The Production of Understanding*

BRUCE G. LINK

Columbia University and
New York State Psychiatric Institute

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While there is little doubt that sociological theory and research has had an important impact on the way people think about health and health care, mental health and medical sociologists are often confronted with challenges concerning the utility of the work that they do. Among the doubters are deans, funding agencies and family members. We are challenged by the ascendency of biological interpretations of human behaviors, by the incompatibility between the contextual view we prefer and the very strong individualistic orientation of our culture, and by the fact that we do not have an applied arm that trains the professionals who treat health and mental-health conditions. How do we respond to this challenge? The title of this paper gives a short answer: "The Production of Understanding." I propose that a powerful but under-recognized value of our work is the generation of explanations about health and mental health matters that help people understand the other side of an "us"/"them" divide. We produce understanding in a context in which misunderstanding is regularly constructed by powerful people who offer victim-blaming explanations for the circumstances experienced by people with less power. The production of understanding serves as an important counterbalance to this tendency. Our work shapes the way people think about problems related to health and mental health, limits the power of inaccurate victim-blaming accounts and provides understanding about why health and mental health are mal-distributed among people from different social circumstances.

There is little doubt that sociological theory and research has influenced the way policy makers, treatment providers and people in general think about and understand the causes, consequences and treatment of mental and physical illnesses. At the same time such people are often unaware that they have been influenced by sociological understandings and frequently see little practical utility in the research of sociologists. In this paper, I seek to identify an essential contribution that a sociological perspective provides as a means of identifying for myself, and hopefully for others, one critical reason why the work we do has important consequences for people's mental and physical health.

I approach this task by constructing the basis for doubting the practical utility of sociological perspectives. As such, I observe that sociologists, like myself, who study health and mental health, are often challenged by pointed queries as to the utility of what we do. Questions arrive from many sources. They come from funders who are skeptical as to the practical value of the work we do; from deans who are unconvinced of the salience of the social in matters of health; and from parents, children, siblings and friends who are simply befuddled as to how anyone can make money when the product they proffer is so thoroughly obscure (save "teaching others the same

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inchoate trade"). In the context of qualms such as these, how do we answer the question, "What is the practical value of the work we do?" What exactly is the value of adopting a sociological perspective on mental health and illness?

CONTEXTUAL CIRCUMSTANCES FACILITATING CHALLENGES TO OUR UTILITY

But why do we need to pose the question of whether sociological approaches have practical value in addressing mental and physical illnesses? Why do funders, deans and family members question the utility of what we do? First, there is the challenge posed by biological/genetic explanations, with many seeing their ascendency as threatening to, and in conflict with, sociological explanations. And since much of the institutional power lies with the medical/biological perspective on mental and physical illnesses, the ideas of sociologists and other social scientists are at risk of being underappreciated. Sometimes this tendency is very explicit, as when Heston (1988), an influential genetically oriented researcher, called for redirection of funds from environmentally oriented research to "hardball biology." When Blair Wheaton (2001) received the Pearlin Award two years ago, he diagnosed the tendency to give precedence to such genetic factors "biomania" and pointed out that the inclination was not limited to the priorities of funding agencies and medical schools but had captured popular culture as well. Genetic explanations are central to the way our families, friends and colleagues have come to understand everything from heart attacks to hiccoughs.

Second, we live in an individualistic culture that emphasizes both the ability of the individual to control his or her personal fate and the importance of doing so (Becker 1993). In this regard, social psychologists have identified as "the fundamental attribution error": A very general tendency to attribute the behavior of others to internal dispositions rather than to environmental circumstances (Ross 1977). As a consequence, explanations for why events occur in people's lives and what should be done to address any problems that arise because of such events tend to focus on individual behaviors and individual solutions. Sociological explanations frequently run counter to the individualistic explanations that people apparently both prefer and assume to be correct and, therefore, also run counter to favored ways of interpreting what is going on and why. In this context, sociological explanations are deviant explanations and are placed at distinct risk of being seen as remote, abstract and absurd.

Third, although sociologists can help evaluate interventions or understand the social distribution of individually based treatments, we do not train professionals who provide direct care to people with mental and physical health problems. While there are a few exceptions to this general tendency, when we compare sociology to medicine, psychology or social work, we note that sociology's practitioners are distinctly under-represented in the provision of direct care to patients—we simply do not train people for front line treatment roles. Moreover, the mental-health treatment system—our principal societally sanctioned institutional response to the occurrence and distribution of mental illnesses—mainly delivers individually based interventions like psychotherapy and pharmacotherapy. Because our focus is distinct from the individualistic bent of these major forms of intervention, we tend not to contribute information that can be used in delivering them nor do we play a major role in training the individuals who provide them. Thus, the utility of our work is removed from the major ways our society seeks to ameliorate the problems of mental illness. Again this puts us at a distinct disadvantage when people make judgments about the relevance of the work we do.

The absence of an applied arm also indirectly influences the relative credibility of the explanations we construct. The public seeks the expertise of doctors for health problems, procures the counsel of psychiatrists and psychologists for emotional problems, and thus generally encounters the practitioners of these professions as authorities who can help them when they are vulnerable. It has become part of our culture to assign expertise and authority to people who fill such roles, for us to say "let's ask the doctor" or for a Dear Abby column to advise an anguished supplicant to seek psychological counseling. The day-to-day enactment of such encounters leads naturally to the belief that people who fill the roles of

physician, psychiatrist or psychotherapist are knowledgeable about health and/or mental-health matters and, therefore, that the explanations they construct for why such problems arise have validity. The perceived validity of sociologists' explanations for health and mental-health problems do not benefit from these processes—no one advises a person to "consult the local sociologist," and, as a consequence, people are not accustomed to thinking that sociologists have credibility in such matters. This may seem of little consequence until we remind ourselves that everyone is part of "the public" who forms these opinions: The powerful people who shape health and mental-health policy and the editors, funders, family members and deans who are so uncertain about the utility of our work.

A strong emphasis on biological and genetic factors, a cultural context that emphasizes individual actions in understanding personal fates, and the absence of an applied arm are some, but certainly not all, of the social circumstances that lie behind the questions and doubts that sociologists encounter concerning the utility of their work in the areas of health and mental health. So what is it that we do? The title of this paper gives a very short version of one answer I would like to consider: "The Production of Understanding." I propose that one very important thing that mental health and medical sociologists do is to generate explanations about health and mental-health matters that help people understand the other side of an "us"/"them" divide. In what follows, I shall elaborate what I mean in more detail, indicate how we might enhance the effective production of understanding and point to some of the reasons why doing so is such an important undertaking.

THE SOCIAL CREATION OF MISUNDERSTANDING

As a first step, it is important to recognize that, to a very large extent, misunderstanding regarding the origins and maintenance of health and mental-health inequalities is socially produced. To be sure, some part of existing misunderstanding is due to the fact that there are areas of ignorance that have always existed. But there is far more to it than that. Misunderstanding is socially produced in at least two important ways.

First, divisions between "us" and "them" are associated with vast differences in day-to-day experience, and these vast differences make it difficult to understand what life is like on the other side of such a divide. For white people (at least well-dressed ones), New York City cabs are available with the flick of a finger, and the possibility that a free one might pass by is a problem they rarely need to consider. People who have never been hospitalized for mental illness assume that their presence will be acknowledged when they are with others and that they will not be talked about as if they were not present. With the accumulation of many, many such missed experiences, white people or people who have never been hospitalized for mental illness are left relatively clueless as to what it's like on "the other side of the divide." Even if such people are well-meaning and full of good intentions, differences in social circumstances will reliably insure some degree of misunderstanding.

A second source of socially constructed misunderstanding arises from efforts to explain why rewards are so thoroughly maldistributed across an "us"/"them" divide. Faced with dramatic differences, it is such an easy and popular dodge for privileged and powerful people to attribute problems, disappointments and despair in those of lower status to characteristics such powerful people are certain separate "their kind" from such lower-status individuals. When this occurs, the people on top in any "us"/"them" bifurcation can say, "We are moral, just, smart, hard-working and of good character, and if only 'they' had these attributes 'they' wouldn't be so odd, dull, insecure or mired in adversity." This inclination to "victim-blame" as William Ryan (1971) called it routinely creates misunderstanding across "us"/"them" divisions. And, critically, when powerful people act on their misunderstandings, they have the capacity to enhance substantially the misery of those below them.

Misunderstanding can, of course, also flow from people who are lower in status to people who are much higher. The same kind of typifications of "them" (those on top) can be administered by an "us" who is lower in status such that "they" are "greedy, oppressive, uninformed and mean." But in this instance, people on the bottom of a potent "us"/"them" divide

are less likely to have access to the social, economic, cultural and political power required to make their typifications have severe discriminatory consequences for those above them (Link and Phelan 2001). At the same time, people of higher status have access to extensive resources that permit them to dispute or quash any claims made about them by people who are lower in status, even if the typifications are in fact accurate. In this way, misunderstandings that travel up from lower- to higher-status people are routinely and effectively challenged and are much less likely to become dominant misunderstandings.

The principal reason that socially created misunderstanding is important to consider is its general tendency to locate a "problem" in the dispositions of those who experience the problem: The "weak, lazy, impulsive, incompetent, symptom ridden, dim-witted *them*." As we shall see, sociologists create understandings that generally run counter to this tendency and therefore provide a counterbalance to its rampant effectiveness.

But, before proceeding, I consider two additional reasons why the concept of socially created misunderstanding is important. First, to the extent that the misunderstandings carry consequences for health and mental health, such misunderstandings become an important determinant of the social distribution of mental and physical disorders. If, for example, powerful people make assumptions about why poor women have children that lead to punitive welfare policy, the health and mental health of millions of women and children can be affected. When misunderstandings have health consequences, the sensibilities of sociologists should be engaged so that the nature of the misunderstanding can be exposed and its consequences minimized or averted. Second, as misunderstanding is an active enterprise, new forms of "us"/"them" misunderstanding may always be created. Indeed, a pessimistic assessment would expect new and more sophisticated misunderstandings to emerge in areas where the interests of high-status people are particularly salient as in maintaining privileged access to the best medical care. In other words, there is likely to be a strong and enduring need for the production of understanding as new misunderstandings are created by people who benefit from the misunderstandings they create.

COUNTERACTING MISUNDERSTANDING AND CREATING UNDERSTANDING

What does it mean to create "understanding"? One way to reason about this idea is to conjure up the woodcutter that Weber (1964) uses as an example to convey his concept of "versstehen". We might imagine the following sequence: We see the woodcutter outside his house chopping wood on a cold day with a plume of smoke coming from the chimney. We remember that the night before, when we were having a drink with the woodcutter, he told us he was concerned about an impending storm and needed to cut wood to keep his family warm when the storm arrived. We can put this together and "understand" why he is chopping wood. We say we *understand* the woodcutter's actions. In the areas the sociology of health and mental health, our job is to do the same thing in situations where the knowledge of subjective motives and objective contextual clues are not so obvious as they are in the example of the woodcutter. Our job is to investigate people's subjective motives and analyze objective contexts so as to construct explanations that further our understanding of health circumstances. If we are successful, we will promote understanding of people whose situations might otherwise be misunderstood. Can we think about our work as accomplishing such an aim?

At the turn of the last century, two books were compiled to reflect the current state of knowledge in the area of the sociology of mental health. The first of these was Allan Horwitz and Teresa Scheid-Cook's (1999) *A Handbook for the Study of Mental Health* and the second Aneshensel and Phelan's (1999) *Handbook of the Sociology of Mental Health.* A careful review of either of these monographs will yield numerous examples as to how sociologists produce understanding and counteract misunderstanding. Aneshensel and Phelan directly engage the idea that the sociological study of mental health and illness allows a different understanding of the sources and consequences of mental illnesses. The most influential idea running through the *Handbook* is the idea that "social group differences—SES, race, ethnicity, age, poverty—are somehow linked to corresponding differences in exposure to the conditions that cause disorder" and that, collectively, the chapters in the *Handbook* are per-

suasive in indicating that "social arrangements and processes are fundamental to understanding the causes of mental illness and its consequences" (Aneshensel and Phelan 1999).

Aneshensel and Phelan tell us that the collective impact of the chapters in their *Handbook* produce understanding concerning the social patterning of mental illnesses. There is also a strong legacy for the production of understanding in some of the classic studies in mental health sociology. One of the first of these was provided by an interdisciplinary team headed by sociologist John Clausen. The so-called Yarrow and Clausen studies (Clausen and Yarrow 1955; Yarrow et al. 1955) provided poignant insights into the predicament experienced by families when the husband/father developed a mental illness and into the extreme difficulties wives encountered in coming to the conclusion that their husbands had a mental illness. Hollingshead and Redlich (1958) provided the concept of "lay appraisal" of initial symptoms of mental illnesses (among many other contributions) that has provided a useful means of understanding the processes the lay public engages in trying to identify what kind of a problem (if any) lies before them (laziness, rudeness, criminality, mental illness or a normal variant of despair). Confronted by the social distribution observed in some of the first survey research data concerning the true prevalence of mental illness collected in the Midtown Manhattan Study, Srole's "sociologist's sight lines" sought to explain, and thereby make understandable, the social patterning he observed. According to Srole (1962), three socially linked phenomena were likely involved: (1) the poverty complex, (2) the role-discontinuity predicament and (3) the stigmatize-rejection mechanism. Finally, Erving Goffman's (1961) study *Asylums* provided a dramatic account of what it was like to become a patient in a mental hospital at that time. Although in somewhat different ways, each one of these classic studies tells us something about what it is like to be on the other side of an "us"/"them" divide.

But what exactly produces the understanding? Examples that are instructive in answering this question can be derived from the work of Leonard Pearlin and his colleagues (Pearlin and Johnson 1977; Pearlin and Schooler 1978; Pearlin et al. 1981; Pearlin 1989). Pearlin constructs *explanations* that link social arrangements to emotions and feelings through processes that are themselves subject to extensive social shaping. Consider as a particularly prominent example, the "Stress Process" and Pearlin et al.'s (1981) specification of that process. Involuntary job disruptions produce role strains, particularly economic strains, that then have serious consequences for self-confidence and inhibit a person's capacity to feel in control of his or her life: Distress is a likely consequence. It is an explanation. Anyone listening can *understand* how adversity emerges in societal arrangements and cascades through intervening processes to influence emotions and feelings. One can travel in the collective shoes of those exposed to job disruptions and understand how their lives are affected. The conclusion, then, is that a good explanation allows understanding.

The stress process has been an enormously successful explanatory paradigm in the sociology of mental health and illness. It helps us understand how and why a very long and diverse list of environmental adversities are connected to psychological distress and mental disorder. Just a few examples of such adversities are single parenting, caregiving, job loss, disasters, economic downturns and all the acute and chronic stressors that end up in the check-list measures that our interview protocols contain. The sustained elaboration and further development of the stress paradigm (Ali and Avison 1997; Brown 2002; Dohrenwend 1998a; 1998b; Turner Wheaton and Lloyd 1995, Wheaton 1990, Thoits 1995) suggest that its continued use may provide explanation for, and understanding of, an even more extensive array of human difficulties. Although mental-health sociologists cannot claim full credit, "stressful circumstances" is the public's most popular attribution of cause for vignette descriptions of mental illnesses, ahead of genetics, chemical imbalances in the brain, and the way a person is raised (Link et al. 1999). Apparently the public uses the stress paradigm to *understand* the origins of mental disorders—to understand someone who might otherwise be misunderstood and placed securely on the other side of an "us"/"them" divide.

While the stress process, with its elaborations, extensions and specifications, is probably the central explanatory model within the sociology of mental illness, another challenge is to understand disability among people who have been hospitalized for mental illness. The

standard approach is to attribute disability to illness, to explain problems with work, social connections and self-regard by referring to symptoms. A modified-labeling-theory explanation claims that some significant part of any observed disability in this group is due to social processes and not illness symptoms. The explanation indicates that people develop conceptions of what it means to have a mental illness—including how others are likely to react to a person hospitalized for mental illness—early in life. If a person then develops a mental illness and enters a mental hospital, these beliefs become personally relevant and potentially very harmful to self esteem (Rosenfield 1997; Link et al. 2001), social interactions (Farina et al. 1968), social network ties (Link et al. 1989; Perlick et al 2001), quality of life (Rosenfield 1997), employment and earning power (Link 1982, 1987). To attribute all observed disability to illness is a socially constructed misunderstanding that is counterbalanced by a modified-labeling-theory explanation.

MOTIVATIONS TO ENGAGE IN THE PRODUCTION OF UNDERSTANDING

If sociologists of mental health are drawn to the production of understanding, why are they so drawn? To be sure, there are institutional roles that someone must fill—someone must teach the sociology of mental health—and there are, of course, modest inducements to increase the likelihood that someone will. Additionally, we might immodestly claim that our area is one of enormous fascination, full of interesting scientific puzzles and intriguing disputes. But the inducements are indeed quite modest, other areas of inquiry also offer intense fascination, and someone else could always be found to fill the institutional roles. So why us?

There are, of course, many, many reasons, and I know I risk oversimplification by focusing on just one and one that certainly does not apply to everyone in the sub-discipline. But I suspect that many of you are, like me, and drawn to sociology and drawn to this area of sociology because of an intense distaste for the injustice that resides in so many of the "us"/"them" divisions that permeate our society. We recognize with Wheaton (2001) that the range of emotions and feelings we study represent the "ultimate dependent variable" and that when injustices associated with /"us"/"them" divisions cascade downward to these feelings, they deny people what they really want: Happiness and freedom from intense psychic pain. We are motivated to do what we can to set this right, and the craft we have developed involves explaining how it all happens. We are drawn to the production of understanding as a sort of "calling."

It is odd but also true that it is personally somewhat embarrassing to admit that the description I have just drawn applies to me. I am completely convinced that we really need a group of people who look at things from the "other side" and that having such a group has considerable beneficial impact. So many social processes insure that the perspectives and interests of the more powerful side in an "us"/"them" divide are forcefully articulated and faithfully executed that the need for a group with the opposite inclination is abundantly clear. Why am I so demure? Having an orientation like the one I just described puts one at a real risk of bias, and admitting the orientation reveals to others one's personal vulnerability to that bias. If we come to our subject with the orientation I just described, we must simultaneously embrace an enormous responsibility to put treasured ideas to stern tests; we must find ways to put such ideas at real risk of being proven wrong.

TESTING: PUTTING EXPLANATIONS AT RISK OF BEING PROVED INCORRECT

If we bring strong sentiments, and thus strong attachments, to the explanations we create, we must be extremely attentive to testing rigorously our ideas. If we get attached to an explanation because it seems to challenge an "us"/"them" divide, and the explanation is at least consistent with some facts, it is all too easy to assume that it must be correct: It must be a good explanation. But to the extent that we allow ourselves to be lax in this way, we undermine what we seek to achieve; we inhibit the production of understanding because we too easily allow ourselves to get it wrong. Following some reasonable variant of Popperian thought (Popper 1959), we need to seek ways to put explanations at risk of being proved incorrect; we need to blend the empathic creative streak that allows us to generate

explanations with a dogged determination to put cherished beliefs at risk of failing. We should really push only those ideas that have survived tough encounters with the empirical world. The production of understanding requires that we merge a capacity to explain with a capacity to test.

Perhaps there are many ways to construct good tests, but for me, the most effective route has been to engage conflicting explanations: Labeling versus psychiatric perspectives, social selection versus social causation, reductionist explanations for socioeconomic disparities in health versus fundamental-cause explanations. In each case there are different accounts, different stories indicating how observed associations develop. The required task is to think from within the context of each explanation, following through the story it tells to what one might expect to find if that story is true. A strong test is located when reasoning faithfully derived from each of two or more competing explanations makes a different prediction about an observable fact. Thus a good test is one whose execution is likely to change the confidence we hold in at least one existing explanation or theory. Put another way, we have a good test when there is something at stake in the data.

Implied in the forgoing reasoning about strong tests is the avid pursuit of risk. If one has a favored explanation, seeking a risky situation for that explanation may seem horrendously counter-intuitive. My own initiation to the enactment of this approach came when I reported to my dissertation sponsor, Bruce Dohrenwend, that I had a finding consistent with my modified-labeling-theory hypothesis. Needless to say, I was very excited. Bruce Dohrenwend acknowledged my excitement with a single word, "Good," and then added, "Now try to destroy it." It was the counter-intuitive nature of the advice that made it so memorable, but the real reason it should be remembered is that it was and is very good advice: To seek risky situations for explanations. The best (only?) way to support an explanation is to put it at risk of being proved incorrect.

Having a cherished idea lose credence as a result of a good test sounds very unpleasant. In my own experience, it is, at least for a while. A paper my colleagues and I published in 1992 on the connection between mental illnesses and violent behaviors recounts an instance in which an hypothesis of mine proved to be wrong (Link, Andrews and Cullen 1992). I thought prior studies had wrongly reported elevated rates for people with mental illnesses because of biases associated with the use of official arrest statistics and because of problems with the control groups employed. If rates were wrongly reported to be elevated, they could contribute to a stereotype of dangerousness and enhance the stigma people with mental illnesses experience. But our study found the same elevated rate as prior studies, even though our design was able to remove the biases that had plagued those studies. I had been wrong. But finally accepting that I was wrong was very important, as it provided an opportunity to construct understandings that allowed the possibility of a higher rate among people with mental illnesses. I could, for example, acknowledge the higher rate but understand that higher rate as no different than other very normal rate differences between males and females, young people and older people, high-school educated people and college-educated people. Moreover, it allowed the possibility of understanding why the elevated rate might be present. In a subsequent study, my colleagues and I were able to focus on psychotic symptoms might be related to violence through the Thomas Theorem, "if people define situations as real they are real in their consequences" (Link et al. 1999). In this case, admitting that I had been wrong allowed the construction of a potentially better understanding, one that incorporated more empirical facts than my initial belief had allowed.

The production of understanding requires risk-taking with our ideas, and when we take risks, we can be proven wrong. It is intrinsically difficult to have a cherished idea fail, particularly when that cherished idea requires substantial effort to construct and to test. Because of this, I believe that we would greatly enhance our enterprise if we collectively sought ways to reward people who have good ideas that fail in risky situations. Instead of a tone of "nyah, nyah you were wrong," we should seek to honor the person whose good idea came up short on empirical test. If we were able to do this, people might be more bold in constructing explanations, less likely to hedge in the identification of precise predictions, and less averse to seeking out really risky situations for tests of their ideas. Put simply, the production of understanding would be enhanced.

DOES THE PRODUCTION OF UNDERSTANDING HAVE IMPORTANT CONSEQUENCES?

Translation of Sociological Understandings

A major and laudable goal espoused by the National Institutes of Health has been to foster "translational" research in which social science ideas are made useful for health-enhancing action. Translational research asks social scientists to use their understandings to, for example, modify health-relevant behaviors (smoking, diet, exercise), encourage the appropriate use of medical care (medication compliance, cancer screening), cope more effectively with stress and effectively respond to environmental hazards (seat belts, window guards, toxic household products). Engaging these issues is certainly one way to think about the beneficial consequences of the production of understanding. For example, by understanding people's contextual circumstances, we might help explain why they are "non-compliant" with medication regimens to control diabetes or psychotic symptoms. Such understandings might lead to ideas that ameliorate the contextual circumstances and help in the management of severe and life-threatening illnesses. Thus, some sociological ideas are amenable to smooth translation into something that has relatively immediate utility for prevention and intervention. Every time we can translate our ideas into specific actions, we should. Moreover, if we cannot do this ourselves, we should reward with our esteem people who can. It is one way that the "production of understanding" can have important consequences for people's mental and physical health.

But we should not allow this framework to define our utility. Lying behind a narrowly focused conception of translational research is a powerful assumption that says that understandings are only useful insofar as they can be translated into specific actions that alter pathways from social or biological circumstances to health outcomes. Anyone who accepts this view is almost certain to conclude that a substantial portion of our work has little practical utility. One reason is that, to a large extent, the task we have set for ourselves is to understand the social circumstances or "structural arrangements" that both create the profile of disease "risk factors" and shape their distribution in populations. This often places us one step back from the health behaviors (smoking, diet, exercise, etc.) that are thought to be the ripest venues for translational efforts in a narrowly focused approach. Moreover, many of the social circumstances we seek to understand and may wish to change involve "us"/"them" divisions between relatively more and relatively less powerful people. Because the more powerful side of an "us"/"them" division often benefits in one way or another from any social circumstances that are in place, changing those circumstances brings resistance. In a very general way, changing the behavior of powerful people or especially changing the circumstances that provide them with the power they exercise is considered impolitic and impractical and therefore untranslatable. Certainly, from a narrowly-focused conception of translation, this is true.

But a broader vision that allows a longer time frame for consequences to occur; considers the influence of social, cultural, and economic factors that are more distal influences on health; and includes a diffuse set of health consequences rather than specific outcomes provides a different vantage point from which to consider the value of the production of understanding. In considering some aspects of this broader view, I begin by describing the utility of our detachment from direct involvement in health-care delivery.

The Importance of Detachment

How do we think about the utility of our work outside of a narrowly focused translation-to-action model? Earlier, in describing why we so frequently receive questions about our utility, I drew attention to the fact that mental-health and medical sociology do not train or license people who provide clinical services to people with health or mental health problems. While this is a drawback when it comes to an easy answer to the utility question, not having an applied arm also supplies a significant and very useful detachment. We are not wooed by drug manufacturers nor do we need to lobby for the interests of a large clinical arm that needs boundaries drawn around its clinical activities, licenses, insurance and all the engagement with powerful concerns that this entails. The detachment provides freedom, and when we are at our best, this freedom enhances

our capacity to "tell it like it is." For example, in describing how people feel about the side effects of psychotropic medications, we do not have to worry about losing (or not receiving) a lucrative consulting post with a major drug company, nor do we have to dwell (for very long) on the possibility that our manuscript, our application for employment, or our request for promotion might be reviewed by someone who is so employed. Mental-health and medical sociologists are thereby well positioned to "tell it like it is" with respect to many issues of this nature. I see substantial utility in this role alone. We need people who are disengaged from these processes watching what is happening and understanding why.

The Broad and Diffuse Impact of the Production of Understanding

But if the production of understanding is facilitated by our relatively detached position, how would it happen that we would have any impact on anything? To answer this question, we need to step out of a mode of thinking that asks us to consider the effect of specific understandings on specific outcomes. We need to step away from conceptions that tell us that the understandings we create are useful only to the extent that they can be translated into specific planned actions. We need to think beyond the particular understandings we personally create to the overall impact of the collective body of understandings all of us create. The effects of this body of understanding are and will be diffuse. We will rarely see effects powerfully reflected in a single policy decision. Nor will we be able to identify the impact of this collective body of understanding on individual behavior in the kind of randomized design a tough-minded methodologist might demand. Rather, the understandings we create influence the way people conceptualize a broad range of health-related problems, the way they think about why things are the way they are, what needs to be changed, and how such change might be actualized. Mechanic and Aiken (1986) speak directly to this point:

> The results of social science may on occasion be immediately useful, but more often they percolate at the perimeters of policy-making and clinical activity, and are used when they fit a particular context or agenda. In the longer range, the work we do becomes common currency—what many come to define as "common sense"—and implicitly affects the public media, government issue papers, and the processes of professional education and patient care. In our society almost all educated people think and work in a way influenced by the social sciences, although many are unaware of how they came to think about problems this way. (P. 2)

The circumstances just described make it difficult to identify specific examples of sociological understandings that have led to specific changes. Nevertheless, it seems useful to identify some generic ways in which such understandings might have an impact and to give examples that are illustrative of these possibilities. In this regard, understanding on the part of the "us," the "them," and any significant audience for "us"/"them" encounters is likely to shape who can do what to whom and how the actors are affected by any actions taken.

How the Production of Understanding Can Affect Persons with Relatively More Power

As a start, consider the more powerful group in an "us"/"them" divide and three ways in which they might be influenced by sociological understandings. First, when the procedures and processes that construct and support an "us"/"them" division are exposed, they can make the future use of those same processes and procedures embarrassing and, therefore, at least a little more difficult to enact. Along these lines, one possible example is Goffman's (1961) description of the process of becoming a patient in a mental hospital, with all of the identity stripping and debasement he found that process entails. The person was stripped of external identities and forcefully socialized into a new, very low-status position marked by institutional garb and expectations of obsequious behavior. Goffman was not the only one to have noticed these processes, but his capacity to allow the reader to understand how it might feel to be exposed to them gave his work great weight. Some (but not all) of the processes and procedures he described as typical in the late 1950s are relatively rare in psychiatric hospitals today. Although these changes occurred for many reasons, the sociologically informed descriptions of Goffman and others were almost certainly a contributing factor.

Second, as previously discussed, sociological understandings can serve as an important counterbalance to the victim-blaming tendencies of more powerful groups. The stress process is a good example, as it links social conditions to patterns of individual distress and disorder. In so doing, it serves as a counterweight to ideas that attribute group differences to the innate weaknesses or bad behavior that characterizes "them."

Third, even well-intentioned people who profess a strong desire to reduce injustice across "us"/"them" divides may need to check carefully any assumptions about what a particular "they" might need. An outstanding example is social historian David Rothman's (1971) account of the discovery of the asylum in the nineteenth century. According to Rothman, well-intentioned reformers became convinced that the turmoil and disorder created by massive immigration and urbanization were the root causes of mental illness. Steadfast in their convictions, the reformers sought the creation of "asylums": Orderly institutions located in bucolic settings away from the illness-generating turmoil of the urban centers. Of course, their location away from these centers made it hard for family or friends to visit, provide support, or check on hospital conditions—circumstances that may well have facilitated the transformation of "asylums" into the "total institutions" Goffman described. In sum, the production of sociological understanding can expose the processes maintaining "us"/"them" divisions, provide counter-balancing explanations to explanations that blame the victim, and provide checks on well intentioned but misguided people who act on misunderstandings.

How the Production of Understanding Can Influence Those with Relatively Less Power

The production of understanding can also have beneficial effects on the less-powerful group in an "us"/"them" divide. Although the nature of this influence probably has many facets, I shall mention three that seem particularly prominent. First, a good explanation provides an articulation of group members' experience. This is critical in the context of a common inclination toward misunderstanding in the dominant culture. Such an explanation can provide an excellent reason to reject the dominant culture's explanations and thereby protect individuals from internally accepting the stereotypes the dominant view entails. In addition, the academic trappings surrounding the explanations we construct—their publication in scientific journals and their encoding in a knowledge base that is taught to students, included in lectures and used to shape future research and policy—provide such explanations with cultural legitimacy and power. When the explanation brings to light the lived experience of the less-powerful group, it does it in a way that confers broad legitimacy on that experience.

Second, when we produce understanding, we can sometimes proceed beyond what people might be able to tell us about their individual experiences. For example, an injustice might be perceived by a person in some inchoate way but, if asked, such a person might find it hard to articulate exactly what the injustice was. The felt experience might be one like Steele's (1997) description of "a threat in the air" (with regard to racial stereotypes). But the validity of such a claim (absent Steele's experimental studies) might be placed in doubt by people on the other side of an "us"/"them" divide because it is difficult for them to understand exactly what the threat is. Sometimes our work can specify precisely what the injustice is and how it is produced. I am reminded in this regard of the impressive work of those engaged in research on expectation states. The processes they study produce dramatic differences in power and influence in small-group encounters, but neither casual observers nor group participants would likely be able to pinpoint what those processes are. It just sort of happens—the guys on top with respect to external statuses (yes, guys) end up having more power and influence even though the task the group is asked to pursue has nothing to do with skills associated with those statuses. When researchers identify the processes that create status differences and are able to manipulate those processes so as to produce differentials in power and influence, the understanding of all of us is enhanced (e.g., Ridgeway and Erikson 2000). We can now pinpoint how it happens. For example, our understanding of group differences in tests of cognitive ability shifts when we learn from Lovaglia et al. (1998) how status processes can be manipulated experimentally in groups of white college students to create test-score differences on a par with average differences between whites

and blacks. This is important for all of us to understand, but for people who are harmed by what would otherwise be subterranean processes, the new understanding provides validation and a capacity to reject attempts to dismiss summarily claims of status-based injustice.

A third benefit that people on the less powerful side of an "us"/"them" divide can derive from the production of understanding is to use it as a foundation for group-based efforts to challenge the dominance of more powerful groups. When the processes that create and sustain "us"/"them" divides are understood, those processes can form the basis for the creation of common interest groups. For example, the patient/consumer movement in the area of the mental illnesses has used understandings of labeling, stigma, and discrimination as central components of their empowerment efforts. Further, such understandings help specify precisely what a collective interest group may wish to challenge or reject in the dominant group's view. Group social support to oppose stereotypes of dangerousness, laziness, or incompetence can be achieved and a valid basis for rejecting those stereotypes derived. Additionally, understandings can be instrumental in guiding group efforts aimed at reducing power differences across an "us"/"them" divide. Such efforts are, of course, critical because power differences are what put real teeth into victim-blaming, labeling and stereotyping. Without power over access to jobs, schools, media, housing and political influence, the victim-blaming, labeling and stereotyping would reside in the realm of cognitive beliefs—unpleasant to confront but far less consequential than they otherwise might be (Link and Phelan 2001).

CONCLUSION

At the outset of this paper, I referred to a difficulty I have experienced in articulating the precise ways in which our work has useful consequences. I drew attention to the fact that mental health and medical sociologists are sometimes challenged about the utility of their work by deans, funding agencies, and family members. These challenges can, as in my own case, lead to self doubts and in some instances to a kind of diffidence in situations in which challenges to our utility might be present. Upon reflection, I have decided to cast this particular form of self doubt aside. I stand resolutely unapologetic about what I do. I cannot imagine wanting to do anything else, nor, given my capacities, engaging in any activity that could be more useful.

I wrote this paper to offer an answer to the sceptics' doubts. I imagine, with amusement only, actually standing before the funder, the dean, or the family member and declaring, "Now I can tell you what I do: I produce understanding." Nevertheless, I did write the paper with "them" in mind. I thought that, in a longer answer, I could highlight an important but under-recognized and under-appreciated outcome of our efforts and that at least some of "them" might come to see our work in a more positive light. But if I wrote the paper with "them" in mind, I wrote it *for* "us." Even if we explain our utility very clearly, and even if we are able to demonstrate the diffuse consequences that producing understanding can have, many of "them" would prefer that we did other things. More to the point, I believe that many of you are like me and that we have, at times, been reduced to a diffident stance, to shoulder shrugs when pointed questions are cast our way, or even to joining the chorus that seeks to chastise us for failing to do work that matters. I wrote this paper to encourage a counter-balancing tendency: To identify an essential feature of our work, so that we might recognize it, champion it, and carry it forward to secure a strong future for the production of understanding.

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Bruce G. Link is Professor of Epidemiology and Sociomedical Sciences at the Mailman School of Public Health of Columbia University and a Research Scientist at the New York State Psychiatric Institute. His interests include the nature and consequences of stigma for people with mental illnesses, the connection between mental illnesses and violent behaviors, and explanations for associations between social conditions and morbidity and mortality.