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## **ASA SOCIOLOGY OF MENTAL HEALTH FALL 2021 Newsletter**

Prepared by Teresa L. Scheid, Please send items for the spring newsletter to [tlscheid@uncc.edu](mailto:tlscheid@uncc.edu)

### **Announcements**

Please send new announcements or questions to [socmentalhealth@gmail.com](mailto:socmentalhealth@gmail.com)

### **Topics Covered in this Newsletter**

Council Members

Call for 2022 Awards

Call for Papers, 2022 ASA Meetings and 2022 Stress Conference

Suicide: Useful Resources (by T. Scheid)

Happy Holidays!

## **Council Members**

Chair: Tony N. Brown, Rice University

Chair-Elect: Donna McAlpine, University of Minnesota-Twin Cities

Past Chair: Pamela Braboy Jackson, Indiana University

Section Secretary/Treasurer: Bianca Manago, Vanderbilt University

Council Member at Large: Matthew Grace, Hamilton College

Student Representative: Max Elliott Coleman, Indiana University Bloomington

Award Committee Chair: Elaine Wethington, Cornell University

Membership Committee Chair: Brittany Hearne, University of Arkansas

Publications Committee Chair: Joseph D. Wolfe, University of Alabama-Birmingham

Nominations Committee Chair: Fernando I. Rivera, University of Central Florida

**(elections are soon so send Fernando an email to nominate new council members).**

## **2022 Call for Section Awards**

### **Sociology of Mental Health Award 2022 Nominations Call**

### **Send Nominations to Elaine Wethington ([ew@cornell.edu](mailto:ew@cornell.edu))**

#### **Leonard I. Pearlin Award for Distinguished Contributions**

This award is given for distinguished contributions to the sociological study of mental health. Thanks to the generous donation from Leonard Pearlin, the mental health section of the ASA has created this annual award. The award honors a scholar who has made substantial contributions in theory and/or research to the sociology of mental health. Nominations should include a CV of the nominee and a letter of support describing the nominee's contributions to the sociology of mental health. Nominations should be sent to the Awards Committee Chair for the Mental Health Section, **Elaine Wethington at [ew20@cornell.edu](mailto:ew20@cornell.edu), by February 1, 2022.**

#### **Award for Best Publication in Mental Health**

This award is given for the best published article, book or chapter in the area of the sociology of mental health. The publication date needs to have been within the last two years. The awards committee will also conduct a search of works published in the past two years for potential candidates for this award. Letters of nominations for this award should be sent to the Awards Committee Chair for the Mental Health Section, **Elaine Wethington at [ew20@cornell.edu](mailto:ew20@cornell.edu), by March 1, 2022**

## **Award for Best Dissertation in Mental Health**

This award is given for the best doctoral dissertation in the area of the sociology of mental health. The dissertation should have been completed within the previous two academic years. While not required, a letter from your dissertation advisor would be helpful. Please send a letter of nomination and a paper based on the dissertation (or dissertation synopsis) to the Awards Committee Chair for the Mental Health Section, **Elaine Wethington at [ew20@cornell.edu](mailto:ew20@cornell.edu), by April 1, 2022.**

## **Graduate Student Paper Award**

The ASA Sociology of Mental Health section solicits nominations for the Annual Graduate Student paper award in the area of the sociology of mental health. This distinction will be given to a current graduate student for the best published or unpublished article, book or chapter in the area of mental health. The paper should have been completed within the previous two academic years by a current graduate student. Papers authored by more than one student are acceptable but papers coauthored with faculty are not eligible. Section Members are encouraged to submit nominations. Self-nominations from graduate student members of the section are also welcome. Please send a letter of nomination and a paper to the Awards Committee Chair for the Mental Health Section, **Elaine Wethington at [ew20@cornell.edu](mailto:ew20@cornell.edu), by May 1, 2022.**

## **CALL FOR PAPERS:**

### **2022 ASA Annual Meetings: Sociology of Mental Health Section Sessions**

#### A. Immigration and Immigration Policy: Implications for Mental Health

Immigration and immigration policy are risk and protective factors neglected in the sociology of mental health. On the one hand, mechanisms including family separation, stigma, harassment, and so on undermine immigrant individuals' and communities' sense of psychological well-being. On the other hand, mechanisms including collective identity, culture, progressive policies (e.g., DACA), and so on protect immigrant individuals' and communities' sense of psychological well-being. This session invites papers interrogating the mental health significance of immigration and immigration policy, and mechanisms through which they influence mental health.

Organizer: David Takeuchi ([dt5@uw.edu](mailto:dt5@uw.edu))

#### B. Social Determinants of Mental Health among Neglected Populations (90 minutes)

Considerable social science research relies on data from individuals in Western, educated, industrialized, rich, and democratic (WEIRD) societies, who represent as much as 80 percent of respondents and research participants, but only 12 percent of the world's population. The same is true in the sociology of mental health, where it seems heterogeneity and variation in lived experiences remain under-appreciated empirically and theoretically. What are sociologists of mental health missing when we rely on data from narrow population groups and assume theories apply universally across communities and societies? This session invites papers privileging

social determinants of mental health among neglected populations.

Organizer: Kimberly R. Huyser ([kimberly.huyser@ubc.ca](mailto:kimberly.huyser@ubc.ca))

### C. Mental Health Challenges Created by Mass Incarceration and the Carceral State (90 minutes)

The nation's three largest mental health care treatment facilities are jails in LA County, California and Cook County, Illinois, and on New York City's Rikers Island. Increasing numbers of studies document how mass incarceration ravages communities, though not all communities experience comparable levels of harm. Given continued expansion of the prison industrial complex, this session invites papers examining how incarceration shows direct and collateral mental health significance for individuals and communities. This session also invites papers addressing pathways that may counteract the insidious nature of collateral consequences for those connected to the incarcerated. Organizer: Sirry Alang ([sma206@lehigh.edu](mailto:sma206@lehigh.edu))

There will also be roundtables, which provide excellent opportunities for discussion and feedback. Please look to the ASA meeting page to see the regular sessions for mental health (which are independent of the section sessions described above) and also many opportunities to bring mental health research to other sociological areas of research. You can also volunteer to be a presider or discussant.

### **Call For Papers: 17th International Conference on Social Stress Research**

We are now accepting submissions to be considered for the conference program on June 4-6, 2022 at the Kimpton Brice Hotel in Savannah, Georgia. We will review full papers or extended abstracts (with sufficient evidence of the substance and scientific merit of the paper). Please email submissions by January 21, 2022 to [Catherine.Moran@unh.edu](mailto:Catherine.Moran@unh.edu)

Possible thematic sessions include:

- Stressors associated with COVID-19
- Childhood/adolescent stress and adversity
- Work, occupational, and unemployment-related stressors
- Stress in family contexts
- Gender and stress processes
- Race, ethnicity, culture and discrimination stress
- Intersections of physical and mental health
- Catastrophic and traumatic stress
- LGBTQIA+ stressors
- Neighborhood contexts of stress

### **Suicide: Useful Resources, Prepared by T. Scheid**

I wanted to provide some information about youth suicide, driven by the alarming increases during the COVID pandemic, but within the context of rising rates since the early 2000's. I am also concerned by my recent experiences with students (both undergraduate and graduate) and a 13 year old neighbor who has had two hospitalizations in the past six months. I know many of us have had family members and friends struggle with suicide, and our expertise in mental health makes us an invaluable resource. I have worked with Faculty Council and our own Counseling Center at UNC-C to address student access to mental health and have found this information

useful to share with those who are may not be aware of the social context of suicidal behaviors, or many readily available resources.

## **Some Background**

Exemplar: Emile Durkheim, *Suicide*, published in 1897

Durkheim first published an article on suicide and then taught a yearlong course on suicide in 1889-90 and collected data on suicide for seven years (source reference: Steven Lukes, 1973, *Emile Durkheim: His Life and Work: A Historical and Critical Study*. Penguin Books). A very close friend of Durkheim's did commit suicide, but the topic of suicide had been a subject of much debate and was viewed as a growing social problem at that time, "and there was an unresolved dispute as to whether or not suicide was related to mental disorder" (Lukes, pg. 192). At the same time, Durkheim (as the person to establish Sociology as a social science) was interested in issues related to social integration given the current social and political divides in 19<sup>th</sup> century France (much as we have today). There was concern over "social dissolution" and critiques of excessive individualism, as opposed to communism. This political/social nexus is reflected in Durkheim's development of the concepts of egoism and anomie.

"Egoism existed where society is not sufficiently integrated at all points to keep all its members dependent upon it... while anomie springs from the lack of collective forces of groups established for the regulation of social life." (Durkheim quoted in Lukes, pg. 199).

Durkheim viewed suicide rate as a *social fact*, something that exists independent of the individual, and was interested in explaining rates of suicide, not individual instances of suicide. "He saw suicide as the antithesis of social solidarity, and a high suicide rate as an index of the inadequate effectiveness of social bonds (Lukes, pg. 206). This led Durkheim to differentiate between egoistic suicide (where individuals are isolated), altruistic suicide (where the individual is too strongly connected to society and commit suicide due to group pressure), and suicide as a result of anomie – where society does not offer social bonds, or adequate regulation of the individual.

The difference between egoism and anomie is important, but easily missed. When one is isolated and lonely, suicide is possible – and this could be egoistic suicide or anomie depending on WHY an individual is socially isolated. Both involve normlessness, but egoism is a "breakdown of the self; anomie is the breakdown of the constraining legal and moral norms" (Lukes, pg. 207). If we look at suicides among white men following the 1929 crash, this is a clear example of suicide due to anomie... the collapse of the economic framework which gave this GROUP of men meaning. If an individual gambles and loses their savings and then commits suicide, that is an example of suicide due to egoism. A good example of altruistic suicide has to do with certain cults or military membership (think Japanese pilots in WWII).

In summary, for Durkheim the most individual act (suicide) was linked to levels of social integration and dissolution. However, Durkheim clarified his explanation, excluding cases where "insanity may be considered a determining factor of suicide" (as quoted in Lukes, pg. 214). The social "currents" generating suicide for Durkheim are relevant today (and may account for our relatively high rates of suicide): "the state of moral individualism, excessive

individualism, pessimistic currents, a state of crisis and perturbation... the state of deep disturbance from which all civilized societies are suffering.” (Lukes, pg. 214-5). Lukes goes on to argue that Durkheim developed a social-psychological theory about the social conditions for individual health. That under adverse social conditions and inadequate social integration (or too much in the case of altruistic suicide) certain individuals respond by committing suicide (pg. 217).

There is a new book on suicide by Jason Manning (*Suicide: The Social Causes of Self-Destruction*, The University of Virginia Press) section members may want to look at (its on my reading list, but I haven’t gotten to it yet).

*When Night Falls: Understanding Suicide*. 1999. Kay Redfield Jamison. Vintage Books.

This is a good general treatment of suicide, drawing on research, literature, and first hand accounts by Jamison, a psychiatrist living with bi-polar disorder who has written eloquently of her own experiences. Along with Durkheim, Jamison notes that rates of suicide world wide are relatively stable at 1 to 4 percent of adults attempting suicide (i.e. some level of suicide is “normal” in Durkheim’s language). However, rates of adolescent suicide are higher: 2 to 10 percent. Depression and psychiatric illness are important, as is stress, and Jamison notes that stress effects not only our immune system, but also the sleep wake cycle which can lead to exacerbation of symptoms for those with depression and bi-polar disorder (and I would add anxiety). Most research points to a significant increase in stressful life events prior to the onset of both mania and schizophrenic episodes (and obviously depression) and are also related to relapse and longer recovery times.

Substance abuse is also predictive of suicide, especially when combined with mental health problems (i.e. co-morbidity). Depression, substance use, anxiety, irritability and restlessness (mania or psychosis), and features of the major personality disorders all lead to social isolation (i.e. return to Durkheim’s emphasis on social bonds) – to an “Impoverished and solitary personal life” (Jamison, pg. 111).

T. Scheid’s Note: It is important to note this book predates the rising rates documented by the CDC beginning in 2000. In addition to the many stressful events of the past 20 years, we also have a opioid epidemic. We now know a great deal more about how stress changes the chemistry of the brain affecting the hippocampus region, and also growth and resiliency. Chronic stress has the same negative effects on the brain as does aging.

The Stress-Diathesis Model applied to Suicide (summarizing data reported by Jamison).

Precipitating Factors:

- Biological Predisposition
- Personality (temperamental factors such as aggressiveness and impulsivity)
- Substance Abuse
- Chronic Medical Conditions
- Social Factors (especially trauma, isolation, chronic stressors)

Protective Factors (Durkheim's social bonds – TS note)

- Religion
- Children
- Financial Security
- Social Supports

Triggers for Suicide:

- Psychiatric illness
- Drugs and alcohol
- Personal or financial crisis
- Other suicides (and Jamison devotes some time to how the media can report on suicide so as not to trigger other suicides).

Gender and age are also important, as is the season (most suicides are committed in the spring or early summer, not in the winter and this data has been shown over time historically as well as cross-nationally).

Guns are also important; in the US guns are responsible for the majority of suicides. In terms of prevention, limiting access to guns is important, as is adequate mental health and substance abuse treatment (both of which are currently lacking). Of interest is that doctors have very high rates of suicide (especially among residents, related to the stress of residency), so reporting suicidal ideation to one's doctor may not result in adequate treatment. Jamison, writing in 1999 (pg. 288), concludes that "Major success at suicide prevention is (not) a realistic goal if treatment for mental illness remains out of reach for millions of Americans because health insurance is poor or non-existent."

Alexander Crosby and Leigh Willis. 2017. "Preventing Adolescent Suicidal Behavior: Integrating Sociology and Public Health", Chapter 25 in A Handbook for the study of Mental Health, 3<sup>rd</sup> Edition, Scheid and Wright, editors, Rutgers University Press.

This chapter includes information about self-harm, suicidal ideation, and suicide attempts. According to 2015 CDC data, for every successful suicide there are 200 attempts. which is a frightening statistic. The chapter provides an overview of the epidemiology of adolescent suicide. While males are more successful, rates among females are increasing. Age is also significant, with younger adolescents having lower rates than the older groups (10-14; 15-19; 20-24). (TS note: this is changing with COVID and on-online learning with middle school students at very high risk). Suicide is also related to social disadvantage, and there are also higher rates among youth living in rural areas. While stress is clearly a critical factor, Crosby and Willis note that younger people may be more adaptable, though they are more likely to feel helpless and to have fewer coping mechanisms (TS note: important issue for research!).

Crosby and Willis draw on the 2002 IOM report "Reducing Suicide: A National Imperative" for strategies.

- I. Universal Prevention:
  - a. Public Education with school -based awareness education.

- b. Media Awareness
  - c. Restrict Access to Lethal Weapons (both guns and medications including aspirin)
  - d. Poverty Reduction
- II. Community Approaches: Communities that care, with efforts to deal with substance use and abuse as well as suicide prevention. Social media can be beneficial if used properly to provide education and linkages to social supports.
- III. Implementation and Dissemination of Research and Intervention Efforts. “There is still much we do not know about protective factors against Suicide” (pg. 528). A recent effort as an example of what Crosby and Willis mean is the American Psychological Association providing information to the NIMH on new research directions to prevent Black youth suicide. The NIMH had sent out a request for information. Among the APA’s recommendations was for support for longitudinal research on how child-rearing practices and abuse affect Black youth, as well as for research on developmentally appropriate social media, and research on the design and delivery of school mental health services.

## **Recent Information**

The Nation’s Health. January 2021. “Health Workers Reaching Patients Who May Have Suicidal Thoughts.” Review of information provided by APHA writer Mark Marna who reviews suicide prevention efforts reported during the APHA 2000 meetings. Given that many people who have attempted or died by suicide visited a healthcare provider in the proceeding weeks (according to NIMH data), there are opportunities for intervention. Healthcare professionals could use a screening method called QPR (Question them about suicide; Persuade them to seek/accept help; Refer them to appropriate resources). On-line training is provided by the QPR institute. Another resource is Project 2025, developed by the American Foundation for Suicide Prevention to reduce the annual US suicide rate by 20% in 2025. It is also important to simply be observant, especially for those at higher risk (the article mentions LBTQ people who have a 40 % higher risk of suicide).

Mental Health America (MHA) also has a focus on youth mental health and suicide. The report, “Young Peoples’ Mental Health in 2020: Hope, Advocacy, and Action for the Future” focuses on the need for leaders to “listen” to youth. Based upon their survey of more than 1,900 14 to 24-year olds, MHA reported that nearly half (45 %) of those between 14-18 were **not** hopeful about the future (with more than half of LBTQ teens not hopeful). Those surveyed provided information about what resources they need and targeted access to mental health professionals and mental health breaks at work or school. They also wanted to learn more about mental health, and training to support their peers’ mental health. The report describes several programs which are supporting young peoples’ mental health. The report concludes that schools need to invest in peer support systems as well as mental health education and that resources must also be invested in young peoples’ advocacy so that they know how to make changes.

As a follow up to the report, MHA has sponsored a series of webinars and town halls. I attended several of these (and they were also recorded and made available to participants). “Our Future in



the Mind” was a two-day event held via U-Tube (Friday evening and Saturday) which had several excellent sessions. The one on Suicide featured a PhD Psychologist (a black male) and 3 speakers who were suicide survivors. The survivors advised us to watch out when people say they’re “okay” – especially if they seem just a little bit off. Look for sudden mood changes, as well as dark jokes. All of the participants stressed that “It’s OKAY to ask someone very directly if they are thinking about suicide, it helps to be “seen”. Ask if they are thinking of hurting themselves; let them know you take this seriously. Take time to listen and be non-judgmental. So often they are feeling alone and believe that no one understands what they are feeling. Let them know you care with even small gifts of kindness. The theme of talking directly was reiterated by all the participants, and this is of course directly related to the stigma surrounding discussions of suicide or mental health problems.

Another session I was able to attend was “Mental Health in the Schools” where participants described a number of initiatives in grade and high schools which incorporated mental health into the curriculum and promoted wellness practices. A simple thing is to provide a place where students can meet and discuss mental health, or just take a time out to “play.” Youth advocates identified a major challenge that students simply are not educated about mental health or the political process and hence did not know who to make changes.

In terms of college students, a community- based approach is needed where students have access to education, training, peer supports, and professional counseling when necessary. There is a shortage of mental health workers on most campuses. Some examples of what schools and colleges can provide include physical spaces to gather and talk; mental health days; care counselors (peer supports with mental health training) and training the educators about mental health.

Faculty can also take an important role in changing the campus culture. Drawing from an editorial published in The Charlotte Observer (Friday, October 18), “One of the biggest failures of higher education is that it teaches students that their GPA is more important than their well-being, that high levels of stress are normal, that poor mental health is just the price you have to pay for academic success. A supportive campus environment means increasing access to resources. It means teaching faculty to identify and assist students in crisis, and to give grace when it’s needed. It means institutionalizing peer-to-peer support networks, because students who are struggling are more likely to talk to other students. It means having a comprehensive suicide prevention plan and developing crisis response frameworks.”

## **Concluding Thoughts**

In terms of a more sociological framing, peer and youth advocacy is an important source of empowerment and resiliency. Youth need to take back the power to change those systems that are not serving their needs. Mental health is also an intersectionality issue, and should be linked to efforts to promote diversity, equity, and inclusion. More open awareness of, and programs to address mental health and suicide, will also reduce both self and societal level stigma. Also relevant is sources of anxiety, and ways we have learned to deal with stress and anxiety. I myself experience a great deal of climate anxiety, as are so many young people. I look forward

to the stress conference mentioned above to advance our understandings of stress, anxiety, and mental health outcomes (both positive (resiliency or advocacy) and negative (substance abuse and suicidal behaviors)).

## **Research Ideas**

I think it would be interesting if we contributed ideas about how our campuses are (or are not) dealing with the mental health of not only students, but faculty and staff. Dr. Zinobia Bennefield and I were members of a Black Student Mental Health Task Force during 2020 and 2021 and everyone was frustrated by the lack of investment into staffing and campus outreach, especially given no-one was on campus to access what had been previously an office-based service. Telehealth was the only option, but viewed as even less accessible by many students.

What is your campus doing?

What have you experienced with your students? What is working? What isn't?

We could build a data base that would be useful for initiatives for innovation, implementation, and innovation.

What kinds of research are you or your students engaged in to advance mental health in schools?

What about gun violence and gun control? What legislation is being advanced in the wake of yet another mass shooting?

What about climate change, disasters, and mental health outcomes? What role does climate anxiety play in exacerbating anxiety and depression, and can advocacy reduce the feelings of helplessness and lack of control so central to anxiety and depression?

What research questions are you addressing?

***Happy Holidays and Enjoy a Peaceful Moment!***

