cultivate for gain or pleasure. (pp. 30-31)
As all medical disorders are socially constructed, evidence of organic dysfunction in human phenomena is not sufficient to warrant the ascription of illness; human values determine which physical conditions will be conceptualized medically. Yet, not only is organicity insufficient for a medical formulation, it is also unnecessary (Conrad, 1980). In fact, the notion of illness originated long before humans gained a detailed understanding of the human body (Ingleby, 1982; Sedgwick, 1982b). Sedgwick (1982b) suggests that illness constructions are generally applied to deviances in human functioning for which the cause is ascribed to a specific set of factors acting within the individual. Whether these factors are seen as operating in the body, the mind, or the soul depends on culturally specific views on the nature of human functioning. In addition, these constructions arise in parallel with some form of individually focused treatment or therapy which is seen as useful in alleviating the affliction. Thus, arguments supporting or refuting the concept of mental disorder based upon the physiological status of behavioral phenomena are moot. If the cause of behavioral deviance is ascribed to intra-individual factors and medical treatment is the desired response, "mental illnesses can be conceptualised within the disease framework just as easily as physical maladies such as lumbago or TB" (Sedgwick, 1982b, p. 38).

Contrary to the antipsychiatric position, the fact that mental disorder diagnoses incorporate social values does not demonstrate their ineligibility as medical conceptions. Once the social basis of knowledge is recognized, it
becomes clear that reality can be constructed in innumerable ways. The key question for postmodern philosophers is not whether mental disorder conceptions are valid, but whether they are desirable. Eisenberg (1988) states that "what distinguishes one description of the universe from another is not any final correspondence with the real chains of nature but its efficacy for human purposes" (p. 8). In order to determine the efficacy of mental disorder conceptions, it is necessary to examine their impact on the social world.

**Ideology critique.** One method used by some postmodern theorists to assess the sociopolitical ramifications of a theory or conceptual system is "ideology critique," an approach derived from Karl Marx's critical social analysis of the capitalist political-economic system and commonly associated with the neo-Marxist Critical Theory of Max Horkheimer, T. W. Adorno, and other members of the Frankfurt School (see Kellner, 1989). In contrast to the common understanding of "ideology" as ideas or beliefs representative of a particular individual, group, philosophical system, or sociohistorical era, a Marxist interpretation suggests a more insidious form of consciousness. To Marx, the ideology characteristic of a society in any historical period reflects the ideas of those in power and these ideas, in turn, serve to justify their dominance. Marx and Engels explain this thesis in "The German Ideology":

> The ideas of the ruling class are in every epoch the ruling ideas: i.e., the class which is the ruling material force of society, is at the same time its ruling intellectual force. The class which has the means of material production at its disposal, has control at the same time over the means of mental production, so that thereby, generally speaking, the ideas of those who lack the means of
ment production are subject to it. The ruling ideas are nothing more than the ideal expression of the dominant material relationships, the dominant material relationships grasped as ideas; hence of the relationships which make the one class the ruling one, therefore, the ideas of its dominance. (1845/1972, pp. 136-137)

In this formulation, the prevailing ideological system in a community is propagated by the dominant class in order to promote its socioeconomic interests and maintain the status quo. Ideology thus reflects a set of stratagems to convince the populace that the current social structure is, in fact, to their advantage, or at least, the only one possible. However, as most sociopolitical systems support striking material inequities and uneven distributions of power, ideological mechanisms tend to incorporate distortions or misconceptions of social reality; ideology is thus frequently referred to as "false consciousness." The aim in ideology critique is to determine the extent to which the theories and concepts which constitute the basis of knowledge mask or misrepresent reality in ways which legitimate the status quo and prevent political change. Knowledge systems which conceal political interests in this manner are said to be "ideological" (Comaroff, 1982; Ingleby, 1981; Jones, 1986; Prilleltensky, 1989; Sampson, 1981).

This understanding of ideology, however, is widely disputed within the various postmodern movements (see e.g., Kellner, 1989; Lather, 1991; Turner, 1990). Central to the debate is the highly contentious notion of false consciousness, problematic within some postmodern discourses, such as poststructuralism, which highlight the relativity of all knowledge forms.
According to theorists who espouse a relativistic framework, "there is no false consciousness, for such a concept assumes a true consciousness accessible via 'correct' theory and practice" (Lather, 1991, p. 112). Karl Mannheim, for example, extended the concept of ideology to Marxism itself in his attempt to "demonstrate the partisan, contextual and existentially determined nature of all cognition, thought and theories" (Kellner, 1989, p. 24). From this alternative perspective, one discourse is not held to reflect reality more or less accurately than others, but rather each is viewed as tied to particular social practices and supportive of a particular organization of power relationships in society. As all forms of knowledge contain assumptions which promote particular interests, all knowledge is ideological. Thus, ideology may support domination by hegemonic groups (i.e., "hegemonic ideology"; Kellner, 1989), yet, as Gramsci points out, ideology can be resistant or even subversive to hegemonic interests (Turner, 1990). However, to remain consistent with the principal authors reviewed in this chapter and in keeping with the tradition of Critical Theory, the term ideology will be used here to refer specifically to hegemonic ideology; that is, ideas which serve to maintain or strengthen the dominant power structure.

Whether ideology is conceptualized as pertaining to all forms of knowledge or restricted to knowledge which serves dominant interests, ideology critique remains a pertinent model for examining cultural forms of meaning. By illuminating the vested interests underlying our assumptions
about the world, this form of analysis plays a crucial role in linking ideas to their social context and, thereby, in demonstrating the social significance of knowledge (Comaroff, 1982). In general, methodological approaches which conceptualize social elements in isolation from their context capture their surface appearance, but not their social roots, and thus lead to ideological theories. A good example is the positivist epistemology traditionally employed in the social sciences (Jones, 1986). As previously outlined, positivist scientists not only view human and social subjects as facts, distinct from their relations to the social system, but also boast that their methods are value-free. In the attempt to eradicate value-laden influences, positivism actually conceals, rather than eliminates, its value base, making it a particularly useful mechanism for the propagation of ideology.

Ideology critique has been rigorously applied to positivist psychiatric models by numerous authors, with a particular focus on the concept of mental disorder. Traditional psychiatric conceptions are shown to serve an ideological function in two primary ways. First, mental disorder concepts tend to legitimate the existing social order by medicalizing deviant behaviors and denying their socially relevant meanings. Second, by attributing the cause of psychiatric disturbance to individual malfunctioning, mental disorder models mask the social origins of human distress and thereby protect the social order from criticism and reform; in this light, psychiatric diagnosis can be seen as a
form of victim-blaming. These formulations will be examined in the following sections.

**Mental disorder as the medicalization of social deviance.** One way in which psychiatric diagnoses support the existing sociopolitical system is by incorporating social norms into judgments of healthy versus disordered psychological functioning. By medicalizing social deviance, psychiatry in effect denies the meaning and intentionality in nonconforming modes of behavior and experience; conduct which threatens the status quo is effectively silenced, while compliance to the social order is upheld as a natural phenomenon. This position, outlined in detail by Ingleby (1972, 1974, 1980, 1981, 1982, 1983) and other theorists, is particularly indebted to the antipsychiatrists whose insightful interpretations of psychiatric symptoms restored meaning to human experiences formerly stripped of sense by medicalized formulations.

The work of the antipsychiatrists convincingly illustrated mental disorder as a form of socially deviant human activity. Yet, "social deviance," though central to a Szaszian analysis, does not fully capture the essence of the "inner voyage" portrayed by Laing or the "residual rule-breaking" described by Scheff. What separates psychiatric disturbance from other forms of nonconforming behavior is our inability to understand it; "the mentally ill do not deviate from norms of morality so much as of rationality." (Ingleby, 1982, p. 124). Hence, while social norms play a key role in the diagnosis of mental disorder, incomprehensibility forms the central criterion (Horwitz, 1982).
However, as Ingleby (1982) explains, rationality itself is socially constructed; the cultural repudiation of rationality in psychiatric disturbance is therefore based on value judgments. As Laing's discerning analysis of schizophrenia suggested, mental disorder symptoms are unintelligible, not because of their inherent irrationality, but because their meaningfulness has been denied. From this perspective, psychiatric diagnosis essentially reformulates meaningful human behavior and experience into irrational symptoms of disordered psychological functioning.

Fundamental to psychiatric interpretations of these unintelligible symptoms is the denial that they are under the control of free will (Veatch, 1973). The process by which mental disorder conceptions eradicate agency from human experience has been referred to as reification, that is, "the reduction of human realities to the order of things" (Ingleby, 1972, p. 57). The error in reified models of human functioning lies in their negation of "praxis," the fundamental quality which distinguishes human conduct from the movements of inanimate objects. While objects are directly controlled by causal forces, human praxis involves activity, such as perception, experience, and behavior, which is intentional, goal-directed, and can be accounted for by its meaningfulness. Reification occurs when the meaningful activity of human agents is explained as if it were the inevitable result of causal factors, that is, as if it were a "thing." This process inevitably results in the dehumanization of experience and the limitation of human possibilities. Of course, this is not to
suggest that natural phenomena, such as organic or environmental variables, do not impact upon human psychological functioning, but instead implies that humans respond actively to these factors (Ingleby, 1972, 1980).

In order to determine the intention of praxis, and hence its meaning, it must be interpreted within the surrounding context, as the means required to reach a particular goal is determined by contextual variables. Therefore, it is primarily through the failure to consider contexts that human behavior is rendered meaningless and interpreted within reified formulations (Ingleby, 1972). The relevance of context to interpretations of psychiatric disturbance has been clearly demonstrated by the antipsychiatrists. Their consideration of contextual variables, such as the family (Laing), the asylum (Goffman), and social roles (Scheff), led to the conclusion that mental disorders are actually meaningful reactions to intolerable situations. Ingleby (1980), however, shifts attention from these microsocial structures to the socio-cultural environment of Western society in general. He suggests that the human problems with which psychiatry is concerned represent responses to the conflicts and tension which arise within the current dehumanizing socioeconomic system: "mental illness may be an expression of pain, discontent, or protest arising from social conditions" (Ingleby, 1981, p. 10). Psychiatric knowledge ignores the deleterious impact of the prevailing social order and subsequently views negative reactions to it as irrational. Without recognition of the context in which they arise, these responses are ascribed to faulty physical or
psychological mechanisms. Herein lies the ideological function of mental
disorder conceptions: distress and suffering expressed in response to social
problems are reified as medical symptoms, silencing their socially significant
meanings. Clearly, "deciding what constitutes a 'warrantable' response to
one's situation is largely and unavoidably a political decision" (Ingleby, 1980,
p. 53). Conceptualizing challenges to the status quo as symptoms of
psychiatric disorder effectively prevents social change (Conrad, 1975, 1976;
Ingleby, 1980, 1983). Moreover, individual treatments are prescribed for what
are essentially political problems (Hurvitz, 1973; Ingleby, 1980). This position
has been clearly articulated in feminist critiques of psychiatry. Feminist
authors suggest that the suffering experienced by women arises largely in
response to their subordinate role in society and that the misrepresentation of
their distress as a symptom of mental disorder is a political measure directed
toward maintaining the sex role structure (Chesler, 1972; Homer, 1977).

Though intended to remove personal responsibility from certain forms
of emotional distress, psychiatric reifications are inextricably tied to moral
condemnations. But as they regulate morality without seeming to do so, they
serve as a particularly insidious form of social control (Conrad, 1980; Fox, 1977;
Zola, 1972). By medicalizing deviant behaviors which challenge the social
system, psychiatry imposes a repressive force which, in its subtlety, renders a
more destructive blow than direct means of oppression. Furthermore, with the
ascription of psychiatric labels, threats to the social order are not only silenced,
but are also subject to correction, for what is "sick" must be returned to "health" (Dean, 1976; Ingleby, 1972, 1980, 1983; Zola, 1972). The effectiveness of this ideological mechanism is evident in the increasing expansion of psychiatric formulations into everyday life (Zola, 1972). Since Freud and the advent of "neurosis," psychiatry has broadened its focus from the severely incapacitating forms of mental disorder which require hospitalization to mild levels of distress (Ingleby, 1983). Moreover, in recent years, the psychiatric establishment has expanded its domain to include modes of deviance once considered purely moral issues; e.g., alcoholism, drug abuse, suicide, hyperactivity, learning problems, and criminal behavior (Conrad, 1975, 1976, 1980; Fox, 1977; Veatch, 1973).

However, psychiatry's ideological function rests not merely on its censuring of negative reactions to current social practices, but also in its implicit legitimization of behaviors that conform to these practices. Inherent in labelling human activity as a symptom of psychiatric disturbance is the assumption that there is a correct, essentially "nondisordered," way for human beings to function. Thus, firmly embedded within mental disorder conceptions lies an implicit model of human nature - the psychiatric image of normal, healthy psychological functioning (Castel, 1983; Ingleby, 1972). But this portrayal presents "as 'natural' what is actually a culturally constituted and socially motivated image of man" (Comaroff, 1985, p. 52). The mental health establishment promotes the view that existing social arrangements and our
conformity to them are the inevitable outcome of human nature (Philp, 1985; Zuberi, 1983). Just as mental disorder conceptions reify nonconformity as a malignant process, psychiatry’s notion of "normality" reifies adherence to social norms as a natural phenomenon. In this variant of reification, the forms of psychological experience observed in the social majority are abstracted from the sociohistorical conditions which mediate them and presented as fundamental characteristics of the human mind (Sampson, 1981).

This analysis of ideology not only questions the social basis of mental disorder conceptions, but also challenges Western culture’s formulation of rationality itself. Our cultural construction of "reason" serves primarily to reinforce an image of human beings which supports the interests of dominant segments in industrial capitalist society. Human activity which quietly conforms to the status quo is deemed rational and hence, healthy; conduct which conflicts with or in some way threatens the social order is deemed irrational and, as such, mentally disordered. Nevertheless, nonpositivist accounts of psychiatric disturbance have offered a plausible alternative by reestablishing the link between mental disorder and intelligibility. Psychiatric symptoms have been shown to represent meaningful responses to insufferable, dehumanizing situations, suggesting that rationality, like beauty, is in the eye of the beholder.

From Foucault’s (1961/1965) perspective, however, rationality is far from relative, for reason, by definition, is tied to a particular set of social
practices. Accordingly, the ideological basis of psychiatric diagnosis lies not in the denial of mental disorder's reason but in the exaltation of rationality and its associated forms of conduct to the status of ultimate truth. In his celebrated antipsychiatry treatise, *Madness and Civilization*, Foucault sets out to recover madness prior to its emergence as a psychiatric category and, by tracing the cultural response to madness through to its construction as a medical entity, seeks to expose the sociohistorical context out of which our current conceptualizations developed (Turkel, 1990). Foucault suggests that madpersons were first isolated from the rest of society in the post-renaissance era due to their inability to work: "In the classical age, for the first time, madness was perceived through a condemnation of idleness and in a social immanence guaranteed by the community of labour" (p. 58). However, the rejection of the madperson occurs not for economic reasons but "because he crosses the frontiers of bourgeois order ... and alienates himself outside the sacred limits of its ethic" (p. 58). In accordance with the authors discussed in this section, what ultimately underlies the banishment of madness is its deviance from the bounds of rationality. Yet, for Foucault, it is not the refutation of madness's reason that serves a political function but the supremacy of rational thought itself. With the dawn of the Age of Reason in the seventeenth century, rationality emerged as a moral issue. Reason was glorified as the very essence of humanity; consequently, madness, which was by nature "unreason," was exiled from human interchange (Flaherty, 1986).
The commitment of madpersons to asylums revealed society's newly emerged condemnation of unreason: "confinement is the practice which corresponds most exactly to madness experienced as unreason, that is as the empty negativity of reason; by confinement, madness is acknowledged to be nothing" (Foucault, p. 116). Perhaps irrationality has been medicalized, not because we cannot accept its true meaning, but because we cannot tolerate its inherent lack of meaning.

Whether or not behaviors deemed mentally disordered are inherently meaningful, medicalized mental disorder conceptions play a significant role in maintaining the prevailing social order by framing behaviors which do not fit within its ethic as unnatural.

Mental disorder as victim-blaming. Adherents of an alternative ideology critique are concerned with the social interests served by individualistic causal models constructed to explain psychiatric disturbance. Contrary to the previous approach, these critics do not dispute conceptualizing certain behaviors as abnormal or disordered, but instead question the person-centered focus which mental disorder conceptions engender. This position, clearly elucidated by Prilleltensky (1989, 1990b) and Albee (1982a, 1982b, 1986), holds that ascribing the cause of emotional problems to factors within individuals protects the status quo by directing attention away from etiological elements within the social system. Though similar to Ingleby's proposal that psychiatric diagnoses nullify intelligible responses to conflicts arising within
society, this formulation de-emphasizes the role of human praxis and gives greater significance to the social forces which create human suffering. From this perspective, Western society's emphasis on individual agency and self-determination significantly exaggerates the extent of individual freedom and power within present social structures and leads to holding individuals responsible for personal problems which are largely outside of their control (Berger & Kytle, 1985; Comaroff, 1982).

Central to this formulation is the thesis that environmental stress plays a crucial role in the genesis of psychiatric disturbance and that the origins of stress can be found in the social, economic, and political structures which form the foundations of society. In Western culture, the competitive basis of capitalism fosters conditions particularly conducive to the development of mental disorders. Albee (1982a) suggests that "excessive industrialization requires the dehumanization of work, submergence or elimination of individuality, loss of individual creativity, of a sense of identity and of personal competence" (p. 25). In general, the experience of living in a society that views people as "commodities" has a detrimental impact on all individuals (Beit-Hallahmi, 1974). However, the strains which accompany daily life are not distributed evenly throughout the population. Inequalities perpetuated by the social order lead to more pronounced levels of stress for those individuals who experience the frustrations, degradations, and material constraints associated with poverty, unemployment, social marginality, and powerlessness
(Albee, 1982b, 1986; Berger & Kytle, 1985). The contention that these environmental pressures lead to psychiatric disturbance is supported by epidemiological research demonstrating the overrepresentation of women, the poor, and other disempowered individuals among the mentally disordered (Abramowitz & Dokecki, 1977; Albee, 1986). As Gil (1978) states, "when people are forced to adjust to an insane reality which frustrates their material, social, and psychological needs, they tend to develop various forms of ill-health" (p. 67).

This account is by no means a social-reductionist model of psychiatric disturbance; its advocates acknowledge the etiological significance of diverse factors both in and outside the individual including biological components (Albee, 1982a; Berger & Kytle, 1985; Sarason, 1981). They do propose, however, that the psychiatric establishment significantly understates, and often completely denies, the social environment's role as a causal agent. Prilleltensky (1990b) suggests that traditional psychiatric models are essentially asocial: abnormal behavior is attributed to the malfunctioning of either organic or psychological processes located within the individual and environmental influences are largely ignored. Though more progressive formulations recognize the impact of environmental forces, the problem continues to be framed as an intra-individual defect. Stress or traumas from the past may be seen as having produced the internal disorder, yet the role of current social forces continues to be disregarded (Ryan, 1971). When
acknowledged, ongoing environmental pressures tend to be reduced to individualized terms, so that "stress," for example, comes to be understood as a part of one's "life-style" (Comaroff, 1982).

The psychiatric establishment's humanitarian effort to liberate individuals from personal responsibility for their afflictions has evidently failed (Comaroff, 1982; Kirmayer, 1989). Rather than alleviating blame, psychiatry's acontextual image of human functioning shifts attention from the social and cultural sphere to the inner world of the individual and consequently holds persons accountable for disturbances which are often the result of adverse social conditions. This process has been referred to as "blaming the victim" (Ryan, 1971). For persons suffering from psychiatric distress, the effects of victim-blaming are profound. "When human suffering is interpreted in terms of a deficient organism, a distinct conforming message emerges quite clearly: poor nutrition, detrimental living conditions, unemployment, and poverty in general are 'determined' by the inability of those people to help themselves" (Prilleltensky, 1990b, pp. 770-771). Assigning a diagnosis of mental disorder is, in effect, an invocation of conservative morality; it communicates to patients that the root of their adversities is themselves and that in order to return to health they must change from within (Simon, 1970). The corresponding treatment encourages patients to adapt to their circumstances in society; health is recognized by the willingness to keep one's place in the social order (Berger & Kytle, 1985; Gil, 1978). But inevitably, the optimal functioning that is
desired will not be possible without significant changes in existing social structures (Beit-Hallahmi, 1974).

Psychiatric diagnosis serves as one example of a general tendency in Western society to conceptualize human distress in individualistic terms rather than as part of the sociomoral context (Kirmayer, 1989). The medical field in general endorses unifactorial disease models in which individuals are held responsible for their own health, despite dramatic inequalities in health status across socioeconomic lines (Comaroff, 1982; Eisenberg, 1981). Another example can be seen within the discipline of psychology, where an individualistic bias pervades both research and practice; although endorsement of environmentalist theories is common, people continue to be conceptualized as asocial or narrowly interpersonal beings whose functioning occurs independent of the sociohistorical context (Caplan & Nelson, 1973; Prilleltensky, 1989; Sarason, 1981; Sedgwick, 1974).

The proliferation of person-blame explanations for social ills has serious repercussions for the socioeconomic political system. By focusing attention on the intra-individual concomitants of socially based problems, these formulations divert attention from the deleterious effects of various social institutions and thus free these structures from responsibility. Blaming the victim protects the establishment from criticism, averts political crisis, and consequently maintains the status quo (Albee, 1982a; Berger & Kytle, 1985; Caplan & Nelson, 1973; Prilleltensky, 1989). From this perspective, the
ideological basis of mental disorder conceptions is clear - distress arising as a result of conflicts within the social order is disguised as human frailty, thereby promoting individual adaptation and sociopolitical stability.

**Comparison of two ideology critiques.** These alternative ideology critiques offer strikingly similar formulations of psychiatric disorders, yet diverge on some important issues. Although both models conceptualize mental disorders as reactions to oppressive socioeconomic structures, the first approach highlights the role of human praxis in responding to these stressors, while the second endorses a causal model with environmental forces as the major etiological factor. The former position holds that political interests are served by describing socially deviant behaviors as mentally disordered; human agency is emphasized and the entire concept of mental disorder is rejected as ideological. In the latter position, theorists assert that political interests are served by attributing mental disorders to individual dysfunction; the role of human agency in deviant behavior is downplayed and only asocial mental disorder conceptualizations are viewed as ideologically based. These conflicting views have been debated in the literature (see e.g., Busfield, 1988; Ingleby, 1983; Sedgwick, 1982b).

A contentious issue between these opposing camps is whether psychiatric labels should be endorsed - an important concern as the language used to conceptualize human problems determines the nature of the solution which society provides (Caplan & Nelson, 1973; Magaro, 1976). Prilleltensky
(1990b) and Sedgwick (1981, 1982b) suggest that the rejection of psychiatric labels deprives suffering individuals of ameliorative services. Supporters of this position hope that mental health efforts can be directed toward primary prevention and social change (e.g., Albee, 1981, 1982b, 1986). But other theorists suggest that medical concepts such as "illness" and "disorder" will only lead to medically based responses as these terms themselves are ideologically loaded (e.g., Sarbin, 1969; Scull, 1975). Sampson (1977) proposes a formulation in which health and illness are sought, not in the individual, but within larger, collective social groups or systems. Veatch (1973), on the other hand, advocates creating a new nonmedical, yet individualistic category for "non-culpable deviancy caused ... by the lack of various forms of psychological, social, and cultural welfare" (p. 71). In contrast, Ingleby (1983), though originally opposed to mental disorder diagnoses, resigns himself to the use of psychiatric labels but encourages politically based interpretations:

There seems little point in holding out against the strong pressures to call [mental patients] "ill," especially since that is often the label the person is asking for. Yet it is still possible, I would maintain, to ascribe to such a condition a political significance that transcends any that a physical illness could possess. That is to say, these conditions are "socially constructed": psychiatry, in its "productive" capacity, has devised categories and practices for handling them that are linked intimately to political assumptions about each person's place in the social order. (p. 181)

Although critics of positivist psychiatry do not agree on the form which new conceptions should take, they do concur in their opinion of existing psychiatric formulations; acontextual mental disorder conceptions are seen as
supporting the inequitable social practices of Western society by describing the human distress which arises within these social arrangements as symptoms of psychological dysfunction. In order to seriously address the suffering which pervades human existence within the current dehumanizing social system, these medicalized models undoubtedly need to be replaced.

The role of mental health professionals in the dissemination of mental disorder ideology. Critical to the implementation of new models for conceptualizing socially based human problems is an understanding of the psychiatric establishment’s role in the dissemination of the traditional formulations to be supplanted. As the diagnosis and treatment of psychiatric disturbance is the exclusive domain of mental health practitioners, it is tempting to implicate these professionals as wilful agents of social control, imposing psychiatric knowledge at the service of majority interests. Yet, this is not the image which postmodern theorists present.

An important issue to consider is whether mental health clinicians actually impose mental disorder ideology upon the population. Despite their harsh critiques of psychiatric professionals, most postmodern authors point to the cultural origins of psychiatric conceptions. As Foucault (1961/1965) and other historical theorists (e.g., Scull, 1975) have shown, madpersons were banished from society long before psychiatric explanations of madness gained ascendance. With the hegemony of psychiatry over the care of madness, newly formed medical descriptions replaced what were originally culturally
based moral condemnations. Furthermore, Scheff (1966) suggests that the label of mental disorder is first imposed by laypersons, not clinicians, in response to abrogations of social rather than medical norms. Thus, psychiatric diagnoses are as much public as they are professional ascriptions (Horwitz, 1982, Ingleby, 1982).

Moreover, the portrayal of mental health practitioners as wilful agents of social control runs up against the fact that mental disorder ideology is embraced by its victims; for, in the majority of cases, individuals willingly present themselves for psychiatric care (Albee, 1986). As Roffe (1986) suggests, ideology is far more than a set of beliefs imposed upon a reluctant populace; embedded deeply within social institutions, such as the family and the educational system, ideology shapes the personality itself, so that individual psychological structures come to reflect the social practices by which they were molded. Ingleby (1980, 1983) concludes that these emotionally based personal ideologies in fact socially construct the experience of psychiatric distress by preventing the connection of feelings to relevant situational contexts. Unwanted or misunderstood emotions are consequently interpreted within the mental disorder schemas prevalent in the culture. For example, a belief in the sacred ethics governing family life may lead unemployed mothers with young children to discredit the feelings of despair and apathy that frequently arise due to their stressful situation and to subsequently experience themselves as clinically depressed.
Yet, while mental disorder conceptions may seem out of their hands, clinical practitioners play an active role in the legitimization of these lay constructions. Scull, (1975) in examining the historical development of psychiatric knowledge, suggests that eighteenth century medical personnel were not called upon to explain madness, but rather successfully lobbied to have their formulations adopted. By assimilating madness into medical models, these "moral entrepreneurs" concealed under the guise of objectivity what had once been unabashedly moral judgments, branding cultural constructions with a stamp of professional-scientific credibility (Caplan & Nelson, 1973; Ingleby, 1982). Though psychiatric diagnoses may not be based in the views of mental health professionals alone, the medicalized explanations which these practitioners provide are the key to their ideological status. The adoption of victim-blaming or reification as interpretive models in clinical practice is, however, rarely seen as an intentional strategy for the deception of social victims and subsequent protection of class interests. Rather, most authors suggest that the application of these theoretical distortions occurs unconsciously through epistemological biases which pervade our cultural ethos (e.g., Caplan & Nelson, 1973; Fox, 1977; Ingleby, 1972; Sarason, 1981). In reference to psychologists, Prilleltensky (1989) states:

Their assistance in perpetuating the current state of affairs does not derive, in my opinion, from a conscious effort to serve themselves by deceiving the population as to the nature of power relations in society. It derives mainly from a very efficient socialization that taught them not to question, to any threatening degree, the existing social system. (p. 796)
Two factors have been outlined as underlying this uncritical stance toward dominant cultural values. First, the incorporation of social mores into medicalized conceptions underlies the psychiatric establishment's prominence in Western society. Consequently, the subscription to majority views is critical to the advancement of mental health practitioners' professional power (Ingleby, 1983; Scull, 1975; Simon, 1970). The second factor is that most clinicians are members of the dominant social class who stand to benefit from the preservation of the existing social order (Prilleltensky, 1989; Sarason, 1981). Thus, the endorsement of mental disorder ideology is also beneficial to clinicians' personal socioeconomic position. In summary, though psychiatric professionals are far from the oppressive tyrants depicted in some antipsychiatry portraits, their provision of "ideological ammunition" (Prilleltensky, 1989) for the protection of the status quo cannot be seen as a mere byproduct of scientific endeavors distinct from their own interests. In order to encourage the psychiatric establishment to adopt nonideological formulations of human problems, they must be made "aware of the sociocultural determinants of their professional endeavors" (Prilleltensky, 1990b, p. 801).

Mental health frameworks and sociopolitical values. Castel (1983) maintains that psychiatry's permeability to mainstream values in the nineteenth century was due to the absence of a theoretical base upon which to ground its knowledge. He suggests that as a result of advancements in
twentieth century psychiatric theory, the mental health profession has achieved greater autonomy from societal views and consequently has the potential for breaking its ties with the dominant ideology or even for subverting it. This potential can be seen today in many mental health professionals' attitudes, reflecting a "feeling of underlying solidarity with the patient, of suspicion of a conformist definition of normality, and often of political critique of the role played by a repressive social structure in the aetiology of mental illness" (Castel, 1983, p. 262).

According to Prilleltensky (1990b), the various theoretical orientations prevalent in the mental health system incorporate different levels of analysis, ranging from the "asocial" to the "macro-sociopolitical," and hence promote ideology to different degrees. Biological models focus on the genetic, neurochemical, and neurostructural concomitants of psychiatric disturbance and are thus exclusively asocial. Psychological formulations, including psychodynamic, cognitive, behavioral, and humanistic, conceptualize mental disorder as an intra-individual problem, be it in the individual's emotions, thinking, behavior, or overall experience; these models consider contextual variables, such as upbringing, stress, and trauma, yet address their interventions at the level of the individual, and consequently tend also to be asocial. Social systems approaches, including family therapy and industrial psychology, consider the situational and interpersonal context as critical to human problems and therefore, focus their interventions on the immediate
social environment; Prilleltensky (1990b) describes these models as "microsocial." A broader social-contextual orientation, such as that espoused by community psychology and community social work, is primarily focused on the socioeconomic forces which impinge upon human existence; this is the "macrosocial" model. Finally, an extension of the community orientation encourages political activity in order to challenge existing social structures, and is thus referred to by Prilleltensky (1990b) as the macro-sociopolitical approach (see also Albee, 1982, 1986; Prilleltensky, 1989, 1990a; Sarason, 1984). As Prilleltensky (1990b) suggests, the greater the focus on social variables in the genesis of psychiatric disturbance and on sociopolitical interventions as solutions to these human problems, the less mental health practices function ideologically.

A positivist view holds that the selection of a particular psychiatric formulation and treatment approach is fundamentally rooted in theoretical-scientific considerations. In contrast, postmodern theorists have alleged that the endorsement of a specific theoretical perspective is determined, at least in part, by the clinician's own sociopolitical values (e.g., Albee, 1981, 1982a; Sedgwick, 1974). This has been articulately stated by Szasz (1961):

> What the psychiatrist's socioethical orientations happen to be ... will influence his ideas on what is wrong with the patient, what deserves comment or interpretation, in what possible directions change might be desirable, and so forth. (p. 116)

It has been suggested that individuals advocating a right-wing, conservative perspective are likely to emphasize personal rather than societal deficiencies as
explanations for human problems; conversely, persons espousing a left-wing, liberal or radical view are seen as more likely to focus attention on the cultural environment (e.g., Albee, 1982a; Sedgwick, 1974). This formulation is supported by the work of Pastore (1949) who investigated the relationship between scientists' political values and their stated position on the nature-nurture controversy. Through interpretations of their theoretical writings, Pastore found that conservatives tended to endorse heredity as the basis for individual and group differences, while liberals and radicals espoused environmental explanations.

**Empirical Research**

Although the past three decades have seen a proliferation of theoretical treatises assaulting positivist formulations of mental disorder, few empirical studies have been conducted to investigate the ideological basis of these conceptions. The dearth of empirical research in this area is largely due to the postmodern position that positivism and its empirical-scientific methods are ideological in and of themselves, as has been discussed in this review. The objective status of mental disorder cannot be determined by empirical approaches; nor can these methods demonstrate that psychiatric conceptions are socially constructed - for these are philosophical issues rooted in opposing epistemological and ontological perspectives. Nevertheless, if understood as reflecting current social practices rather than fundamental timeless realities,
empirical research can be useful for describing social phenomena in a particular sociohistorical context. Furthermore, as positivist theorists place tremendous importance on empiricist methods and snub philosophical works as unscientific, claims that mental disorder conceptions are politically based will likely be disregarded unless backed by empirical evidence. Although empirical support for a postmodern position on mental disorder cannot prove its ideological basis, such research may be helpful in educating mental health professionals about the political values inherent in their practice. In essence, if one wishes to convince others of a particular view, one must explain it to them in their language.

Demonstrating empirical support for the contention that asocial mental disorder conceptions function ideologically in twentieth century Western society is perhaps an unwieldy task. For example, epidemiological research has consistently shown that members of lower socioeconomic groups are substantially overrepresented among psychiatric patients (Abramowitz & Dokecki, 1977), suggesting that psychiatric disturbance is significantly related to socioeconomic contexts. However, positivist interpretations of these data suggest that psychiatric patients' lower social status is a result rather than a cause of their mental disorders; that is, patients are believed to "drift" toward unemployment, poverty, etc. (Robertson, 1969). Moreover, in order to demonstrate empirically that asocial conceptions of mental disorder are ideological, research would have to show, not only the importance of social
variables in the genesis of psychiatric disturbance, but also that the use of
asocial formulations helps to maintain sociopolitical stability.

A more viable research focus would be to investigate the factors which
lead some mental health clinicians to endorse ideologically based, asocial
models and others to address the sociopolitical contexts in which psychiatric
conditions arise. As the literature review in this chapter suggests,
endorsement of ideological psychiatric formulations may be mediated by
clinicians' own sociopolitical values; conservatives have been hypothesized to
favor asocial models, while liberals and radicals have been hypothesized to
espouse socially based models. Empirical evidence supporting this contention
would serve three primary functions. First, it would help theorists who
advocate the adoption of socially based mental health models to understand
the variables which lead some clinicians to support asocial models. Second, it
would demonstrate the political nature of mental health theories to positivist
theorists and practitioners. Third, it would support the position that asocial
psychiatric models function ideologically, simply because conservative
practitioners, by definition, are generally more motivated than liberals or
radicals to maintain the status quo. No empirical studies were found in the
literature which directly addressed the relationship between clinicians'
sociopolitical values and consideration of social contexts in mental disorder
formulations. However, a few studies were related to this issue and are thus
reviewed below.
In an extensive survey of New York city adults, Elinson, Padilla, and Ferkins (1967) found that laypersons endorsed socio-environmental explanations for mental illness significantly more than hereditary, moralistic, or organic causes. Similarly, Wahl (1987) found that laypersons viewed schizophrenia as due to psychosocial causes and as requiring psychosocial treatments. In contrast, mental health professionals in Wahl’s study stressed biological causes of schizophrenia and medically based interventions. Wahl concludes that his results indicate the need for psychiatric professionals to educate the public on mental health issues. From an alternative perspective, these studies suggest that mental health professionals are more likely than laypersons to interpret psychiatric disturbance ideologically.

Müller (1973) asked psychiatrists from six countries about their views on mental illness and the future of psychiatric services. He found that psychiatrists were heavily invested in traditional psychiatric models; no respondents believed that mental illness “does not exist” and no alternatives were offered to the existing service arrangements in the mental health system. Although Müller’s sample size was extremely small, these results suggest that psychiatrists are conservative in their stance toward the possibility of changing established medical practices.

Some researchers have compared clinical practitioners’ constructions of mental health across a variety of mental health professions. In a study including psychologists, psychiatrists, social workers, and psychoanalysts,
Haugen, Tyler, and Clark (1991) found that clinicians' mental health constructions did not differ significantly as a function of their professional group membership or theoretical orientation. In a similar project, Jensen and Bergen (1988) investigated the mental health values of psychologists, psychiatrists, social workers, and marriage and family therapists. As in the previous study, they demonstrated that professional groups had similar mental health constructions, but in contrast, found these constructions to vary as a function of theoretical orientation. Of particular importance to the present study was the finding that mental health constructions were related to clinicians' political values. Specifically, conservatives were more likely than liberals to value traditional morality as a part of a mentally healthy lifestyle. Together these studies suggest that clinicians' political values have a greater influence than their professional affiliation and at least as much influence as their theoretical orientation on their views of what constitutes healthy psychological functioning.

A number of researchers have used analogue studies to investigate the relationship between mental health clinicians' sociopolitical values and biases in clinical judgment. The analogue approach involves the manipulation of patient characteristics such as race, gender, socioeconomic status, and values in clinical case vignettes to assess the impact of these variables on diagnostic determinations. The majority of these studies have been conducted by Stephen Abramowicz and his colleagues. Overall, only a limited number of empirical
investigations have yielded significant results and even within these studies the findings have been relatively sparse. In one study, Abramowitz et al. (1976) found that mental health clinicians who espoused traditional social values, compared to those who held less traditional values, assigned lower ratings of emotional maturity to both female and male patients. In another study, Abramowitz et al. (1975) reported that counsellors with traditional social values rated case histories of female clients as indicative of poorer psychological adjustment than did less traditional counsellors. Abramowitz, Abramowitz, Jackson, and Gomes (1973) varied client gender and political orientation in a 2 X 2 vignette design and demonstrated that more conservative counsellors, but not their liberal peers, assigned higher ratings of maladjustment to a left-wing politically active female than to a similarly described male. In a study of African-American mental health professionals, Benefee, Abramowitz, Weitz, and Armstrong (1976) found that clinicians with nontraditional social beliefs evaluated an African-American patient more favourably than a Caucasian patient, while traditional clinicians tended to have the opposite racial bias. Amira, Abramowitz, and Gomes-Schwartz (1977) manipulated the race and socioeconomic status of a 10-year-old male student in a 2 X 2 vignette design. Their results showed that school psychologists with more traditional social values, but not those with less traditional values, evaluated a lower-class African-American student as less mentally retarded than a middle-class African-American student. The 'traditional psychologists'
ratings of retardation for the lower-class African-American pupil were also lower than less traditional psychologists' retardation ratings for the same lower-class African-American pupil and a middle-class Caucasian pupil. In response to this unexpected result, the authors suggested that the traditional psychologists' favouritism of the lower-class African-American pupil and more negative evaluations of the middle-class African-American pupil may represent discrimination against more socially mobile African-American students as they pose a greater threat to the existing social order.

These highly specific and complex interactional effects may represent anomalies more than evidence of a true relationship between clinical biases and practitioner sociopolitical values. In an extensive review of analogue studies, Abramowitz and Drokecki (1977) conclude that "the conservative-traditional practitioner is seldom guilty of undue harshness toward the socially marginal person" (p. 471). This opinion was supported by results from a more recent study conducted by Gartner and his colleagues (Gartner, Harmatz, Hohmann, Larson, & Gartner, 1990). These researchers found that conservative and liberal clinical psychologists preferred patients whose political ideology corresponded to their own; yet clinicians' ratings of pathology, stress level, and maturity did not differ as a function of the patients' or their own political orientations. Gartner et al.'s results suggest that although clinicians preferred same-ideology patients, they did not let their political values affect their clinical evaluations.
Clearly, these analogue studies do not provide strong evidence to suggest that mental health professionals' sociopolitical values influence or bias their clinical judgments; but the conception of bias in these investigations is overly narrow and simplistic. Bias is seen as a prejudice on the part of clinicians leading to the overpathologizing of women, individuals from lower socioeconomic groups, and other disempowered persons. These researchers have failed to consider the biases inherent in Western culture which lead to real differences in psychological distress for marginal members of society. The question of bias in mental health practice should not so much be whether clinicians overpathologize marginalized individuals, but whether they recognize the socioeconomic variables which contribute to these individuals' higher levels of distress.

In conclusion, though no empirical research has been conducted that directly investigates the relationship between clinicians' endorsement of ideological mental disorder formulations and their personal sociopolitical values, a few studies have suggested the following: mental health clinicians endorse asocial mental disorder models more than laypersons; psychiatrists are resistant to changing ideological psychiatric formulations; mental health practitioners' conceptions of healthy psychological functioning are related to their sociopolitical values; clinicians' sociopolitical values sometimes moderate biases in their assessments of client functioning.
Overview of the Present Study

Statement of the Problem

Positivist psychiatry holds that mental disorder formulations are grounded in sound scientific criteria. In contrast, postmodern theorists have suggested that psychiatric conceptions are ideological in that they divert attention from the dehumanizing social structures which give rise to human suffering and, thereby, protect the status quo. This review suggests that mental health professionals contribute to the perpetuation of these political constructions and stand to benefit from their implementation. Furthermore, it has been hypothesized that the extent to which clinical practitioners subscribe to these ideological models is rooted in their own social and political values. To date, no empirical studies have directly addressed this contention. It is the purpose of the present study to examine the thesis that mental health clinicians' endorsement of mental disorder ideology is related to their sociopolitical world view.

Research Design

Research packages containing a demographics questionnaire, four vignette questionnaires, and a sociopolitical values questionnaire were mailed to clinical psychologists throughout the United States. Endorsement of mental disorder ideology was measured through responses to the four vignette questionnaires designed by the author, based upon the literature review. Each
vignette provides a brief description of an individual experiencing psychological distress who has been seen for an initial interview at a mental health clinic. The vignettes were specifically designed so that each character’s history is indicative of at least a provisional diagnosis in the DSM-III-R. In addition, the descriptions include a variety of microsocial and macrosocial contextual variables which could potentially account for the individual’s problems. Consequently, the cases can be formulated within any combination of biological, psychological, interpersonal/situational, and societal perspectives. After each vignette, there are five questions requiring participants to provide the following:

(i) a rating of the degree to which the person is in need of help (on a 7-point Likert scale),

(ii) a rating of whether there is evidence of a mental disorder (on a 7-point Likert scale), and a provisional diagnosis,

(iii) ratings of the extent to which each of four factors is responsible for the person’s problems,

(iv) ratings of the extent to which interventions focused on each of four factors are likely to contribute to the resolution of the person’s problems, and

(v) ratings of the extent to which each of four strategies is likely to contribute to the prevention of similar problems in the general population.

The four factors for questions 3, 4, and 5 correspond to the four mental health perspectives (biological, psychological, interpersonal/situational, and societal)
discussed above and will be referred to as "mental health factors." In accordance with Prilleltensky's (1990b) terminology, the Biological and Psychological factors are both considered "asocial" mental health factors; the Interpersonal/Situational factor is designated as the "microsocial" mental health factor; finally, the Societal factor is conceptualized as the "macrosocial" mental health factor.

Personal sociopolitical values were assessed by participants' responses to questions on various socioeconomic issues included in a scale measuring the dimension of liberalism-conservativism and by their responses to two items on the demographics questionnaire requiring ratings of self-reported political orientation and political party preference.

Research Hypotheses

On the basis of the literature reviewed in this chapter, the following hypotheses were made:

**Hypothesis 1:** It was predicted that participants' ratings of the degree to which the person is in need of help (item 1) would be positively correlated with their ratings of the degree to which there is evidence of a mental disorder (item 2).

**Hypothesis 2:** It was predicted that participants' sociopolitical values would be significantly correlated with their ratings of mental disorder (item 2).
Specifically, more conservative participants were expected to give higher evidence-of-mental-disorder ratings than more liberal participants.

**Hypothesis 3:** It was predicted that the relationship between need-of-help ratings (item 1) and mental disorder ratings (item 2) would vary as a function of sociopolitical values. Specifically, these variables were expected to be more highly correlated for more conservative participants.

**Hypothesis 4:** It was predicted that ratings assigned to each mental health factor would be consistent across problem responsibility factors (item 3), problem resolution factors (item 4), and prevention strategies (item 5).

**Hypothesis 5:** It was predicted that ratings assigned to each mental health factor would be consistent across vignettes.

**Hypothesis 6:** It was predicted that ratings assigned to problem responsibility factors (item 3), problem resolution factors (item 4), and prevention strategies (item 5) would be lower for the macrosocial factor (Societal) than for all other mental health factors (Biological, Psychological, and Interpersonal/Situational).

**Hypothesis 7:** It was predicted that ratings of mental disorder (item 2) would be significantly related to ratings of problem responsibility factors (item 3), problem resolution factors (item 4), and prevention strategies (item 5). More specifically, mental disorder ratings were expected to be positively correlated with scores on the asocial mental health factors (Biological and
Psychological) and negatively correlated with scores on the microsocial (Interpersonal/Situational) and macrosocial (Societal) factors.

**Hypothesis 8:** It was predicted that sociopolitical values would be significantly related to ratings of problem responsibility factors (item 3), problem resolution factors (item 4), and prevention strategies (item 5). For the asocial mental health factors (Biological and Psychological), more conservative participants were expected to have higher factor scores than more liberal participants. Conversely, for the microsocial (Interpersonal/Situational) and macrosocial (Societal) mental health factors, more liberal participants were expected to have higher factor scores than more conservative participants.

**Hypothesis 9:** It was predicted that the relationship between ratings of mental disorder (item 2) and ratings of problem responsibility factors (item 3), problem resolution factors (item 4), and prevention strategies (item 5) would vary as a function of sociopolitical values. Specifically, these variables were expected to be more highly correlated (in the directions outlined in Hypothesis 7) for more conservative participants.
CHAPTER II

METHOD

Participants

Research materials were mailed to 810 clinical psychologists sampled randomly from the National Register of Health Service Providers in Psychology. All potential participants resided in the United States of America. Further details regarding the participant sample are provided in the Results Section.

Materials

Participants were requested to complete a demographics questionnaire, four vignette questionnaires, and the Social Attitudes Scale (SAS), a measure of sociopolitical values (Kerlinger, 1970; Shaw & Wright, 1967).

Demographics Questionnaire. In order to assess the demographics of the sample, participants were asked to fill out a demographics questionnaire created by the author (see Appendix A). Questions were asked on the following subjects: gender, age, state of residence, ethnic/racial identity, years of professional experience, primary theoretical orientation, primary practice setting, population of community in which primary practice setting is located, use of diagnosis, self-rated political orientation (SRPO), and political party
preference (PPP). The political orientation variable required participants to make a mark on a 17 cm continuum ranging from strongly liberal (0 cm) to strongly conservative (17 cm) with moderate as the midpoint. Responses to this variable were scored in mm from the left endpoint of the line.

**Vignette Questionnaires.** The four vignette questionnaires described in the introduction are presented in Appendix B. Mental health factor ratings on questions 3, 4, and 5 were scored along a 17 cm continuum similar to that used for the self-rated political orientation measure. Again, responses to each question were scored in mm from the left endpoint of the line.

**Social Attitudes Scale.** The SAS (Kerlinger, 1970; Shaw & Wright, 1967) is a 26-item self-report inventory which measures liberal versus conservative political values (see Appendix C). Respondents are asked to indicate on a 6-point Likert scale, the extent to which they agree with statements about various sociopolitical issues; for example, "Unemployment insurance is an inalienable right of the working person," and "There should be no government interference with business and trade." Liberal values are reflected by agreement on 13 items and conservative values by endorsement on the remaining 13. Kerlinger (1970) found that these liberal and conservative items tended to fall into two factors. On the basis of this and other attitudinal research (Kerlinger, 1967, 1980; Kerlinger, Middendorp, & Amon, 1976), he concluded that social attitudes are dualistic rather than bipolar in nature.
However, his findings were inconsistent and depended upon the degree of political conviction in his samples, extreme political views being associated with more unidimensional factor structures. Furthermore, critics have suggested that Kerlinger's findings were due to methodological problems, such as the differential effects of acquiescence response bias on positively and negatively worded items (Ray, 1972), and his interpretation of factor structures supporting dualism when bipolar factor solutions also existed (Zdep & Marco, 1969).

Psychometric studies show the SAS to be a reliable and valid measure of political values. Shaw and Wright (1967) reported split-half reliability estimates of .78 and .79 for the liberal and conservative factors, respectively. Test-retest reliabilities over a three-month interval were found to be .85 and .84 for liberal and conservative dimensions, respectively (Kerlinger, 1970). In support of the SAS's convergent validity, the conservativism factor correlated substantially with measures of authoritarianism and rigidity, and both the liberal and conservative factors were positively correlated with a politically neutral measure of dogmatism. Neither factor had a substantial correlation with intelligence or social desirability, reflecting their discriminant validity (Kerlinger, 1970).

However, the liberal and conservative factors were negatively correlated with each other ($r = -.26$; Kerlinger, 1970), suggesting that they do not represent two independent factors, and thus supporting the use of the SAS as
a unidimensional scale. The construct validity of the SAS as a unidimensional measure was supported in a study investigating the impact of leadership style on group interactions in liberal versus conservative subgroups. Using the SAS as a bipolar scale, Gilstein, Wright, and Stone (1977) divided individuals into two political groups. Liberalism was found to positively correlate with measures of responsiveness to others, flexibility in both thinking and social behavior, and spontaneity and self-confidence in social situations. Conservativism, on the other hand, was found to be positively related to conformity to societal norms.

In the present study, the SAS was used as a unidimensional measure of sociopolitical values, with the scores for liberal responses reversed and higher scores indicative of conservativism. One item (the first example illustrated above) was altered to remove sexist language.

Procedure

The questionnaire package was mailed to clinical psychologists following Dillman's (1978) recommendations for mail surveys. Included in the mailing package was the questionnaire battery, a cover letter stating the purpose of the study and general instructions (see Appendix D), a set of specific instructions for the completion of the questionnaires (see Appendix E), and a self-addressed stamped envelope. The clinicians were informed that returning the questionnaire package would be taken as an indication of their
consent to participate in the study. The questionnaires were presented in the following order: demographics questionnaire, vignette questionnaires, and the SAS. Two weeks after the research materials were mailed, a follow-up postcard was sent to each clinician (see Appendix F). The postcard was designed to encourage potential participants to complete and return the questionnaire and to thank those who had already done so.
CHAPTER III

RESULTS

Analysis of the data was conducted in two stages. Preliminary analyses were performed to prepare the data for further statistical analysis, to describe the nature of the participant sample, to examine the different measures of sociopolitical values, and to create composite variables for use in later analyses. The results of these procedures are presented in the first section of this chapter. For the principal analyses, a series of hierarchical regressions were conducted to investigate the predictors of mental disorder ratings; hierarchical regressions were also employed to assess the predictors of each mental health factor; and profile analyses/MANOVA’s were performed to examine the mental health factors and compare their ratings across subsamples of participants with differing sociopolitical values. These analyses are outlined in the second section of this chapter. All statistical procedures were conducted using the Statistical Package for the Social Sciences (SPSS) Data Analysis System (see Norusis, 1990a, 1990b).
Preliminary Analyses

Development of the Final Data Set and Treatment of Missing Values

From the original 810 questionnaires sent out, 2 were returned by the postal service as undeliverable. Out of the remaining 808 questionnaires, a total of 147 were received, representing a return rate of 18.2%. Of those questionnaires received, 17 were dropped from the analyses due to significant missing data, generating a final sample of 130 participants (a 16.1% return rate for useable questionnaires).

Although questionnaires with a considerable number of nonresponses were excluded from the study, dropping all participants whose questionnaires contained missing data would have reduced the sample substantially, and thus some questionnaires with missing values were included in the final data set. In order to address these missing data points, two strategies were taken. When a questionnaire had missing values on demographic variables, it was deleted from analyses in which the relevant variable was under investigation, but included in all other analyses. In contrast, for nondemographic variables, means based on available data were substituted for missing values prior to data analysis. Mean substitution is a generally acceptable approach to the treatment of missing data due to its conservativeness - although missing values are estimated, the overall mean for each variable does not change. However, it should be noted that mean substitution does reduce a variable’s variance,
subsequently diminishing its correlation with other variables (Tabachnick & Fidell, 1989).

**Description of the Participant Sample**

The demographic characteristics for the final participant sample are presented in Table 1. Concerning gender, 67.7% of the clinical psychologists were male and 32.3% were female. The average age of respondents was 53.1 years. With respect to ethnic/racial identification, 95.4% of practitioners described themselves as Caucasian, whereas 4.6% identified themselves with other ethnic/racial groups (e.g., Hispanic, 0.8%; Italian American, 0.8%; European American, 0.8%; Hispanic, Caucasian, and Asian/Pacific Islander, 0.8%). This distribution of personal characteristics is consistent with other mail surveys of American psychologists (see Haugen, Tyler, & Clark, 1991; Jensen & Bergin, 1988).

Geographic statistics indicate that all major regions across the United States were represented in the participant sample: 23.5% of clinicians were from the southeastern and mid-Atlantic states, 21.8% from the northeastern states, 19.3% from the southcentral states, 15.1% from the Great Lakes region, 14.3% from the southwest and Hawaii, and 5.9% from the northwest and Great Plains region. Of the communities in which the respondents' primary practice settings were located, 26.4% had a population of less than 100,000, 34.1% had a
Table 1

Demographic Characteristics of the Sample

<table>
<thead>
<tr>
<th>Variable</th>
<th>n (%)</th>
<th>M (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>88</td>
<td>(67.7)</td>
</tr>
<tr>
<td>Female</td>
<td>42</td>
<td>(32.3)</td>
</tr>
<tr>
<td><strong>Age (years)a</strong></td>
<td>53.1</td>
<td>(10.1)</td>
</tr>
<tr>
<td><strong>Ethnic/Racial Identification:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>124</td>
<td>(95.4)</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
<td>(4.6)</td>
</tr>
<tr>
<td><strong>Geographic Location:b</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Southeast &amp; Mid-Atlantic</td>
<td>28</td>
<td>(23.5)</td>
</tr>
<tr>
<td>Northeast</td>
<td>26</td>
<td>(21.8)</td>
</tr>
<tr>
<td>South Central</td>
<td>23</td>
<td>(19.3)</td>
</tr>
<tr>
<td>Great Lakes</td>
<td>18</td>
<td>(15.1)</td>
</tr>
<tr>
<td>Southwest &amp; Hawaii</td>
<td>17</td>
<td>(14.3)</td>
</tr>
<tr>
<td>Northwest &amp; Great Plains</td>
<td>7</td>
<td>(5.9)</td>
</tr>
<tr>
<td><strong>Population of Practice Setting Community:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;100,000</td>
<td>34</td>
<td>(26.4)</td>
</tr>
<tr>
<td>100,000-499,999</td>
<td>44</td>
<td>(34.1)</td>
</tr>
<tr>
<td>500,000-1,000,000</td>
<td>15</td>
<td>(11.6)</td>
</tr>
<tr>
<td>&gt;1,000,000</td>
<td>36</td>
<td>(27.9)</td>
</tr>
<tr>
<td><strong>Years of Professional Experience:</strong></td>
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<td></td>
</tr>
<tr>
<td></td>
<td>20.3</td>
<td>(10.1)</td>
</tr>
<tr>
<td><strong>Theoretical Orientation:</strong></td>
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<tr>
<td>Eclectic</td>
<td>47</td>
<td>(36.2)</td>
</tr>
<tr>
<td>Cognitive/Behavioral</td>
<td>38</td>
<td>(29.2)</td>
</tr>
<tr>
<td>Psychodynamic/analytic</td>
<td>29</td>
<td>(22.3)</td>
</tr>
<tr>
<td>Other</td>
<td>16</td>
<td>(12.3)</td>
</tr>
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</table>

continued
Table 1 continued

<table>
<thead>
<tr>
<th>Variable</th>
<th>n (%)</th>
<th>Value (% or)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice Setting:</td>
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<td></td>
</tr>
<tr>
<td>Private Practice</td>
<td>73</td>
<td>(56.2)</td>
</tr>
<tr>
<td>Hospital</td>
<td>30</td>
<td>(23.1)</td>
</tr>
<tr>
<td>Outpatient Clinic</td>
<td>16</td>
<td>(12.3)</td>
</tr>
<tr>
<td>Other</td>
<td>11</td>
<td>(8.5)</td>
</tr>
<tr>
<td>Use of Diagnosis&lt;sup&gt;e&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>≤50%</td>
<td>22</td>
<td>(17.2)</td>
</tr>
<tr>
<td>&gt;50%</td>
<td>106</td>
<td>(82.8)</td>
</tr>
<tr>
<td>Self-Rated Political Orientation:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Liberal</td>
<td>84</td>
<td>(64.6)</td>
</tr>
<tr>
<td>Conservative</td>
<td>32</td>
<td>(24.6)</td>
</tr>
<tr>
<td>Moderate</td>
<td>14</td>
<td>(10.8)</td>
</tr>
<tr>
<td>Political Party Preference:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Democratic</td>
<td>85</td>
<td>(65.4)</td>
</tr>
<tr>
<td>Republican</td>
<td>27</td>
<td>(20.8)</td>
</tr>
<tr>
<td>None or Other</td>
<td>18</td>
<td>(13.8)</td>
</tr>
<tr>
<td>Social Attitudes Scale</td>
<td>M (SD)</td>
<td>79.9 (16.0)</td>
</tr>
</tbody>
</table>

Note. N = 130 unless otherwise noted.
<sup>a</sup>N = 120 for total sample.
<sup>b</sup>N = 119 for total sample.
<sup>c</sup>N = 129 for total sample.
<sup>d</sup>N = 129 for total sample.
<sup>e</sup>N = 128 for total sample.
population of 100,000 to 499,999, 11.6% had a population of 500,000 to
1,000,000, and 27.9% had a population of greater than 1,000,000.

The clinicians had an average of 20.3 years of postgraduate professional
experience. With respect to primary theoretical orientation, 36.2% of clinicians
identified themselves as eclectic, 29.2% as cognitive/behavioral, 22.3% as
psychodynamic/psychoanalytic, and 12.3% subscribed to other theoretical
perspectives (e.g., humanistic, 3.8%; systems, 2.3%; biological, 1.5%; gestalt,
1.5%). Regarding primary practice setting, 56.2% of respondents reported
working in a private practice, 23.1% in a hospital, 12.3% in an outpatient clinic,
and 8.5% in other practice settings (e.g., forensic setting, 2.3%; HMO, 1.5%).
Concerning clinical diagnosis, 82.8% of practitioners reported that they assign
DSM-III-R or ICD-9 diagnoses to more than 50% of their clients/patients,
whereas 17.2% indicated that they assign diagnoses to 50% or less of their
clientele.

On a continuum ranging from strongly liberal to strongly conservative
with moderate as the midpoint, 64.6% of respondents identified their political
orientation as liberal, 24.6% identified themselves as conservative, and 10.8%
located themselves directly at the moderate midpoint. Democratic was
identified as the political party preference of 65.4% of respondents, Republican
was selected by 20.8%, and "none" or "other" was chosen by 13.8% (e.g., none,
9.2%; Independent, 3.1%). The mean score on the Social Attitudes Scale (SAS)
was 79.9, 11 points below the scale’s midpoint in the liberal direction.
Examination of the Sociopolitical Values Measures

As previously outlined, the construct "sociopolitical values" was assessed by three different measures: the Social Attitudes Scale (SAS), self-rated political orientation (SRPO), and political party preference (PPP). For the statistical analyses, SAS and SRPO were selected as the principal measures of sociopolitical values as they are both continuous variables and thus have more variance than the categorical variable PPP. Most of the analyses investigating the relationship between sociopolitical values and other variables were conducted twice, alternating SAS and SRPO as the measure of the sociopolitical values construct. However, SAS and SRPO themselves were strongly correlated, \( r = .74, p < .001 \), and thus the separate analyses yielded highly similar results. As the 26-item SAS represents a more complex and multi-faceted measure of sociopolitical values than the single-item SRPO, and as its reliability and validity have been well documented, results from the SAS analyses were selected for presentation in this chapter.

Reliability. The internal consistency estimate for the SAS was well within acceptable limits, Cronbach’s \( \alpha = .87 \). Internal consistency coefficients are not relevant to the two single-item sociopolitical values measures and therefore no reliability statistics are available for these variables.

Relationships between sociopolitical values and the demographic variables. The primary purpose of this research was to investigate the role of sociopolitical values in mediating endorsement of mental disorder ideology.
To insure that any significant findings were due more to the participants' sociopolitical values than to differences in gender, age, theoretical orientation, etc., the relationships between SAS and the demographic variables were investigated. These relationships were assessed utilizing Pearson product-moment correlations for the continuous demographic variables and ANOVAs for the categorical demographic variables. SAS's correlations with both Age, \( r = -.05, p > .05 \), and Years of Professional Experience, \( r = -.09, p > .05 \), were nonsignificant. But, as previously noted, SAS and SRPO were highly correlated, \( r = .74, p < .001 \); liberalism on SAS was associated with liberalism on SRPO. Summary statistics for the demographic variable ANOVAs are presented in Table 2. SAS scores did not differ as a function of the categorical demographic variables, with the exception of PPP, \( F(2, 127) = 33.24, p < .001 \). Tukey's HSD post hoc comparisons demonstrated significantly different SAS scores across all three PPP groups: participants who identified Democratic as their political party preference had the most liberal sociopolitical values (\( M = 73.7 \)), those who selected "none" or "other" had the second most liberal values (\( M = 84.4 \)), and participants who chose Republican had the least liberal values (\( M = 96.7 \)). Together these findings indicate that SAS was significantly related only to demographic variables which represented alternative measures of sociopolitical values.

Creation of subsamples of participants with differing sociopolitical values. A few of the principal analyses (e.g., MANOVA) required use of a
Table 2

Demographic Variable ANOVA Summary Statistics for SAS Scores

<table>
<thead>
<tr>
<th>Source of Variation</th>
<th>SS</th>
<th>df</th>
<th>MS</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group</td>
<td>831.90</td>
<td>1</td>
<td>831.90</td>
<td>3.31</td>
</tr>
<tr>
<td>S/group</td>
<td>3218.42</td>
<td>128</td>
<td>251.45</td>
<td></td>
</tr>
<tr>
<td>Ethnic/Racial Identification</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group</td>
<td>143.77</td>
<td>1</td>
<td>143.77</td>
<td>.56</td>
</tr>
<tr>
<td>S/group</td>
<td>32873.55</td>
<td>128</td>
<td>256.82</td>
<td></td>
</tr>
<tr>
<td>Geographic Location&lt;sup&gt;a&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group</td>
<td>1691.55</td>
<td>5</td>
<td>338.31</td>
<td>1.35</td>
</tr>
<tr>
<td>S/group</td>
<td>28419.49</td>
<td>113</td>
<td>251.50</td>
<td></td>
</tr>
<tr>
<td>Population of Practice Setting Community&lt;sup&gt;b&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group</td>
<td>948.22</td>
<td>3</td>
<td>316.07</td>
<td>1.23</td>
</tr>
<tr>
<td>S/group</td>
<td>32067.98</td>
<td>125</td>
<td>256.54</td>
<td></td>
</tr>
<tr>
<td>Theoretical Orientation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group</td>
<td>1854.94</td>
<td>3</td>
<td>618.31</td>
<td>2.50</td>
</tr>
<tr>
<td>S/group</td>
<td>31162.38</td>
<td>126</td>
<td>247.32</td>
<td></td>
</tr>
<tr>
<td>Practice Setting</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group</td>
<td>596.09</td>
<td>3</td>
<td>198.70</td>
<td>.77</td>
</tr>
<tr>
<td>S/group</td>
<td>32421.23</td>
<td>126</td>
<td>257.31</td>
<td></td>
</tr>
<tr>
<td>Use of Diagnosis&lt;sup&gt;c&lt;/sup&gt;</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group</td>
<td>235.35</td>
<td>1</td>
<td>235.35</td>
<td>.91</td>
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<td>S/group</td>
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<td>126</td>
<td>258.57</td>
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<tr>
<td>Political Party Preference</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group</td>
<td>11345.38</td>
<td>2</td>
<td>5672.69</td>
<td>33.24***</td>
</tr>
<tr>
<td>S/group</td>
<td>21671.94</td>
<td>127</td>
<td>170.65</td>
<td></td>
</tr>
</tbody>
</table>

continued
Note. $N = 130$ unless otherwise noted.

$^a N = 119$ for total sample.

$^b N = 129$ for total sample.

$^c N = 128$ for total sample.

$^{***} p < .001$. 
categorical measure of sociopolitical values. Thus, the entire participant sample was divided into two subsamples (n = 65 per group), based on a median split of SAS. SAS was utilized for the creation of these subgroups in order to maintain a consistent sociopolitical values measure for all statistical procedures.

However, it should be noted that the resulting subsamples did not represent two distinct sociopolitical groups, as the sample consisted of more participants who identified themselves as liberal than participants who identified themselves as conservative. For the group of clinicians who scored below the SAS median, 90.8% identified their political orientation on SRPO as liberal and 4.6% selected conservative; the remaining 4.6% placed themselves directly at the moderate midpoint. On PPP, 90.8% of this group chose the Democratic party as their political party preference, only 1.5% favored the Republican party, and 7.7% indicated "none" or "other." For those participants who scored above the SAS median, 44.6% identified themselves as conservative on SRPO, 38.5% marked their orientation as liberal, and 16.9% fell at the midpoint. On PPP, preferences were split evenly between the Democratic (40.0%) and Republican (40.0%) parties; the remaining 20.0% of participants chose "none" or "other." These results indicate that the median split yielded one group consisting mainly of liberal participants and another group with a mixture of liberals and conservatives. As the clinicians in the first group had lower SAS scores (i.e., more liberal values) than the clinicians in the second
group, these two subsamples will be referred to as the "Comparatively Liberal" group and the "Comparatively Conservative" group, respectively. However, when summarizing results and when discussing findings from analyses in which SAS was used as a continuous variable, the phrases "more liberal" and "more conservative" will be employed to describe participants with differing sociopolitical values.

Creation of Composite Variables

Prior to conducting the principal analyses, relationships among the multiple measures of each mental health factor (i.e., Biological, Psychological, Interpersonal/Situational, and Societal) were examined. This procedure was undertaken in order to investigate Hypothesis 4, the prediction that ratings assigned to each mental health factor would be consistent across questions 3, 4, and 5 (i.e., questions regarding problem responsibility factors, problem resolution factors, and prevention strategies, respectively); to investigate Hypothesis 5, the prediction that ratings assigned to each mental health factor would be similar across vignettes; and finally, to evaluate the possibility of creating composite variables for use in subsequent analyses. Intercorrelation matrices for each of the mental health factors are presented in Appendix G. The consistency of the mental health factors across questions and across vignettes was assessed by calculating Cronbach’s $g$ coefficients for composite measures of each factor (see Table 3). All coefficients were found to be within acceptable limits suggesting that ratings of mental health factors were similar
Table 3
Cronbach's Alpha Reliability Coefficients for the Mental Health Factors

<table>
<thead>
<tr>
<th>Composite</th>
<th>B</th>
<th>P</th>
<th>I/S</th>
<th>S</th>
</tr>
</thead>
<tbody>
<tr>
<td>V1-Q3,4,5</td>
<td>.76</td>
<td>.82</td>
<td>.78</td>
<td>.84</td>
</tr>
<tr>
<td>V2-Q3,4,5</td>
<td>.84</td>
<td>.80</td>
<td>.85</td>
<td>.89</td>
</tr>
<tr>
<td>V3-Q3,4,5</td>
<td>.87</td>
<td>.88</td>
<td>.85</td>
<td>.90</td>
</tr>
<tr>
<td>V4-Q3,4,5</td>
<td>.87</td>
<td>.84</td>
<td>.86</td>
<td>.90</td>
</tr>
<tr>
<td>Q3-V1,2,3,4</td>
<td>.71</td>
<td>.76</td>
<td>.67</td>
<td>.76</td>
</tr>
<tr>
<td>Q4-V1,2,3,4</td>
<td>.64</td>
<td>.72</td>
<td>.75</td>
<td>.79</td>
</tr>
<tr>
<td>Q5-V1,2,3,4</td>
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<td>.82</td>
<td>.77</td>
<td>.75</td>
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<tr>
<td>All</td>
<td>.88</td>
<td>.91</td>
<td>.90</td>
<td>.92</td>
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</table>

Note. B = Biological; P = Psychological; I/S = Interpersonal/Situational; S = Societal; V = vignette; Q = question.
across questions and vignettes; thus, both Hypotheses 4 and 5 were supported. However, coefficients based on within-vignette, across-questions composites (Range = .76 to .90) were generally higher than coefficients based on same-question, across-vignettes composites (Range = .64 to .82). Moreover, composites based on all 12 items (4 vignettes × 3 questions; i.e., total composites) generated the highest coefficients (Range = .88 to .92). On the basis of these results, it was decided that subsequent analyses involving mental health factors would be conducted utilizing both total and within-vignette composites.

Cronbach’s α coefficients were also calculated for total (across-vignette) composites of need-of-help ratings (HELP) and mental disorder ratings (MD). These coefficients were lower for both HELP (α=.66) and MD (α=.56) than those found for the mental health factors. Nevertheless, they are indicative of some consistency, and thus HELP and MD composite variables were utilized in subsequent analyses.5

**Principal Analyses**

**Hierarchical Regression Analysis: Prediction of Mental Disorder Ratings**

The first set of principal analyses was designed to examine the extent to which sociopolitical values influence use of the mental disorder concept as a descriptor for people’s problems. Three predictions regarding use of the

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5 HELP and MD composite variables’ relationships with other variables may be somewhat smaller than would be expected had the Cronbach’s α coefficients been higher.
mental disorder label were made. In Hypothesis 1, it was suggested that participants' need-of-help ratings would be positively correlated with their mental disorder ratings. In Hypothesis 2, it was predicted that participants' sociopolitical values would be significantly related to their mental disorder ratings (specifically, conservativism would be associated with higher evidence-of-mental-disorder ratings). Finally, in Hypothesis 3, it was proposed that the correlation between need-of-help ratings and mental disorder ratings would be greater for participants with more conservative sociopolitical values.

**Zero-order correlations.** Pearson product-moment correlations were calculated to assess relationships between need-of-help ratings (HELP), mental disorder ratings (MD), and sociopolitical values (SAS), per vignette and for HELP and MD composites (see Table 4). HELP was positively correlated with MD for composite variables, $r = .50$, $p < .001$, and for each vignette separately, with the exception of vignette 1; thus, higher need-of-help ratings were associated with higher evidence-of-mental-disorder ratings. SAS was not significantly related to MD for the composite variable or individual vignettes, with the exception of vignette 2, where it had a significant negative correlation, $r = -.21$, $p < .05$. Therefore, sociopolitical values were generally not related to mental disorder ratings, though on vignette 2, more liberal sociopolitical values were associated with higher ratings of mental disorder (contrary to Hypothesis 2 which predicted the opposite relationship). Of interest, though not relevant to the hypotheses, SAS was found to be negatively correlated with HELP for
<table>
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</tr>
<tr>
<td>SAS</td>
<td>.00³</td>
<td>-.18*</td>
</tr>
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</table>

Note. MD = mental disorder ratings; HELP = need-of-help ratings; SAS = Social Attitudes Scale.
³Correlation coefficient is not exactly 0.
*p<.05. **p<.01. ***p<.001.
the composite variable, \( r = -0.25, p < 0.01 \), and for each individual vignette, except vignette 3; this finding indicates that more liberal sociopolitical values were associated with higher need-of-help ratings.

**Creation of interaction terms.** Prior to conducting the regression analyses, HELP X SAS interaction terms were created for both composite and individual vignette HELP scores. To develop the interaction terms, participants' HELP and SAS scores were "centered" by subtracting the group mean from each individual's score; a new variable for the interaction term was then created by multiplying the transformed HELP and SAS scores together. The HELP X SAS interaction effect tests the homogeneity of the slopes resulting from MD on HELP regressions calculated separately for the Comparatively Liberal and Comparatively Conservative subsamples. A significant interaction, indicating that the slopes do indeed differ, would support Hypothesis 3, the prediction that the relationship between HELP and MD would vary as a function of sociopolitical values.

**Regression analyses.** Hierarchical regression analyses were performed to evaluate the unique contributions of HELP and SAS in predicting MD, and to assess the statistical significance of the HELP X SAS interaction terms. HELP and SAS were entered into the equation simultaneously at step 1, followed by the HELP X SAS interaction term at step 2. Table 5 displays the results of regression analyses conducted for composites and each individual vignette.
## Table 5

**Hierarchical Regression Analyses for Mental Disorder Ratings**

<table>
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<tr>
<th>Variable</th>
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<td>.008</td>
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<td>.001</td>
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<td>.005</td>
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<td>.004</td>
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<td>.008</td>
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</table>

*Note.* HELP = need-of-help ratings; SAS = Social Attitudes Scale.

^a$\Delta R^2$ is not exactly 0.

***p<.001.
Only for vignette 2 were MD’s correlations with HELP and SAS both significant (see Table 4). Therefore, the results from step 1 were examined for this vignette exclusively. On vignette 2, HELP and SAS together accounted for 36% of the variance in MD, $R^2 = .36$, $F(2, 127) = 36.12$, $p < .001$. However, only HELP made a unique contribution to the equation, $\beta = .58$, $t(127) = 7.96$, $p < .001$. This finding suggests that the more liberal participants’ higher evidence-of-mental disorder ratings on vignette 2 were tied to the correlation between liberalism and higher need-of-help ratings.

The results from step 2 were inspected for composites and for each individual vignette. The interaction term was not statistically significant for the composites or individual vignettes, indicating that the relationship between need-of-help and mental disorder ratings did not differ as a function of clinicians’ sociopolitical values.

MD regression results summary. Together these analyses indicate that need-of-help ratings were moderately associated with mental disorder ratings. As predicted in Hypothesis 1, participants who assigned higher need-of-help ratings were more likely to view vignette subjects’ problems as evidence of mental disorder. Sociopolitical values, on the other hand, were generally not associated with mental disorder ratings. Thus, Hypothesis 2, the prediction that conservativism would be associated with higher evidence-of-mental disorder ratings, was not supported. Nor did sociopolitical values significantly influence the relationship between need-of-help and mental disorder ratings.
Thus, Hypothesis 3, the prediction that the correlation between need-of-help ratings and mental disorder ratings would be greater for participants with more conservative sociopolitical values, was also not supported.

Hierarchical Regression Analysis: Prediction of Mental Health Frameworks

The second set of principal analyses was employed to assess whether use of the mental disorder concept was related to endorsement of particular mental health factors and whether practitioners' sociopolitical values influenced their overall mental health frameworks. Three predictions were made regarding these issues. In Hypothesis 7, it was suggested that mental disorder ratings would be positively correlated with scores on the asocial mental health factors (Biological and Psychological) and negatively correlated with scores on the microsocial (Interpersonal/Situational) and macrosocial (Societal) factors. In Hypothesis 8, it was predicted that sociopolitical values would be significantly related to mental health frameworks (specifically, more conservative participants were expected to place greater emphasis than more liberal participants on asocial mental health factors and less emphasis than more liberal participants on microsocial and macrosocial factors). Finally, in Hypothesis 9, it was proposed that the correlation between mental disorder ratings and mental health frameworks would be greater for participants with more conservative sociopolitical values.
Zero-order correlations. Pearson product-moment correlations were calculated to assess the mental health factors’ relationships with MD and SAS, per vignette and for MD and mental health factor total composites (see Table 6). As specific hypotheses were made for each of these relationships, one-tail tests of significance were employed. MD was positively correlated with the Biological factor (B) for total composites, r = .21, p < .01, and each vignette separately with the exception of vignette 3. It also had a positive correlation with the Psychological factor (P) for total composites, r = .17, p < .05, and vignettes 1 and 3. It was negatively correlated with the Interpersonal/Situational factor (I/S) but only on vignette 4, r = -.27, p < .01.

Finally, MD was negatively related to the Societal factor (S) for vignettes 1, r = -.16, p < .05, and 4, r = -.15, p < .05. All significant correlations were in the predicted direction. These findings indicate that higher mental disorder ratings were associated with greater endorsement of the Biological and Psychological factors, and that lower mental disorder ratings, on some vignettes, were associated with increased scores for the Interpersonal/Situational and Societal factors.

SAS had a significant positive correlation with B, but only on vignette 4, r = .15, p < .05. It was also positively correlated with P for the total-composite variable, r = .15, p < .05, and vignette 1. It was not correlated with I/S for the total composite or any individual vignettes. However, SAS did have a significant negative correlation with S for the total composite, r = -.35, p < .001,
Table 6
Mental Health Factors’ Correlations with MD and SAS

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mental Health Factor</th>
</tr>
</thead>
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<td></td>
<td>B</td>
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<td>Total Composites</td>
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</tr>
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<td>MD</td>
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<td>SAS</td>
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<tr>
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<td>MD</td>
<td>.23**</td>
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<td>.04</td>
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<td>SAS</td>
<td>.09</td>
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<td>MD</td>
<td>.38***</td>
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<tr>
<td>SAS</td>
<td>.15*</td>
</tr>
</tbody>
</table>

Note. B = Biological; P = Psychological; I/S = Interpersonal/Situational; S = Societal. MD = mental disorder ratings; SAS = Social Attitudes Scale. *p<.05, one-tailed. **p<.01, one-tailed. ***p<.001, one-tailed.
and each individual vignette. Again, all significant correlations were in the hypothesized direction. These findings demonstrate a clear relationship between sociopolitical values and Societal factor ratings; more liberal participants assigned greater weight to this factor than their more conservative counterparts. Conservativism, on the other hand, was associated with higher Psychological factor scores and, on one vignette, higher Biological factor scores.

Creation of interaction terms. Prior to running the regression analyses, MD X SAS interaction terms were generated as outlined in the previous analysis: participants' MD and SAS scores were "centered" and the resulting variables were then multiplied together. The MD X SAS interaction terms assess whether regressions of each mental health factor on MD would differ if calculated separately for the Comparatively Liberal and Comparatively Conservative subsamples. A significant interaction would support Hypothesis 9, the prediction that the relationship between the mental health factors and MD would differ as a function of sociopolitical values.

Regression analyses. Hierarchical regression analyses were conducted to gauge the unique contributions of MD and SAS in predicting each of the mental health factors, and to test the statistical significance of the MD X SAS interaction terms. For each regression analysis, MD and SAS were entered into the equation simultaneously at step 1, followed by the MD X SAS interaction term at step 2. The analyses were performed for total composites and
individual vignettes. Results are reported in Tables 7, 8, 9, and 10 for factors B, P, I/S, and S, respectively.

**Biological factor results.** Only on vignette 4 was B correlated with both MD and SAS (see Table 6). Thus, the results from step 1 were examined for this vignette exclusively. On vignette 4, MD and SAS together accounted for 17% of the variance in B, $R^2 = .17$, $F(2, 127) = 12.88$, $p < .001$. However, only MD made a unique contribution to the equation, $\beta = .38$, $t(127) = 4.73$, $p < .001$. Examination of the zero-order correlations (see Table 6) and the standardized regression coefficients ($\beta$; see Table 7) indicates that SAS's relationship with B became nonsignificant in the regression equation due to the correlation's small size rather than to any overlapping association between SAS and MD. Thus, although more conservative participants were found to assign higher ratings to the Biological factor on vignette 4 than more liberal participants, this relationship between sociopolitical values and Biological factor ratings was quite small.

The interaction term was statistically significant for the composites, $\Delta R^2 = .05$, $F(3, 126) = 6.96$, $p < .01$, but not for any of the individual vignettes. To assess the nature of the MD x SAS interaction, MD's correlation with B was examined separately for the Comparatively Liberal and Comparatively Conservative subsamples. For the Comparatively Liberal group, MD and B were positively correlated, $r = .36$, $p < .01$, whereas for the Comparatively Conservative group, MD and B were not significantly related, $r = .06$, $p > .05$. 
<table>
<thead>
<tr>
<th>Variable</th>
<th>β</th>
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**Note.**  MD = mental disorder ratings; SAS = Social Attitudes Scale.

^a OR^2 is not exactly 0.

*p<.05.  **p<.01.  ***p<.001.
An illustration of the MD X SAS interaction is presented in Figure 1, where
MD on B regression lines are plotted for each subgroup (MD range = ± 1 SD,
calculated separately for each subgroup). Evidently, more liberal participants
associated the Biological factor with mental disorder, whereas more
conservative participants assigned moderate weight to the Biological factor
irrespective of their ratings of mental disorder.

**Psychological factor results.** P was significantly related to both MD and
SAS for total composites and vignette 1 (see Table 6), and therefore step 1
results were considered for both of these analyses. Based on the total-
composite variables, MD and SAS together accounted for 5% of the variance in
P, $R^2 = .05$, $F(2, 127) = 3.43$, $p<.05$, but neither variable made a unique
contribution to the equation. Inspection of Table 6 and Table 8 suggests that
the variables did not serve as significant independent predictors of P due to
the small size of the zero-order correlations. On vignette 1 the two predictors
combined accounted for 14% of the variance in P, $R^2 = .14$, $F(2, 127) = 9.87$,
$p<.001$; both MD, $r = .23$, $t(127) = 2.75$, $p<.01$, and SAS, $r = .28$, $t(127) = 3.33$,
$p<.01$, made significant contributions to the regression equation. These
findings suggest that, for vignette 1, conservativism and higher mental
disorder ratings were both independently associated with higher Psychological
factor scores, but for the total composites, the relationships between these
variables were small.

The interaction term was statistically significant for the composites,
Figure 1. B on MD regression lines for the Comparatively Liberal and Comparatively Conservative subsamples.
Table 8

Hierarchical Regression Analyses for the Psychological Factor

<table>
<thead>
<tr>
<th>Variable</th>
<th>$\beta$</th>
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<th>t</th>
<th>OR^2</th>
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<td>.135***</td>
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<td>.041*</td>
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<td>-.651</td>
<td>.276</td>
<td>2.36*</td>
<td>.042*</td>
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Note. MD = mental disorder ratings; SAS = Social Attitudes Scale.  
*p < .05.  **p < .01.  ***p < .001.
$\Delta R^2 = .08, F(3, 126) = 10.76, p<.01$, as well as vignettes 2 and 4. Interpretation of the MD X SAS interaction for the Psychological factor followed the same procedure as that conducted for the Biological factor. The total-composite variables were selected for the analysis as they demonstrated the largest interaction effect and also represent more general measures of the relevant constructs. MD and P were positively correlated for the Comparatively Liberal subsample, $r = .38, p<.01$, but, for the Comparatively Conservative group, these variables were unrelated, $r = -.04, p>.05$. Figure 2 displays the MD on P regression lines for each subgroup (MD range = ± 1 SD, calculated separately for each subgroup). It appears that more liberal participants tended to associate the Psychological factor with evidence of mental disorder, whereas more conservative participants endorsed the Psychological factor moderately irrespective of their mental disorder ratings.

**Interpersonal/Situational factor results.** I/S was not significantly related to both MD and SAS for total composites or any individual vignettes (see Table 6), and thus step 1 was not inspected for this factor. Furthermore, the MD X SAS interaction was not statistically significant, suggesting that the relationship between MD and I/S did not differ as a function of sociopolitical values.

**Societal factor results.** S was significantly associated with both MD and SAS for vignettes 1 and 4 (see Table 6), and thus step 1 was examined for these two analyses. For vignette 1, MD and SAS together accounted for 23% of
Figure 2. P on MD regression lines for the Comparatively Liberal and Comparatively Conservative subsamples.
### Table 9

**Hierarchical Regression Analyses for the Interpersonal/Situational Factor**

<table>
<thead>
<tr>
<th>Variable</th>
<th>$\beta$</th>
<th>$B$</th>
<th>$SE$</th>
<th>$t$</th>
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<td>.191</td>
<td>.411</td>
<td>.47</td>
<td>.002</td>
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<td>.204</td>
<td>.300</td>
<td>.68</td>
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</tr>
<tr>
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<td>.72</td>
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<td>.368</td>
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<td>.018</td>
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<td><strong>Vignette 4</strong></td>
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<td>-.011</td>
<td>.281</td>
<td>.03</td>
<td>.000(^a)</td>
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</tbody>
</table>

**Note.** MD = mental disorder ratings; SAS = Social Attitudes Scale.

\(^a\) $\Delta R^2$ is not exactly 0.

**$^{**}p<.01.**
Table 10

Hierarchical Regression Analyses for the Societal Factor

<table>
<thead>
<tr>
<th>Variable</th>
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<th>( B )</th>
<th>( SE )</th>
<th>( t )</th>
<th>( \Delta R^2 )</th>
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<td>Total Composites</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Step 1: MD</td>
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<td>9.550</td>
<td>.43</td>
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<tr>
<td>SAS</td>
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<td>-8.367</td>
<td>2.017</td>
<td>4.15***</td>
<td>.120***</td>
</tr>
<tr>
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<td>.538</td>
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<td>.008</td>
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<tr>
<td>Vignette 1</td>
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<td>Step 1: MD</td>
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<td>8.000</td>
<td>1.72</td>
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<td>5.87***</td>
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<td>.474</td>
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<td>.007</td>
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</tr>
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<td>1.47</td>
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<tr>
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<td>.112***</td>
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<td>.471</td>
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<td>.010</td>
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<td>Vignette 4</td>
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<td>.030</td>
<td>.126</td>
<td>.367</td>
<td>.34</td>
<td>.001</td>
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</table>

Note. MD = mental disorder ratings; SAS = Social Attitudes Scale. 
*\( p < .05 \). ***\( p < .001 \).
the variance in S, $R^2 = .23$, $F(2, 127) = 19.29$, $p < .001$, but only SAS made a significant contribution to the regression equation, $b = -.46$, $t(127) = 5.87$, $p < .001$. On vignette 4 the two predictors accounted for 5% of the variance in S, $R^2 = .05$, $F(2, 127) = 3.24$, $p < .05$; however, neither SAS nor MD made unique contributions to the equation. Inspection of Table 6 and Table 10 suggests that S's relationships with SAS and MD on vignette 4, and with MD on vignette 1, became nonsignificant in the regression equations due more to the small size of the zero-order correlations than to any shared variance between SAS and MD.

The interaction term was not statistically significant for the composites or individual vignettes; thus, sociopolitical values did not influence MD's relationship with S.

**B, P, I/S, and S regression results summary.** Together the results of these analyses indicate partial support for Hypothesis 7, the prediction that mental disorder ratings would be positively correlated with scores on the asocial mental health factors (Biological and Psychological) and negatively correlated with scores on the microsocial (Interpersonal/Situational) and macrosocial (Societal) factors. In this study, higher mental disorder ratings were associated with greater endorsement of the Biological and Psychological factors, though these relationships were small. On the other hand, lower mental disorder ratings were moderately associated with increased scores on the Interpersonal/Situational factor, but only on one vignette, and somewhat
associated with increased scores on the Societal factor, but only on two vignettes.

Partial support was also found for Hypothesis 8, the prediction that more conservative participants would place greater emphasis than more liberal participants on asocial mental health factors and less emphasis than more liberal participants on microsocial and macrosocial factors. In this research, endorsement of the Societal factor was moderately associated with liberalism, endorsement of the Psychological factor was somewhat associated with conservativism, but ratings on the Biological and Interpersonal/Situational factors were generally not related to sociopolitical values. In addition, sociopolitical values and ratings of mental disorder interacted, though not in accordance with Hypothesis 9, the prediction that the correlation between mental disorder ratings and mental health frameworks would be greater for participants with more conservative sociopolitical values. For the Comparatively Liberal subsample, both Biological and Psychological factors were associated with higher ratings of mental disorder, but for the Comparatively Conservative group, moderate weight was assigned to these mental health factors irrespective of mental disorder ratings.
Profile Analysis: Comparison of Mental Health Frameworks for the Comparatively Liberal and Comparatively Conservative Subsamples

An alternative method for assessing the relationship between sociopolitical values and mental health frameworks is profile analysis, a specific application of multivariate analysis of variance (MANOVA) in which several dependent variables are measured on the same scale. Profile analysis treats the dependent variables as if they were repeated measures of the same variable and thus is statistically identical to a repeated measures MANOVA. The principal goal of profile analysis is to assess whether profiles of the multiple dependent measures are parallel across groups; that is, whether different groups exhibit similar patterns of dependent variable scores. It also tests for overall differences among groups, that is, whether groups differ on the dependent measures considered collectively, and for overall differences among dependent variable means, that is, whether variable means differ irrespective of groups (Tabachnick & Fidell, 1989).

In the present study, profile analysis was used as a further exploration of Hypothesis 8, the prediction that participants' mental health frameworks would vary as a function of their sociopolitical values. In essence, this hypothesis predicted that the Comparatively Liberal group and the Comparatively Conservative group would have nonparallel profiles of mental health factor scores. The analysis was also intended to evaluate Hypothesis 6, the expectation that participants would assign lower ratings to the macrosocial
factor (Societal) than to all other mental health factors (Biological, Psychological, and Interpersonal/Situational).

**Profile analysis results.** Profile analyses were performed on the four mental health factors (MHF) for both total and within-vignette composites, employing SAS as the grouping variable. The multivariate and univariate analyses yielded highly similar results and consequently only univariate statistics are reported. Profile analysis/ANOVA summary statistics are provided in Table 11. The effect of SAS was not statistically significant for total composites or any of the individual vignettes, indicating that there were no significant group differences on the collective set of mental health factors. As predicted, there was a significant main effect of MHF for total composites, \( F(3, 384) = 122.46, p < .001 \), and each vignette; thus, participants, in general, gave higher ratings to some mental health factors than others. Finally, as expected, the SAS X MHF interaction was significant for total composites, \( F(3, 384) = 6.84, p < .001 \), and vignettes 1 and 2 (although vignette 3 approached significance, \( p = .06 \)); therefore, Comparatively Liberal and Comparatively Conservative subsamples yielded statistically nonparallel mental health factor profiles.

**MHF effect contrasts.** To evaluate the nature of the MHF main effect, mental health factor total-composite means were examined for the total sample. The total-composite means were selected for further consideration as they represent the broadest measure of each individual factor. Table 12
Table 11

Profile Analysis/ANOVA Summary Statistics

<table>
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<tr>
<th>Source of Variation</th>
<th>SS</th>
<th>df</th>
<th>MS</th>
<th>F</th>
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<td>8681.64</td>
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Note. MHF = Mental Health Factors.
*p<.05. ***p<.001.
presents these means divided by 12 (the number of variables in the composite) to reflect the original scale on which the individual variables were measured. In Figure 3, these "averaged" means are presented in a bar graph to illustrate the total sample mental health factor profile. The Psychological factor received the highest ratings ($M = 119.4$), followed closely by the Interpersonal/Situational factor ($M = 115.2$); the Biological factor ($M = 90.3$) and the Societal factor ($M = 74.5$) had the third and fourth highest ratings, respectively.

Within-participants t-test comparisons were conducted to assess whether these MHF total-composite means were significantly different (see Table 13). To control the overall (familywise) type I error rate resulting from multiple comparisons, a modified Bonferroni correction was applied to the standard .05 error probability level ($\alpha$), (Jaccard, Becker, & Wood, 1984; Keppel, 1991). In this correction, $\alpha$ is multiplied by the between-groups degrees of freedom (the number of comparisons normally permitted without requiring adjustment of the standard significance level) to obtain the error probability level considered acceptable for the entire set of comparisons (familywise $\alpha$). The familywise $\alpha$ level is then divided equally among the individual t-tests. Application of the correction formula in this analysis, with 3 degrees of freedom and 6 t-test comparisons $[(3)(\alpha) ÷ 6 = corrected \alpha]$, produced .025 as the corrected per comparison alpha level corresponding to the standard $\alpha$ level of .05. Based on this adjusted probability level, all pairwise comparisons were statistically
Table 12

Mental Health Factor Total-Composite Means and Subsample t-Test Comparisons

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<thead>
<tr>
<th>Factor</th>
<th>Sample</th>
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<td>Total Sample</td>
<td>Liberal</td>
<td>Conservative</td>
<td>t&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Biological</td>
<td>M (SD) 90.3 (30.6)</td>
<td>88.4 (32.0)</td>
<td>92.3 (29.2)</td>
<td>-.73</td>
</tr>
<tr>
<td>Psychological</td>
<td>M (SD) 119.4 (22.2)</td>
<td>116.4 (23.5)</td>
<td>122.4 (20.7)</td>
<td>-1.53</td>
</tr>
<tr>
<td>Interpersonal/Situational</td>
<td>M (SD) 115.2 (23.2)</td>
<td>115.6 (24.5)</td>
<td>114.9 (22.0)</td>
<td>.15</td>
</tr>
<tr>
<td>Societal</td>
<td>M (SD) 74.5 (32.3)</td>
<td>82.6 (31.6)</td>
<td>66.4 (31.1)</td>
<td>2.95&lt;sup&gt;*&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

Note. Total-composite means are averaged to reflect the original scale of the individual variables that comprise the composite.
<sup>a</sup><sub>df = 128.</sub>
<sup>*</sup><sub>p<.0375, per comparison (based on a modified Bonferroni correction of the .05 α level).</sub>
Figure 3: Mental health factor total-composite means for the total sample.
Table 13

*Within-Participants t-Test Comparisons of Mental Health Factor Total-Composite Means*

<table>
<thead>
<tr>
<th>Comparison</th>
<th>Total Sample</th>
<th>Liberal</th>
<th>Conservative</th>
</tr>
</thead>
<tbody>
<tr>
<td>B vs. P</td>
<td>-10.34*</td>
<td>-7.15*</td>
<td>-7.43*</td>
</tr>
<tr>
<td>B vs. I/S</td>
<td>-7.92*</td>
<td>-5.78*</td>
<td>-5.39*</td>
</tr>
<tr>
<td>B vs. S</td>
<td>4.39*</td>
<td>1.12</td>
<td>5.43*</td>
</tr>
<tr>
<td>P vs. I/S</td>
<td>2.68*</td>
<td>.36</td>
<td>4.06*</td>
</tr>
<tr>
<td>P vs. S</td>
<td>15.83*</td>
<td>8.50*</td>
<td>15.68*</td>
</tr>
<tr>
<td>I/S vs. S</td>
<td>18.35*</td>
<td>10.89*</td>
<td>16.33*</td>
</tr>
</tbody>
</table>

Note. df = 129 for the total sample and 64 for each subsample. B = Biological; P = Psychological; I/S = Interpersonal/Situational; S = Societal. *p < .025, per comparison (based on a modified Bonferroni correction of the .05 α level).
significant, suggesting that clinicians did in fact weigh the importance of each factor differentially. Therefore, support was found for Hypothesis 6, the prediction that the Societal factor would be rated lower than all other mental health factors.

**SAS X MHF interaction contrasts.** To explore the nature of the SAS X MHF interaction, MHF total-composite means were inspected for each subsample. Averaged means are presented in Table 12. In Figure 4, the averaged means are displayed in a bar graph to depict the Comparatively Liberal and Comparatively Conservative mental health factor profiles. For both subgroups, the relative importance assigned to each factor did not differ from that assigned to each factor by the total sample; that is, factor means ranked in the same order for the Comparatively Liberal subgroup, the Comparatively Conservative subgroup, and the total sample. However, within-participants t-test comparisons among the mental health factors did differ between subsamples (see Table 13). Whereas all comparisons were statistically significant for the Comparatively Conservative subgroup, only four of the six comparisons were significant for the Comparatively Liberal subgroup. For the Comparatively Liberal group, the Psychological factor was rated more highly than the Biological and Societal factors but not differentially from the Interpersonal/Situational factor; the Interpersonal/Situational factor was rated more highly than both the Biological and Societal factors; however, the Biological and Societal factors did not receive significantly different ratings.
Figure 4. Mental health factor total-composite means for the Comparatively Liberal and Comparatively Conservative subsamples.
The key to the interaction, therefore, was in two areas. First, participants in the Comparatively Conservative group rated the Biological factor as more important than the Societal factor, whereas participants in the Comparatively Liberal group did not assign significantly different weights to these factors. Second, participants in the Comparatively Conservative group rated the Psychological factor as more important than the Interpersonal/Situational factor, whereas participants in the Comparatively Liberal group, again, did not give significantly different ratings to these factors.

An alternative strategy for assessing the interaction effect is to compare the Comparatively Liberal and Comparatively Conservative subgroups on each MHF mean. These between-groups $t$-test comparisons were conducted utilizing the modified Bonferroni test of significance described above. Results are presented in Table 12. For this analysis, with 3 degrees of freedom and 4 $t$-test comparisons $[(3/\phi) \div 4 = \text{corrected } \alpha], .0375$ emerged as the new individual comparison alpha level corresponding to the standard probability level of .05. Based on this adjusted probability level, subsample $t$-test comparisons were significant for the Societal factor, $t(128) = 2.95, p<.05$, but not for the other mental health factors. Evidently, clinicians in the Comparatively Liberal group assigned greater importance to the Societal factor than did clinicians in the Comparatively Conservative group. This finding provides partial support for Hypothesis 8, the prediction that more conservative participants would place greater emphasis than more liberal
participants on asocial mental health factors and less emphasis than more liberal participants on microsocial and macrosocial factors.
CHAPTER IV
DISCUSSION

In this final chapter an attempt will be made to bring together the various issues which have been explored both theoretically and empirically in this research project. First, some of the study's limitations are addressed. Then, in order to give meaning to the onslaught of "numbers" presented in the previous chapter, the results of the empirical investigation are discussed in relation to the research hypotheses and subsequently interpreted within the context of the theoretical treatise presented in the first chapter. Following this analysis, the implications of the empirical project and the theoretical position upon which it is based are discussed along with some recommendations for clinical practice.

Limitations of the Empirical Study

Prior to discussing the results of the research, a number of the study's limitations will be outlined.

Generalizability of the findings. In the interpretation of empirical research it is critical to consider the characteristics of the participant sample, as the nature of the sample significantly impacts upon the generalizability of the findings. In the present study, although participant demographics seem to
reflect the general population of American psychologists, the return rate of 18.2% is quite low compared to that found by other researchers conducting mail surveys with clinical psychologists (e.g., 67%, Haugen, Tyler, & Clark, 1991; 55.4%, Jensen & Bergin, 1988). In order to understand the nature of the select group who did respond, it is necessary to consider why the return rate was so low. One explanation was provided by a few psychologists who returned the research materials uncompleted with a note indicating that the questionnaires were too long and required too much of their time. Another factor may have been the study's requirement for participants to indicate their personal political values; clinicians may have been reluctant to share information in this sensitive area even under anonymity. However, it seems likely that the most important factor responsible for the low return rate was the study's explicit politicizing of clinical judgments, a highly contentious issue largely rejected as unscientific by mainstream psychology. In summary, the clinicians who participated in this research were likely a subset of clinical psychologists who had time available to complete the questionnaires, were open to sharing their political values, and did not object to the study's focus on the relationship between political values and clinical judgments.

Irrespective of which factors were responsible for the low return rate, caution should be used in generalizing the results beyond the subset of clinical psychologists who are motivated to respond to this type of study. It is also important to be cautious in generalizing the results beyond the immediate
sociohistorical context. Thus, this study's findings should be interpreted as most relevant to clinical psychologists living in the United States in the 1990s who are willing to participate in research focused on mental health issues and sociopolitical values. Despite these limitations to generalizability, the results may still give clues for understanding other related, yet unsampled, populations.

**Range of sociopolitical values.** Another limitation of the participant sample is that there were fewer clinicians who espoused conservative values than clinicians who held liberal values. In particular, there was a dearth of practitioners with an extreme conservative orientation. Due to the limited representation of conservative clinicians, the results may underestimate the difference between the theoretical models used by liberal and conservative practitioners. Thus, this study may not have fully captured the influence of sociopolitical values on mental health models.

**Research design.** Some researchers have criticized the use of case vignettes in clinical research due to their limited ecological validity, suggesting that clinicians respond differently in real clinical situations (see Elstein, 1988). However, the use of vignettes for assessing clinical judgments has been defended. Elstein (1988), for example, suggests that hypothetical case vignettes are "quite engaging" (p. 37). Moreover, he proposes that these clinical simulations "provide an opportunity to display the best of clinical judgment" (p. 38) as clinicians are able to focus their attention on a single case, in contrast
to the demands of actual clinical practice. Despite these arguments, there is no
doubt that a written paragraph describing a clinical case provides a somewhat
one-dimensional view of a mental health client and denies the clinician access
to critical information available in clinical interviews. For example, the
clinician is denied the opportunity to ask questions, to observe the client's
interpersonal style, to hear his or her tone of voice, etc. The present study,
however, was not concerned with the accuracy of clinicians' judgments but
rather with the models they use to formulate their clients' problems. It seems
a reasonable assumption that the mental health frameworks used by clinicians
to conceptualize hypothetical case vignettes would be at least similar to the
frameworks they employ with real mental health clients.

However, beyond the limitations of clinical case vignettes, the
questionnaires in general required participants to reduce a number of complex
issues to simplistic, concrete responses. For example, sociopolitical world
views were measured by answers to specific questions and ultimately reduced
to a single number, clearly a gross distortion of the complexity of personal
value systems and beliefs. In addition, the frameworks clinicians use to
understand client functioning were constrained into responses to a few basic
questions. Moreover, the questions required that these frameworks be split
into four factors, when in reality these factors represent inseparable
components of a multi-faceted perspective. In general, the questionnaires
required the reduction of theories, beliefs, and values into scores, resulting in
the loss of their rich multidimensional quality.

Were the Hypotheses Supported?

The research hypotheses focus on three general areas. One area
cconcerns the nature of the clinical psychologists' mental health frameworks.
Another addresses clinicians' use of the mental disorder concept, the
theoretical formulations which underlie their mental disorder conceptions, and
the relationship between mental disorder models and sociopolitical values. A
third area regards the role of sociopolitical values in mediating mental health
frameworks. The findings related to these areas of investigation are discussed
below.

Mental health frameworks. The nature of the clinicians' mental health
frameworks was addressed by Hypotheses 4, 5, and 6. In Hypothesis 4, it was
predicted that ratings assigned to each mental health factor would be
consistent across problem responsibility factors, problem resolution factors, and
prevention strategies. In Hypothesis 5, it was predicted that these ratings
would be consistent across vignettes. That clinicians would espouse
reasonably consistent theoretical models in their mental health formulations
was a critical underlying assumption of this research. If they did not, the
exploration of whether sociopolitical values mediate such models would have
been erroneous. Results demonstrated that the clinicians' mental health
frameworks were consistent within and across vignettes; thus, both Hypotheses 4 and 5 were supported. However, mental health frameworks tended to be slightly more consistent within vignettes than across vignettes. These findings make intuitive sense: if contextual variables are seen as highly responsible for clients' problems, it seems likely that they would be seen as important components of treatment and prevention strategies; moreover, though the importance placed on contextual variables may vary somewhat for different clients, it seems likely that clinicians who see contextual variables as critical factors for some clients would see them as important for others. As outlined in the previous chapter, the statistical analyses were conducted for within-vignette and total-composite measures of each mental health factor. However, as no predictions were made regarding specific vignettes and as mental health frameworks were reasonably consistent across all vignettes, the clinicians' overall mental health frameworks will be the primary focus of discussion in this chapter.

Prior to examining the role of sociopolitical values in mediating mental health frameworks, the nature of the general, or average, mental health framework for all participating clinicians will be considered. Although no predictions were made regarding the relative weights that clinical psychologists would assign among Biological, Psychological, and Interpersonal/Situational mental health factors, it was predicted that all of these factors would be rated more highly than the Societal factor
(Hypothesis 6). This finding was expected as the literature review suggested that most mental health models tend to minimize the importance of macrosocial variables (see e.g., Prilleltensky, 1990b). The research results provided strong support for this hypothesis. The average mental health framework which emerged for the total sample was as follows: the Psychological factor was weighted most highly, followed closely by the Interpersonal/Situational factor; both the Biological and Societal factors were rated considerably lower, though the Biological factor was rated higher than the Societal factor. This model is hardly surprising given that participants were clinical psychologists, and as most psychologically based theoretical perspectives focus on psychological and microsocial components of mental health problems. The finding that participants assigned the least weight to the macrosocial factor demonstrates the tendency of clinical psychologists to downplay the importance of the larger societal context, relative to biological, psychological, and microsocial variables, in their mental health theoretical perspectives.

**Mental disorder conceptions.** Consideration of the clinicians' mental disorder conceptions was addressed by Hypotheses 1, 2, 3, 7, and 9. In Hypothesis 1, it was predicted that need-of-help ratings would be positively related to mental disorder ratings, as clinical psychologists were expected to generally use the mental disorder concept as a descriptor for people who are in need of help. This hypothesis was supported: participants who assigned
higher need-of-help ratings were more likely than those who assigned lower need-of-help ratings to view vignette subjects' problems as evidence of mental disorder. Thus, for the participants who responded to this study, mental disorder labels are intimately linked to the degree to which people need help. This does not mean that the clinicians necessarily see all people who need help as having a mental disorder, but simply that "needing help" and "having a mental disorder" are related components of the clinicians' conceptual schemas for understanding human problems. It seems that participants were at least somewhat wedded to use of the mental disorder concept as a model for understanding people in distress.

Yet, as some postmodern theorists (e.g., Ingleby, 1980) see mental disorder models as inherently decontextualized and asocial (i.e., as minimizing the importance of the social context in human problems), and as conservatives are generally seen as more likely to endorse asocial explanations for human problems than liberals (see e.g., Sedgwick, 1974), it was expected that more conservative participants would use the mental disorder label to a greater extent than more liberal participants (Hypothesis 2). It was also expected that, for the participants with more liberal values, there would be less of a conceptual link between "needing help" and "having a mental disorder." That is, it was predicted that the relationship between need-of-help ratings and mental disorder ratings would be greater for more conservative participants (Hypothesis 3). Neither hypothesis was supported: more conservative
clinicians were no more likely than more liberal clinicians to use the mental disorder concept as a descriptor for human problems; furthermore, participants with differing sociopolitical values were equally likely to associate evidence of mental disorder with the degree of help needed. It seems that, in this study, clinical psychologists who differed in their sociopolitical values did not use the mental disorder label differentially. However, the implications of this finding are somewhat ambiguous - either more conservative practitioners did not utilize asocial conceptions to a greater extent than more liberal practitioners or the assumption that mental disorder conceptions are necessarily asocial is incorrect. This question was addressed by Hypotheses 7 and 9.

In Hypothesis 7, it was predicted that mental disorder ratings would be positively correlated with scores on the asocial mental health factors (Biological and Psychological) and negatively correlated with scores on the microsocial (Interpersonal/Situational) and macrosocial (Societal) factors. This expectation corresponds to the thesis outlined in the literature review that mental disorder conceptions are based in asocial formulations. This hypothesis was partially supported: higher mental disorder ratings were somewhat associated with greater endorsement of the Biological and Psychological mental health factors, and on some vignettes, were associated with less endorsement of the Interpersonal/Situational and Societal factors. Thus, for participants in this study, mental disorder conceptions were associated, to some degree, with more asocial mental health frameworks.
As mental disorder conceptions were somewhat associated with greater endorsement of asocial mental health factors, it was of interest to see whether the mental disorder conceptions of more conservative clinicians were even more asocial, as predicted in Hypothesis 9. This investigation yielded a surprising result: endorsement of both the Biological and Psychological mental health factors was moderately correlated with mental disorder ratings for more liberal participants but not for their more conservative counterparts. Clinicians with more liberal values tended to rate asocial mental health factors highly only when they thought the vignette subjects had a mental disorder, whereas more conservative clinicians rated asocial factors moderately whether or not they saw evidence of mental disorder. This result has significant implications for the finding that mental disorder conceptions were tied to more asocial mental health frameworks. Although the association of mental disorder with low Interpersonal/Situational and Societal factor scores did not differ as a function of sociopolitical values, only the more liberal participants associated mental disorder conceptions with an increased focus on the Biological and Psychological mental health factors.

Overall these results suggest that the clinical psychologists in this study utilized the mental disorder concept to describe mental health clients in need of help, that their sociopolitical values did not impact upon their use of this concept, that mental disorder conceptions were generally associated with more asocial mental health frameworks, but that more liberal participants tended to
associate mental disorder with asocial frameworks to a greater extent than
more conservative participants. This last finding does not indicate that the
more liberal clinicians' mental disorder models were more asocial than those of
more conservative clinicians, but simply that the more liberal practitioners
were more likely to link mental disorder with asocial factors conceptually. The
fundamental question which then arises is whether participants with
contrastingsociopolitical values differed in their mental health frameworks,
irrespective of their endorsement of mental disorder labels.

**Sociopolitical values and mental health frameworks.** In Hypothesis 8, it
was predicted that participants with differing sociopolitical values would
espouse different mental health frameworks. More specifically, more
conservative clinicians were expected to place greater emphasis than more
liberal clinicians on asocial mental health factors and less emphasis than more
liberal clinicians on microsocial and macrosocial factors. This prediction was
grounded in the work of theorists who have outlined the conservative basis of
person-focused explanations for human problems and the liberal or radical
basis of socio-cultural formulations (e.g., Prilleltensky, 1990b; Sedgwick, 1974;
Pastore, 1949). Contrary to expectations, mental health frameworks were
highly similar for individuals with differing sociopolitical values.

Nevertheless, mental health frameworks did vary as a function of clinicians'
values to some extent, providing partial support for Hypothesis 8:
endorsement of the Societal factor was moderately associated with liberalism
and endorsement of the Psychological factor was somewhat associated with
conservativism. Another way of framing the results is that participants in the
Comparatively Conservative group rated the Psychological factor more highly
than the Interpersonal/Situational factor, and the Biological factor more highly
than the Societal factor, whereas participants in the Comparatively Liberal
group did not assign significantly different weights to these factors. Most
striking was the finding that practitioners in the Comparatively Liberal group
assigned significantly higher ratings to the Societal factor than did practitioners
in the Comparatively Conservative group.

The picture which emerges from these results is that the mental health
frameworks of clinical psychologists with differing sociopolitical values were
quite similar. However, more conservative practitioners tended to emphasize
the importance of psychological factors and to minimize the role of
macrosocial variables to a somewhat greater extent than more liberal clinicians.

Integration of the Empirical Findings and the Theoretical Treatise

This empirical research was conducted in order to assess whether
clinical psychologists' endorsement of ideological mental health formulations is
related to their personal sociopolitical values. The results can be
conceptualized as responses to two fundamental questions underlying this
inquiry: Did the clinical psychologists in this study endorse ideological
models for understanding mental health problems?; Did the clinicians’
sociopolitical values influence the extent to which they endorsed ideological formulations? This section will serve to discuss the answers to these questions.

**Endorsement of mental disorder ideology.** The central contention of the theoretical treatise outlined in the first chapter is that traditional mental disorder conceptions serve an ideological function by formulating the multifarious forms of human distress which arise within the inequitable social practices of Western industrial-capitalist society through decontextualized models. Psychiatric theorists associated with the postmodern movements (e.g., Prilleltensky, 1989) have suggested that by focusing on the intra-individual concomitants of human suffering, these asocial formulations divert attention from the deleterious socio-contextual variables at least partially responsible for psychic distress, and thereby serve to protect the existing social system from criticism and reform. In this study, clinical psychologists did use the mental disorder label as a descriptor for individuals in need of help. Furthermore, their mental disorder conceptions were associated with more asocial mental health frameworks, a finding which emphasizes the individualistic focus this concept engenders. These results suggest that if socio-contextual models are to be implemented in mental health practice, re-evaluation of the mental disorder concept will need to be undertaken.

But the participants did not conceptualize the vignette subjects' problems strictly asocially; rather, they tended to espouse a moderate position emphasizing both psychological factors and the immediate social context. It is
promising to see that psychologists place a strong emphasis on contextual variables in their psychiatric formulations. However, the accusation that the practices of mental health professionals implicitly promote hegemonic ideology (e.g., Ingleby, 1981; Prilleltensky, 1989) is not completely off the mark, for the clinicians surveyed tended to minimize the importance of macrosocial factors relative to asocial and microsocial factors in their conceptualizations of mental health problems. Like Goffman, Scheff, and the other antipsychiatrists, the clinicians' consideration of social context was focused more on the interpersonal and situational elements of peoples' lives than on the wider societal realm.

Though harmful microsocial variables, such as repressive family systems, occupational conflicts, and crowded living space, may play an important role in the genesis of psychological distress, these immediate sociocontextual stressors cannot be separated from the broader cultural context of the society in which they exist (see e.g., Sedgwick, 1982b). The way in which society is structured (e.g., how power and material resources are distributed among its members) is intimately tied to the formation of family dynamics, work hierarchies, and other interpersonal systems, as well as the physical environments in which people live. By emphasizing microsocial variables in contextual analyses of mental health problems, clinical practitioners may be "blaming the victim," for these variables are, themselves, casualties of the larger social system. For example, a family systems therapist may recognize
the negative impact of an authoritarian family structure on child development, but by focusing solely on changing the family system, she or he blames the family, itself a victim of an authoritarian social order. This position is clearly presented by Kanter (1974) in her critique of the theories of R. D. Laing: "Laingians, while claiming to understand individual behavior in social context, slam the door shut at the boundaries of the family....They do not examine how family roles and relationships are embedded in a larger community context" (p. 309). In order for psychiatric theory to avoid serving dominant interests (i.e., promoting ideology), it must incorporate a contextual focus which goes beyond the immediate social environment. To do so, mental disorder models must focus on cultural values, mores, beliefs, language, social practices, the distribution of power, the distribution of material resources, and other meta-contextual societal structures which impact upon human functioning.

In this study, however, the clinical psychologists did recognize societal variables in their theoretical models, albeit somewhat less than other mental health factors. Hence, to refer to the psychologists' mental health formulations simply as ideology would be an overstatement. A more realistic framing is that, in general, participants' theoretical formulations were somewhat ideological. Some clinicians' models, however, may not have supported dominant interests, or may even have been counter-ideological.

That clinicians saw microsocial factors as highly important and macrosocial variables as somewhat important in their theoretical models is at
least encouraging. These results indicate that clinical psychologists do take into account contextual variables in their formulations, and suggest that they may be open to developing new models which place greater emphasis on the socio-cultural context of psychological distress.

Sociopolitical values and endorsement of mental disorder ideology. The investigation of the role of sociopolitical values in mediating ideological mental health formulations represents an attempt to make explicit the values underlying the mental health establishment's knowledge, which has been framed as value-free by positivist psychiatric theorists (e.g., Klein, 1978). The theoretical models espoused by practitioners with differing sociopolitical values were surprisingly quite similar. Nevertheless, models embraced by more conservative clinicians were, to some extent, more supportive of hegemonic ideology than those endorsed by more liberal clinicians, due to the more conservative practitioners' relatively greater emphasis on psychological factors and minimization of macrosocial factors. With respect to mental disorder, the finding that sociopolitical values did not influence the clinicians' use of this label demonstrates its universality as a descriptor for human distress among clinicians on both sides of the political spectrum. But the finding that the more liberal practitioners tended to link mental disorder with asocial theoretical perspectives falls in contrast to the hope of theorists such as Ingleby (1983) and Sedgwick (1981) that mental health clinicians might apply mental disorder conceptions with sociopolitical connotations. Though the
more liberal practitioners' general mental health formulations were less ideological than those of more conservative clinicians, their frameworks were increasingly ideological when they saw strong evidence of mental disorder.

Significance of the study's findings. The thesis that traditional mental health models are ideological has been cogently outlined in a number of theoretical treatises (e.g., Albee, 1982a; Ingleby, 1980; Prilleltensky, 1990b). The thesis that mental disorder conceptions are particularly ideological, though a contentious issue among postmodern theorists, has also been clearly elucidated (e.g., Conrad, 1980; Ingleby, 1972). Both of these theoretical positions, discussed in detail in the first chapter, are partially supported by this study's empirical findings. However, the study's main contribution to the critique of positivist psychiatry is the finding that consideration of socio-cultural contextual variables in mental health practice is partially influenced by clinicians' personal sociopolitical values. As Albee (1982a) clearly states, "one's scientific position on a number of contemporary social-psychological issues is a function, in part at least, of one's personal political values and social attitudes" (p. 6).

To positivist psychiatric theorists (e.g., Klein, 1978; Spitzer & Williams, 1982), this infiltration of political values into clinical formulations would likely be interpreted as a form of bias or error, demonstrating the need for more precise diagnostic procedures. From an antipsychiatry position (e.g., Laing, 1967; Szasz, 1961), these results illustrate the political nature of psychiatric
theory and thereby discredit psychiatric knowledge. But in accordance with a postmodern philosophy of knowledge (e.g., Gergen, 1985; Sedgwick, 1982b), in which ideas are seen as socially constructed, all theories and models are political. Thus, these findings simply serve to exhibit some of the sociopolitical underpinnings of mental health theory.

Implications and Recommendations for Clinical Practice: A Socio-Cultural Perspective

The finding that clinical psychologists' theoretical frameworks were partially influenced by their sociopolitical values supports the thesis that mental health practitioners' clinical activities are not distinct from their personal beliefs, views, and interests regarding the nature of social arrangements within society. Like all human activities, mental health practice is a political enterprise. Thus, mental health professionals should be educated as to the value-laden nature of their work. The medico-scientific camouflage which has veiled the psychiatric establishments' theories and practices should be removed by making explicit the values underlying clinicians' theoretical models. This demystification of psychiatric knowledge would serve to shift psychiatric theory from the highly suspect realm of "value-free science" to the political forum of public debate.

But exposing the personal values which underlie clinical practitioners' theoretical frameworks would be merely a first step. A more critical task is to
make explicit the impact of these models on societal functioning. The finding that clinical psychologists subscribed to mental health frameworks which were somewhat ideological, and that their mental disorder conceptions were more ideological than their general frameworks, supports the theme expounded throughout this paper that there is a need for new conceptions, models, and theoretical frameworks for understanding the problems which have been commonly characterized as mental disorder. In addition to addressing the biological, psychological, and microsocial variables which relate to various forms of human distress, these new models should incorporate the broader societal realm as a critical component of human functioning.

Widespread adoption of broad socio-contextual models within the mental health establishment would likely have significant implications for clinical practice, as the forms of treatment which currently predominate the field are grounded in asocial or microsocial theories. One does not have to look far, however, to find alternatives to dominant forms of practice; since the sixties, many nontraditional mental health clinicians have attempted to help individuals in distress by confronting the societal context in which they live. An example of mental health treatment which addresses societal variables is radical therapy, a form of psychotherapy "informed by awareness of the politics of class and race and sex and age, of corporate power and worker alienation, of 'private affluence and public squalor'" (Caspary, 1980, p. 29). In its "defensive" form, radical therapy has been used to assist mental health
clients in coping with an nonsupportive and oppressive social order. In its "aggressive" form, clinicians help clients to recognize the sociopolitical structures which underlie their problems through the raising of political consciousness (Maglin, 1978). This process is articulately presented by Gil (1978), who recommends adoption of 

an alternative therapeutic model which helps humans unravel the causes of suffering and ill-health in the existing social order, their reactions to it, and their defenses against it, and which helps them transcend their system-shaped consciousness and to release their intrinsic life-forces by discovering steps toward self-liberation in the context of collective human liberation. Implicit in this alternative therapeutic model is a conscious political perspective, and unequivocal commitment to humanistic-egalitarian values and institutions, the societal prerequisite for human health and self-actualization through satisfaction of intrinsic human needs. (p. 67)

In addition to encouraging self-liberation, a primary goal of radical psychotherapy is to counteract feelings of powerlessness by empowering individuals to become active in the pursuit of social change (e.g., Caspary, 1980). However, the assumption underlying empowerment through psychotherapy is that individuals can independently overcome the oppressive social structures by which they are bound. It may be unreasonable to expect people marginalized by severe poverty, for example, to have the resources necessary to engage in such activities as petitioning the government or organizing a political rally for increased spending on social assistance.

Wineman (1984) criticizes this individualistic model, while recommending a broader alternative:
Programs which would address material conditions and the distribution of power - full employment, individual and collective control over workplace and housing, economic and social cooperation - are themselves alternatives (and probably the most important alternatives) to conventional psychosocial services which ignore the impact of political/economic/social organization on personal problems. If people with coping problems cannot have their psyches "cured" by the tinkerings of helping professionals, it is just as fanciful to suppose that psychological empowerment can go very far without reasonable prospects for dignified work, decent housing, and social support. (p. 79)

Social change as outlined by Wineman has not only been advocated as a means to ameliorate mental health problems but also as a critical approach to preventing them (Albee, 1982b, 1986).

One movement which has attempted to address the need for social change, while continuing to aid individual members of society, is community psychology. Advocates of community psychology have adopted clinical practices with a social-systemic focus in their attempt to alleviate and prevent human suffering as well as promote "the health and well-being of all members of a community" (Heller, Price, Reinhazor, Riger, & Wandersman, 1984, p. 4).

This movement directs attention toward the fit between individuals and their social environment and thus is concerned with "social change, social justice, politics, economic and social systems as well as individuals" (Rappaport, 1977, p. 19). In an attempt to remove the social-structural barriers which interfere with the ability of individuals and communities to control their own lives, community psychologists have engaged in a broad range of activities including developing empowerment projects (e.g., developing groups for single mothers
attempting to improve government social assistance programs), facilitating
community organization (e.g., organizing food co-ops, housing projects, etc.),
consulting with government agencies (e.g., conducting program evaluations for
community mental health centers), and conducting research on the effects of
various environmental conditions on members of a community (e.g.,
investigating the effects of high population density on psychological
functioning), (Heller et al., 1984).

However, some theorists allege that these community approaches have
fallen short of their goals. Community psychology has been criticized for
remaining distant from the arena of public policy (Sarason, 1984) and for its
predominant focus on coping with, rather than changing, societal structures
(Prilleltensky, 1990b). Nevertheless, some recent attempts to repoliticize
community psychology are evident (e.g., Prilleltensky, 1990b).

Conclusion

Central to this research project is the thesis that broad socio-contextual
mental health models need to be adopted by mental health professionals and
society in general if social change is ever to be recognized as critical for
addressing the plethora of "mental disorders" which afflict the population.
Some encouragement comes from Health and Welfare Canada whose
publication Mental health for Canadians: Striking a balance (1988), though tied
to a medicalized model of mental disorder, proposes a highly progressive interpretation of mental health:

We cannot isolate our ideas about mental health from such wider social values as the desire for equality among people, the free pursuit of legitimate individual and collective goals, and the equitable distribution and exercise of power....Whatever makes it difficult for the individual, the group and the environment to interact effectively and justly (for example, poverty, prejudice or poor coordination of resources) is a threat or barrier to mental health. (pp. 7-8)

As Prilleltensky (1990b) suggests, "only time will tell whether the government is seriously committed to changing these societal adversities" (p. 780). Yet, in the meantime, mental health professionals can play a critical role in societal reform as they are intimately involved in the web of social arrangements through their work with those suffering from its deleterious effects. Mental health practitioners can choose to help maintain existing social inequities by blaming the victims of societal problems, or they can contribute to the process of social change by recognizing the impact of socio-contextual variables on their clients' lives and addressing societal injustice in their work as clinicians, researchers, educators, and administrators. This research is but one contribution among many conducted in the hope of encouraging mental health clinicians to take this latter approach.

Postscript: An Explication of the Values Underlying this Research

Within a relativistic postmodern framework (see e.g., Lather, 1991), research based on a critique of ideology can be ideological in itself as all
knowledge contains assumptions and hidden values which support particular interests. Concealed within our preconceptions about the world, these values shape the process of theory construction, research design, and data collection and interpretation. In order to save Critical Theory from supporting hidden agendas, the methods of ideology critique must be applied to ideology critiques themselves; that is, the values and sociopolitical interests underlying all forms of research must be made explicit. This complex task requires an incisive and critical self-reflexivity:

Research which encourages self and social understanding and change-enhancing action on the part of 'developing progressive groups' requires research designs that allow us as researchers to reflect on how our value commitments insert themselves into our empirical work. (Lather, 1991, p. 80)

Although it is well beyond the scope of this project to thoroughly explore the multifarious ways in which my personal values influenced the research outlined above, I will attempt to briefly delineate for the reader some of the views and interests which permeate this work. I entered this research project critical of traditional psychiatric theories which I saw as damaging for the recipients of mental health care. In my work as a mental health clinician, I have found that these theories tend to blame individuals for their depressions, anxieties, confusions, and problematic personalities which seem to me to arise as reasonable responses to the competitive and alienating social practices which pervade our society. In particular, I view medicalized models such as those associated with the mental disorder conception as narrow, simplistic, and
generally inadequate for addressing the complexities of human suffering. Moreover, I would argue that the individualistic treatments which these models invoke, though crucial for the support of individual members of society, represent piecemeal repairs to an unjust sociopolitical system. The research presented here embodies an attempt to open the eyes of mental health professionals (including myself) to the manner in which we support the prevailing social order through the use of theories which minimize its relevance to human distress. As knowledge can be constructed in innumerable ways, both the theoretical and empirical components of this project are more reflective of these personal views than of "objective reality."

A far more extensive exploration of the values underlying this research could be undertaken. Inevitably, however, the meaning within this work would remain only partially revealed, for within the process of explication lie further assumptions, further meanings, an endless stream of levels at which interpretation could occur. Thus, in the end, like all knowledge, this dissertation supports unseen sociopolitical agendas. It is yet one more sociopolitical perspective, one of infinite possible world views.
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APPENDIX A

DEMOGRAPHICS QUESTIONNAIRE
BACKGROUND INFORMATION

Please answer the following questions:

1. Gender: ______ Male ______ Female
2. Age: ______ 3. Residence: ______ (State)

4. Ethnic/racial identification (check all that apply):
   ______ African American ______ Caucasian
   ______ Hispanic ______ American Indian
   ______ Oriental ______ Other: ______ (please specify)

5. Years of post-graduate professional experience: ______

6. Primary theoretical orientation (select one response):
   ______ Biological ______ Psychodynamic/Psychoanalytic
   ______ Humanistic/Existential ______ Cognitive/Behavioral
   ______ Systems ______ Community
   ______ Eclectic ______ Other: ______ (please specify)

7. (a) Primary practice setting (select one response):
   ______ Community-based clinic ______ General hospital-psychiatric unit
   ______ University clinic ______ General Hospital-nonpsychiatric unit
   ______ Forensic setting ______ Psychiatric Hospital
   ______ Private Practice: ______ (specify type of practice)
   ______ Other: ______ (please specify)

   (b) If hospital, indicate whether public ______ or private ______.

8. Population of community in which primary practice setting is located:
   ______ <100,000 ______ 100,000-499,999 ______ 500,000-1,000,000 ______ >1,000,000

9. Percentage of clients/patients to whom you assign DSM-III-R or ICD-9 diagnoses:
   ______ 0-25% ______ 26-50% ______ 51-75% ______ 76-100%

10. Political orientation (make a mark on the line below to indicate your orientation):

   Strongly Liberal Moderate Strongly Conservative

11. Political party preference:
    ______ Republican ______ Democratic ______ None ______ Other: ______ (please specify)
APPENDIX B

VIGNETTE QUESTIONNAIRES
Vignette 1: Linda, a white 28 year old mother of three daughters, aged 2, 4, and 7, was referred to a mental health clinic by her family physician due to a suicide attempt. In the initial interview she reported feeling exhausted, achy, miserable and generally "at the end of my rope." Throughout the meeting her speech was slow and slurred and her eyes remained fixed on the floor. Apparently, since the father of her youngest two children left the home nine months earlier, she has had little money to support the family. Though she does not work, Linda feels overwhelmed with daily tasks and relies heavily on her eldest daughter to feed and dress the kids. Recently, she has begun having thoughts of harming her children and though she has not acted on these ideas, they have been extremely disturbing to her. When these thoughts arise, Linda protects her children by locking herself in her bedroom and trying to "sleep them off." Over the past two weeks she has spent most of the day in bed unable to read or watch TV. The last straw occurred when her power was cut off because she hadn't paid her electric bill. In describing her reaction she stated: "That was it...there wasn't any, any point...I was a nothing. I just thought if I took the pills it would all go away."

1. Is Linda in need of help? (circle one number)
   1  2  3  4  5  6  7
   No help needed  Moderate help needed  Significant help needed

2. Does the description of Linda suggest evidence of a mental disorder? (circle one number)
   1  2  3  4  5  6  7
   No evidence of mental disorder  Moderate evidence of mental disorder  Significant evidence of mental disorder

Provisional Diagnosis: _______________________

3. Irrespective of whether Linda has a mental disorder, to what extent are each of the following likely responsible for her problems? (Indicate the degree of responsibility by placing a mark on the line below for each of the four factors [B, P, I/S, and S]).

B - Biological factors (e.g., genetics, neurochemistry)
P - Individual psychological factors (e.g., thoughts, emotions, behavior, experience)
I/S - Interpersonal/situational factors (e.g., home/work environment)
S - Societal factors (e.g., socioeconomic/sociopolitical environment)

Not Responsible
Extremely Responsible
4. To what extent would interventions focused on each of the following likely contribute to the resolution of her problems? (Mark each factor on the line below)

B - Biological factors
P - Individual psychological factors
I/S - Interpersonal/situational factors
S - Societal factors

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<tr>
<th>No</th>
<th>Extreme</th>
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Contribution

Briefly describe intervention you would most recommend:


5. To what extent would each of the following strategies likely contribute to the prevention of similar problems in the general population? (Mark each strategy on the line below)

B - Promotion of biological health (e.g., genetic counseling, mother/child nutrition)
P - Promotion of psychological health (e.g., coping skills training in public schools)
I/S - Reduction in interpersonal/situational stressors (e.g., child care at workplace)
S - Societal change (e.g., equitable distribution of power and resources)

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<th>No</th>
<th>Extreme</th>
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Contribution

Briefly describe prevention strategy you would most recommend:


Vignette 2: Jeff, a black male who looked to be in his late thirties, was brought into an inner-city mental health clinic by "Project Care" staff who ran the shelter in which he was staying. They reported that he had recently begun cursing at other residents claiming that they were stealing his money and ideas. Jeff had been at the shelter off and on for about eight months, primarily coming in for food and a warm place to sleep on cold nights. The staff indicated that since they had known him he had kept pretty much to himself and, with the exception of a couple of violent outbursts four months earlier, hadn't caused any problems. In the intake interview Jeff's appearance was filthy and his clothes were worn through with holes. He spoke intensely about himself: "I tell ya it ain't fair for anyone out there...not with that Bush, or...that Clinton, I guess now...but I had this idea, you know, that was gonna solve it all...so I kept it to myself...not that I wasn't gonna share it...it woulda brought it all together for everyone...just that it wasn't safe...but they took it while I was sleeping." Jeff denied having any relatives or friends and said that people in general "can't be trusted...they'll take ya for what they can get." He indicated that he used to work "on the line" but quit because he had been "tricked and manipulated one too many times."

1. Is Jeff in need of help? (circle one number)
   1  2  3  4  5  6  7
   No help needed  Moderate help needed  Significant help needed

2. Does the description of Jeff suggest evidence of a mental disorder? (circle one number)
   1  2  3  4  5  6  7
   No evidence of mental disorder  Moderate evidence of mental disorder  Significant evidence of mental disorder

Provisional Diagnosis: ____________________________

3. Irrespective of whether Jeff has a mental disorder, to what extent are each of the following likely responsible for his problems? (Indicate the degree of responsibility by placing a mark on the line below for each of the four factors [B, P, I/S, and S])

B  - Biological factors (e.g., genetics, neurochemistry)
P  - Individual psychological factors (e.g., thoughts, emotions, behavior, experience)
I/S  - Interpersonal/situational factors (e.g., home/work environment)
S  - Societal factors (e.g., socioeconomic/sociopolitical environment)

<table>
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<th>Not Responsible</th>
<th>Extremely Responsible</th>
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</table>
4. To what extent would interventions focused on each of the following likely contribute to the resolution of his problems? (Mark each factor on the line below)

B  - Biological factors
P  - Individual psychological factors
I/S - Interpersonal/situational factors
S  - Societal factors

| No Contribution | Extreme Contribution |

Briefly describe intervention you would most recommend:__________


5. To what extent would each of the following strategies likely contribute to the prevention of similar problems in the general population? (Mark each strategy on the line below)

B  - Promotion of biological health (e.g., genetic counseling, mother/child nutrition)
P  - Promotion of psychological health (e.g., coping skills training in public schools)
I/S - Reduction in interpersonal/situational stressors (e.g., child care at workplace)
S  - Societal change (e.g., equitable distribution of power and resources)

| No Contribution | Extreme Contribution |

Briefly describe prevention strategy you would most recommend:__________


Vignette 3: Christine, a white 49 year old married mother of two children, aged 14 and 17, reluctantly came to the community mental health clinic at the insistence of her husband Tim who accompanied her. He reported that over the past year she had been drinking from three to six drinks per evening after work, with occasional binges on the weekend. Tim, with tears in his eyes, described how the family was falling apart due to his wife's drinking: "No one seems to communicate any more...the kids are out most of the time." Christine, painting a different picture, suggested that her family had been extremely insensitive to her since she had returned to work as a typist three years earlier. She reported that her boss "expected miracles from me" and said that her job was generally "unrewarding" and "dull." For the past two years she has been suffering with severe headaches and abdominal distress, including nausea and diarrhea, as well as frequent flashes of fear about having to go to work. She has taken "sick days" on numerous occasions because of these problems. Furthermore, she described occasionally waking in the middle of the night in a sweat, her heart pounding, afraid that she was having a heart attack. Christine explained that alcohol was her only way to cope with these feelings as her family was not supportive: "It helps me to relax...I just feel so afraid all the time and no one seems to understand."

1. Is Christine in need of help? (circle one number)
   
   1. No help needed
   2. Moderate help needed
   3. Significant help needed

2. Does the description of Christine suggest evidence of a mental disorder? (circle one number)
   
   1. No evidence of mental disorder
   2. Moderate evidence of mental disorder
   3. Significant evidence of mental disorder

Provisional Diagnosis: ____________________________

3. Irrespective of whether Christine has a mental disorder, to what extent are each of the following likely responsible for her problems? (Indicate the degree of responsibility by placing a mark on the line below for each of the four factors [B, P, I/S, and S])

   B - Biological factors (e.g., genetics, neurochemistry)
   P - Individual psychological factors (e.g., thoughts, emotions, behavior, experience)
   I/S - Interpersonal/situational factors (e.g., home/work environment)
   S - Societal factors (e.g., socioeconomic/sociopolitical environment)

   Not Responsible

   Extremely Responsible
4. To what extent would interventions focused on each of the following likely contribute to the resolution of her problems? (Mark each factor on the line below)

B - Biological factors  
P - Individual psychological factors  
I/S - Interpersonal/situational factors  
S - Societal factors

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Briefly describe intervention you would most recommend:


5. To what extent would each of the following strategies likely contribute to the prevention of similar problems in the general population? (Mark each strategy on the line below)

B - Promotion of biological health (e.g., genetic counseling, mother/child nutrition)  
P - Promotion of psychological health (e.g., coping skills training in public schools)  
I/S - Reduction in interpersonal/situational stressors (e.g., child care at workplace)  
S - Societal change (e.g., equitable distribution of power and resources)

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Briefly describe prevention strategy you would most recommend:


Vignette 4: Trent, a white 9 year old boy in the fourth grade, came to the community mental health clinic with his parents, Julie, aged 36, and Kevin, aged 34, due to chronic difficulties both at school and at home. His teachers report that he is a likeable and bright student, but that they have had significant difficulty controlling his behavior since the first grade. Trent described his teachers' complaints about him in his own words: "I guess they don't like that I kinda get up all the time and that I don't listen so good...its just so boring, sitting there all day...why can't I ever do what I want."

In addition, teachers claim that he is loud and talkative and that he seems unable to stay focused on his work for extended periods of time. Kevin stated that he and Julia are tired of Trent's unruly behavior: "He doesn't seem to understand the meaning of the word 'no.'" Julie and I have had it up to here trying to control him." Julie further explained: "It's been so hard these last few years...with Kevin and I both having to work, but not being able to trust Trent alone in the house. We've had to send him to a neighbor's home at lunch and after school just to keep him from destroying the place."

1. Is Trent in need of help? (circle one number)

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<th>4</th>
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2. Does the description of Trent suggest evidence of a mental disorder? (circle one number)

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Provisional Diagnosis: ________________________________

3. Irrespective of whether Trent has a mental disorder, to what extent are each of the following likely responsible for his problems? (Indicate the degree of responsibility by placing a mark on the line below for each of the four factors [B, P, I/S, and S])

<table>
<thead>
<tr>
<th></th>
<th>B - Biological factors (e.g., genetics, neurochemistry)</th>
<th>P - Individual psychological factors (e.g., thoughts, emotions, behavior, experience)</th>
<th>I/S - Interpersonal/situational factors (e.g., home/work environment)</th>
<th>S - Societal factors (e.g., socioeconomic/sociopolitical environment)</th>
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<td>Extremely Responsible</td>
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</table>
4. To what extent would interventions focused on each of the following likely contribute to the resolution of his problems? (Mark each factor on the line below)

B - Biological factors
P - Individual psychological factors
I/S - Interpersonal/situational factors
S - Societal factors

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Briefly describe intervention you would most recommend:

________________________________________________________________________

________________________________________________________________________

5. To what extent would each of the following strategies likely contribute to the prevention of similar problems in the general population? (Mark each strategy on the line below)

B - Promotion of biological health (e.g., genetic counseling, mother/child nutrition)
P - Promotion of psychological health (e.g., coping skills training in public schools)
I/S - Reduction in interpersonal/situational stressors (e.g., child care at workplace)
S - Societal change (e.g., equitable distribution of power and resources)

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Briefly describe prevention strategy you would most recommend:

________________________________________________________________________

________________________________________________________________________
APPENDIX C

SOCIAL ATTITUDES SCALE
Social Attitudes Scale

Given below are statements on various social issues about which we all have beliefs, opinions, and attitudes. Please respond to each of the items as follows:

-3 Disagree very strongly
-2 Disagree strongly
-1 Disagree
+1 Agree
+2 Agree strongly
+3 Agree very strongly

1. Individuals who are against churches and religions should not be allowed to teach in colleges.*

2. Large fortunes should be taxed fairly heavily over and above income taxes.

3. Both public and private universities and colleges should get generous aid from both state and federal governments.

4. Science and society would both be better off if scientists took no part in politics.*

5. Society should be quicker to throw out old ideas and traditions and to adopt new thinking and customs.

6. To ensure adequate care of the sick, we need to change radically the present system of privately controlled medical care.

7. If civilization is to survive, there must be a turning back to religion.*

8. A first consideration in any society is the protection of property rights.*

9. Government ownership and management of utilities leads to bureaucracy and inefficiency.*

10. If the United States takes part in any sort of world organization, we should be sure that we lose none of our power and influence.*

11. Funds for school construction should come from state and federal government loans at no interest or very low interest.

12. Inherited racial characteristics play more of a part in the achievement of individuals and groups than is generally known.*

13. Federal Government aid for the construction of schools is long overdue, and should be instituted as a permanent policy.

14. Our present economic system should be reformed so that profits are replaced by reimbursements for useful work.

* The marked items are conservative. Nonmarked items are liberal and are reverse scored.
15. Public enterprises like railroads should not make profits; they are entitled to fares sufficient to enable them to pay only a fair interest on the actual cash capital they have invested.

16. Government laws and regulations should be such as first to ensure the prosperity of business since the prosperity of all depends on the prosperity of business.*

17. All individuals who are intellectually capable of benefitting from it should get college education, at public expense if necessary.

18. The well-being of a nation depends mainly on its industry and business.*

19. True democracy is limited in the United States because of the special privileges enjoyed by business and industry.

20. The gradual social ownership of industry needs to be encouraged if we are ever to cure some of the ills of our society.

21. There are too many professors in our colleges and universities who are radical in their social and political beliefs.*

22. There should be no government interference with business and trade.*

23. Some sort of religious education should be given in public schools.*

24. Unemployment insurance is an inalienable right of the working person.

25. Individuals with the ability and foresight to earn and accumulate wealth should have the right to enjoy that wealth without government interference and regulations.*

26. The United Nations should be whole-heartedly supported by all of us.
APPENDIX D

COVER LETTER
September 1, 1993

Dear Colleague:

Over the past few decades, mental health research has demonstrated the importance of diverse factors in human psychological distress. In their practices, mental health professionals often consider the relative significance of genetic, biochemical, psychological, and environmental forces in contributing to each of their patients'/clients' unique configuration of problems. In order to address the multiple aspects of psychological distress, many clinicians have embraced eclecticism in their practice and most mental health facilities have incorporated multidisciplinary models. Nevertheless, the complexity of mental health treatment in the 1990s can leave both practitioners and their patients/clients bewildered by the plethora of treatment approaches available. We are conducting this survey throughout the United States in order to understand the role played by these various approaches in the work of clinical psychologists. In particular, we are interested in the relationship between general social attitudes and the importance placed on various factors affecting mental health.

We would greatly appreciate your participation in this doctoral research project conducted by Iain Twaddle, M.A., from the Department of Psychology at the University of Windsor, in Windsor, Ontario, Canada. We have enclosed a questionnaire package that should take approximately 25 to 35 minutes to complete. On these questionnaires you are asked to offer your opinions on various mental health and social issues. For your convenience, a postage-paid, self-addressed envelope has been included for the return of the research materials. Your completion and return of the questionnaires will be taken as an indication of your consent to participate in this study.

Of course, your participation is strictly voluntary. In order to ensure the anonymity of your responses, no names will be requested on the questionnaires. Should you wish a copy of group results from this study, please do not hesitate to contact Iain Twaddle at the Department of Psychology, University of Windsor, Windsor, Ontario, Canada, N9B 3P4 or call (519) 253-4232, ext. 2217...

This research has been reviewed and cleared by the Ethics Committee of the University of Windsor. Please direct any ethical concerns to the Office of Research Services, University of Windsor, Windsor, Ontario, Canada, N9B 3P4 (telephone number: (519) 253-4232, ext. 3916).

Thank you in advance for your cooperation. Your participation in this project is very much appreciated. Please feel free to contact the principal investigator, Iain Twaddle, at (519) 253-4232, ext. 2217, should you have any questions or concerns.

Sincerely,

Department of Psychology         Associate Professor of            Head,
(Principal Investigator)         Psychology                        Department of Psychology
                                      (Research Supervisor)         

Instructions: On the following pages are four case vignettes and a questionnaire regarding social issues. Each vignette provides a brief description of an initial interview with a mental health client/patient. Please read each one and answer the questions which follow. Some of the questions ask you to rate the significance of four factors by placing a mark for each one along a continuum. For example, question #3 asks "to what extent are each of the following likely responsible for [the client's/patient's] problems?" The factors are as follows:

B = Biological factors
P = Individual psychological factors
I/S = Interpersonal/situational factors
S = Societal factors

To indicate the degree to which you see the factors as responsible for the individual's problems, place a mark on the line for each factor and label the mark with the appropriate letter(s) - B, P, I/S, and S - as illustrated below:

\[ \text{Not Responsible} \quad \text{B} \quad \text{S} \quad \text{P} \quad \text{Extremely Responsible} \]

The instructions for the social issues questionnaire are self-explanatory.
APPENDIX F

POSTCARD
Dear Colleague:

Last week, we sent you a questionnaire concerning opinions on various mental health and social issues.

If you have already completed and returned the questionnaire package, please accept our appreciation. If not, please do so as soon as possible. Because it has been sent to a small sample of American psychologists, it is extremely important that your responses be included in this study.

If by chance you did not receive the materials, or if they were misplaced, please contact Iain Twaddle at (519) 253-4232, ext. 2217, and we will mail another copy to you.

Sincerely,

Iain K.B. Twaddle, M.A.  James E. Porter, Ph.D., C.Psych.
Department of Psychology  Associate Professor of Psychology
University of Windsor  University of Windsor
(Principal Investigator)  (Research Supervisor)
APPENDIX G

MENTAL HEALTH FACTOR

INTERCORRELATION MATRICES
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**Note.** V = vignette; Q = question. 
*_{p<.05}, one-tailed. **_{p<.01}, one-tailed. ***_{p<.001}, one-tailed.
Table G-2

Intercorrelations among the Multiple Measures of the Psychological Factor

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<tr>
<th>Item</th>
<th>V1</th>
<th>V2</th>
<th>V3</th>
<th>V4</th>
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<tr>
<td>Item</td>
<td>Q3</td>
<td>Q4</td>
<td>Q5</td>
<td>Q3</td>
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<tr>
<td>V1-Q4</td>
<td>.76***</td>
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</tr>
<tr>
<td>V1-Q5</td>
<td>.50*** ,55***</td>
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<td></td>
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<tr>
<td>V2-Q3</td>
<td>.36*** ,37*** ,44***</td>
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</tr>
<tr>
<td>V2-Q4</td>
<td>.20* ,25** ,33***</td>
<td>.61***</td>
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<tr>
<td>V2-Q5</td>
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<td>.62*** ,54***</td>
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<tr>
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<tr>
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<td>.33*** ,28***</td>
<td>.46***</td>
<td>.68*** ,68***</td>
</tr>
<tr>
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<td>.52*** ,45*** ,47***</td>
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<tr>
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<tr>
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<td>.46*** ,45*** ,68***</td>
<td>.48*** ,46*** ,57***</td>
<td>.64*** ,60***</td>
</tr>
</tbody>
</table>

Note. V = vignette; Q = question. 
*p<.05, one-tailed. **p<.01, one-tailed. ***p<.001, one-tailed.
Table G-3

Inter correlations among the Multiple Measures of the Interpersonal/Situational Factor

<table>
<thead>
<tr>
<th>Item</th>
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<th>V4</th>
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<td>Q4</td>
<td>Q5</td>
<td>Q3</td>
</tr>
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<td></td>
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<tr>
<td>V1-Q4</td>
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<td></td>
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</tr>
<tr>
<td>V1-Q5</td>
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<td>0.42***</td>
<td>0.44***</td>
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</tr>
<tr>
<td>V2-Q3</td>
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<td>0.44***</td>
<td>0.53***</td>
<td>0.71***</td>
</tr>
<tr>
<td>V2-Q4</td>
<td>0.41***</td>
<td>0.40***</td>
<td>0.50***</td>
<td>0.62***</td>
</tr>
<tr>
<td>V2-Q5</td>
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<td>0.52***</td>
<td>0.35***</td>
<td>0.30***</td>
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<td>V3-Q3</td>
<td>0.32***</td>
<td>0.50***</td>
<td>0.43***</td>
<td>0.38***</td>
</tr>
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<td>V3-Q4</td>
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<td>0.39***</td>
<td>0.35***</td>
<td>0.37***</td>
</tr>
<tr>
<td>V3-Q5</td>
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<td>0.36***</td>
<td>0.23**</td>
<td>0.34***</td>
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<td>0.24**</td>
<td>0.25**</td>
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<tr>
<td>V4-Q4</td>
<td>0.36***</td>
<td>0.37***</td>
<td>0.39***</td>
<td>0.43***</td>
</tr>
</tbody>
</table>

Note. V = vignette; Q = question.
*p<.05, one-tailed. **p<.01, one-tailed. ***p<.001, one-tailed.
Table G-4

Intercorrelations among the Multiple Measures of the Societal Factor

<table>
<thead>
<tr>
<th>Item</th>
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<th>V3</th>
<th>V4</th>
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<td>Q5</td>
<td>Q3</td>
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<td>V1-Q3</td>
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</tr>
<tr>
<td>V1-Q4</td>
<td>.66***</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>V1-Q5</td>
<td>.64*** .62***</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>V2-Q3</td>
<td></td>
<td>.41*** .42*** .46***</td>
<td>-</td>
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</tr>
<tr>
<td>V2-Q4</td>
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<td>.36*** .46*** .43*** .77***</td>
<td>-</td>
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</tr>
<tr>
<td>V2-Q5</td>
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<td>.33*** .33*** .42*** .70*** .71***</td>
<td>-</td>
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</tr>
<tr>
<td>V3-Q3</td>
<td></td>
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<td>.37*** .53*** .46*** .52*** .51*** .37***</td>
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</tr>
<tr>
<td>V3-Q4</td>
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<td>.37*** .54*** .43*** .54*** .53*** .33*** .75***</td>
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<tr>
<td>V3-Q5</td>
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<tr>
<td>V4-Q3</td>
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<td>.40*** .43*** .45*** .43*** .36*** .37*** .56*** .46*** .49***</td>
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<tr>
<td>V4-Q4</td>
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<td></td>
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<td>.29*** .40*** .43*** .49*** .44*** .42*** .59*** .55*** .61*** .82***</td>
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<tr>
<td>V4-Q5</td>
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<td></td>
<td>.30*** .30*** .33*** .39*** .35*** .40*** .50*** .48*** .58*** .70*** .75***</td>
</tr>
</tbody>
</table>

*Note. V = vignette; Q = question.
*p<.05, one-tailed. **p<.01, one-tailed. ***p<.001, one-tailed.
VITA AUCTORIS

Iain Twaddle was born in Winnipeg, Manitoba on February 28, 1965. In 1987 he graduated from the University of Winnipeg with a Bachelor of Arts (Honours) Degree in Psychology. He enrolled in the Adult Clinical Psychology program at the University of Windsor in September, 1987. He received the Masters of Arts Degree in 1989 and the Doctor of Philosophy Degree in 1994. He is currently an Assistant Professor in Clinical Psychology at the University of Guam.