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EDITORIAL

Social psychiatry and sociology

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For over 50 years the credibility of social psychiatry has drawn on two main strengths. First, it has provided us with evidence about the impact of social forces upon mental health. Second, it has enjoyed substantial inter-disciplinary cooperation. Apart from socially-orientated psychiatrists, the project can boast high profile contributions from nurses, clinical psychologists and social workers. At times, some sociologists, such as George Brown, have played a leading role. However, there are many signs that whilst social psychiatry may not be on its last legs it has certainly seen better days. A crucial aspect of its demise has been the recent failure, compared to earlier days, to draw on insights from the social sciences. A good starting point to begin to examine the trajectory of social psychiatry and assess its future prospects is the breakdown in collaboration between the disciplines of psychiatry and sociology.

Psychiatric epidemiology and sociology have become what Fenton and Charsley (2000) have called, ''incommensurate games''. The theoretical and methodological preferences of the two approaches to mental health problems in society have become discrepant. In the past this was not the case and the influence of sociological ideas was clearly evident in the field of social psychiatry and epidemiology. For example, the second generation of research on inequalities in mental health, which took place immediately after the Second World War, saw the emergence of a range of influential studies, which demonstrated a consistent social patterning of mental health problems. This fruitful and productive relationship between sociology and psychiatric epidemiology was predicated on a shared acceptance of the weakness of the construct of mental illness and the strengths of the alternative ways of viewing mental ''disorder''. A point made here by Lawson, a sociological contributor to epidemiological studies of mental health:

> Psychiatry accepted that, as its disease categories were so tenuous and not generally marked by physical signs, the sociologist's concepts of impairment or disability marked by social dysfunctions could be the key to unraveling the rates of mental illness. (Lawson, 1989, p. 38)

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This pragmatic consensus on the importance of the ''social'' and tolerant indifference about the weak validity of psychiatric constructs eventually broke down and sociologists increasingly focused critically on the knowledge base of psychiatry. In the past thirty years, criticisms of psychiatric theory and practice from sociologists (and many psychologists) have emphasised: the weak construct validity of diagnostic categories; the relative absence of longitudinal studies in psychiatric epidemiology; the dominance of empiricism at the expense of theoretical development; a lack of explicit reflection on the ideological nature of psychiatric theory and practice; and the interest work of the drug companies in the mental health industry (Rogers & Pilgrim, 2003).

The second major difference between the disciplines relates now to service contact. Sociologists have been inclined to problematise this, while psychiatry has tended to emphasise the beneficent role of services. Psychiatric epidemiology has focused on mapping the need for early intervention and equitable service access. Services are assumed to be sites of a patient's right to treatment, rather than seen as potential threats to their well being and citizenship. Sociological interest in the new social movement of disaffected users and in psychiatry as a site of State-delegated social control has ensured that this assumption about the benign character of services is challenged.

Psychiatry, for its part, became so suspicious of sociology during the 1970s, because of the latter's link to ''anti-psychiatry'', that it produced some rapid and hostile reactions (e.g., Hamilton, 1973; Roth, 1973). Some erstwhile collaborators with sociology were particularly bitter in their dismissals of criticisms (Wing, 1978). Thereafter, psychiatrists became wary of sociological scrutiny. In the folklore of the profession, some criticisms, such as the claim from Szasz (1961) that mental illness is a ''myth'', have even acquired *sociological* origins (e.g., Gelder, Mayou & Cowen, 2001, p. 120–121). Szasz is a psychiatrist (not a sociologist), as is the new wave of postmodern internal critics (Thomas, 1997; Bracken, 2003), suggesting that the problems of psychiatric theory and practice are not mischievous inventions from social scientists but are endemic and unresolved.

The recent postmodern emphasis within social science on the problematization of knowledge claims can be contrasted with the positivist tradition of Durkheim. This fed the early collaboration between sociology and psychiatry, which endured until 1970 and peaked in the 1950s (Lawson, 1989). It was predated and reinforced by the ecological wing of the Chicago School of sociology, either side of the Second World War, which demonstrated the relationship between social class and mental disorder and which identified treatment inequalities (Faris & Dunham 1939; Hollingshead & Redlich, 1958; Srole & Langer, 1962).

After 1970, but before the full emergence of postmodern social science, sociologists from the Marxian and Weberian traditions began to use medicine as an object of sociological understanding or to illustrate a social theory. By the 1970s, medical sociologists had promoted themselves from handmaiden to ''observer status''. Sociologists increasingly saw themselves as providing a sociology *of* medicine. Prior to that, they had largely been content to make a sociological contribution *to* medicine. This brought distance into the common ideological project of progressive social engineering, which had previously acted to cement the enterprises of medical sociology and social psychiatry.

In the wake of the turbulent 1970s, mainstream psychiatry could have responded in two ways. It could have remained open to debate with its internal and external critics, and benefited from a creative dialogue, or it could have disengaged from sociology. The former would have boosted the standing of social psychiatry but it was the latter that prevailed.

Biomedical reaction was evident on many fronts. Social psychiatry became marginalized within the medical specialty (Moncrieff & Crawford, 2001). Confidence in biomedical reductionism grew with the ''decade of the brain'', to a point of triumphalism (Guze, 1989).

Drugs, which in earlier times were seen as symptom reducing adjuncts to case management, established an increasingly grandiose curative status (''anti-psychotic'', ''anti-depressant'') (Moncrieff, 2002). Of particular note, for our purpose here, was the shift during the 1980s and 1990s within psychiatric epidemiology. The latter became preoccupied with methodological matters and with its reputation as a medical specialism (Fryers, Melzer, & Jenkins, 2000). Links with genetics and neuroscience were now favoured over those with social science (Wittchen, 2000).

This medical introversion was reflected in, and reinforced by, shifts in the Diagnostic and Statistical Manual of the American Psychiatric Association (Mishara, 1994). Its newly discovered neutrality about etiology (contra DSM-I and II) and its behavioural emphasis on symptom checklists had the effect of undermining an understanding of the patient's experience in context. As its advocates noted, DSM-IV put psychiatry firmly ''back in the medical model of basing treatment decisions on diagnosis'' (Blacker & Tsuang, 1999).

By the turn of the century then, the Kraepelinian rather than Meyerian approach to presenting problems was in the ascendancy, expunging both the patient's personal accounts of his or her life and the past and present social circumstances it illuminated. Moreover, not only did psychiatry push sociology away in its ''return to medicine'', sociologists became disinclined to study mental health. Their focus on qualitative methods de-skilled them as epidemiologists. By the 1990s mental health was relatively under-researched, compared both to the 1970s and to other topics in medical sociology (Cook & Wright, 1995).

The upshot of this spiral of mutual distrust has been negative for all parties (including people with mental health problems). Despite the multiple past sources of evidence about the social origins and consequences of mental health problems, relatively they have been weakly represented in recent health research. This has placed a greater emphasis on social inequalities in physical morbidity and mortality (Muntaner et al., 2000). In health inequality research, mental health status has been afforded a central role as a *mediator* but has been studied less often as an *outcome* of social forces (Wilkinson, 1996). A factor in this relative lack of scrutiny of mental health outcomes is the loss of collaborative synergy, which had previously existed, between psychiatrists and sociologists.

The breakdown of the relationship between sociology and psychiatry may continue, lessening even further the viability of social psychiatry. Only a small rump of neo-Durkeimian sociologists may remain in its midst, doing traditional epidemiological research (Kessler et al., 1994). A more optimistic scenario would require concessions on both sides. Psychiatry would need to admit its lack of reflexive capacity to understand its own theory and practice, as contentious socio-political phenomena. This would mean a re-engagement with debates about the role of psychiatry in society and the profession's reified diagnostic categories. In this respect the newer ''critical psychiatrists'', who have not been ready recruits to the traditional cause of social psychiatry, are likely to play a central role. Sociologists would need to rediscover epidemiology and shed the anti-realism of postmodernism. They may discover that it is possible to be empirical without necessarily being empiricist.

Between them, psychiatrists and sociologist might still deliver a research programme, which respects both causes and meanings and they might embark on studies, which are both intensive and extensive (Sayer, 2000). Without this collaboration we will be left with an ''incommensurate game''. On one side will be a positivist programme of RCTs and uncritical epidemiology, which is naïve about the categories it is counting (''naïve realism''). On the other side will be an anti-positivist programme, based on biographical research and the deconstruction of discursive practices. Mind the gap; social psychiatry may disappear.

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