Brit. J. Psychiat. (1978), **132**, 516–17

†*Reading about . . .*

Social Psychiatry

by Julian Leff

People working in the field of social psychiatry concern themselves with social factors which may affect the onset, duration or outcome of psychiatric disorders. This concern encompasses the full range of psychiatric conditions and virtually every aspect of the structure of society, so that in this short review we can only attempt to convey the flavour of the subject and to highlight some salient contributions.

The scientific study of social psychiatry begins with Durkheim's (1897) seminal book on suicide. He employed epidemiological techniques to examine the distribution of suicide in space and time, he established links between suicide and family structure, and on the basis of his findings he formulated, at a high level of abstraction, the concept of *anomie*. Durkheim's book set the pattern for subsequent studies in social psychiatry, his findings have been replicated time and time again, and the concept of *anomie* continues to stimulate work in the closely related fields of social psychology and sociology.

A piece of work which utilised Durkheim's approach and techniques and which represents another milestone on the way is Faris and Dunham's (1939) study of the distribution of psychiatric disorders in the city of Chicago. Their main innovation was a method of describing the geographical and social structure of a city, which enabled them to demonstrate that the principal psychiatric disorders were differentially distributed throughout the city. Despite some methodological crudities of their work, their findings were replicated by Hare (1956), who found that their structural analysis of a city was applicable to Bristol and that not only was schizophrenia concentrated in the central 'zone in transition', but that it was associated with the distribution of single-person households. This finding could be seen as evidence that *anomie*, the breaking of social bonds, is an aetiological factor in schizophrenia, or could be explained by the geographical mobility of the pre-schizophrenic.

The opposition of these two viewpoints created a stamping ground for social psychiatrists for many years. However stronger evidence accumulated on the side of the hypothesis of social and geographical drift, particularly the technically ingenious study by Goldberg and Morrison (1963) showing that schizophrenic men have begun to descend the socio-economic ladder from the starting point of their father's rung well before the onset of their illness. The argument was clinched by Dunham's (1965) re-entry into the fray with a study of schizophrenics in Detroit, which was methodologically much more sophisticated than this earlier work in Chicago. He demonstrated conclusively that the excess of schizophrenics in central zones of the city was due to migrants who had arrived there within the preceding five years *before* the onset of schizophrenia.

This much has been established by years of increasingly sophisticated and focused epidemiological work. The contribution of epidemiology to psychiatry in general is clearly and comprehensively dealt with by Cooper and Morgan (1973). The establishment of the reality of social drift is, however, only the starting point for a new set of inquiries into the factors that motivate the pre-schizophrenic to leave his family of origin and migrate to the isolation of city lodging houses.

The link between migration and psychiatric disorder has intrigued social psychiatrists for much of this century, which has seen large-scale movement of peoples through frequent international wars and speedy transport. The most authoritative work in this area remains Ödegaard's (1932) study of Norwegian immigrants to the United States. Meticulously conducted and including techniques such as age stratification, its methodological rigor has seldom been equalled by subsequent workers. Ödegaard found that the Norwegian immigrants had a higher rate of mental illness, particularly schizophrenia, than their compatriots who remained at home. He postulated selective migration of the more schizoid as an explanation, but matters must be more complex than this as different immigrant groups show considerable variation in their experience of mental illness, some having an excess and others a paucity compared to native groups. This has been convincingly

† An occasional feature in the Book Section where contributors give their personal choice of important, memorable or informative literature.

demonstrated recently by Murphy (1978) for Canadian immigrants. Once again such a finding is only a pointer to more intensive inquiries, in this instance, into the interaction between the pressures to migrate, the background culture the immigrant takes with him, and the new culture he finds himself surrounded by.

Epidemiological techniques have been of great value in establishing associations between psychiatric conditions and social factors, but have their limitations. In particular they cannot be used on their own to determine the direction of cause and effect, but have to be combined with other approaches such as the experimental manipulation of the social environment. This is very difficult to achieve except where the psychiatrist holds sway, namely within psychiatric institutions.

The quality of the environment in psychiatric institutions has been dissected by Goffman (1968) from a sociological point of view. His account is essentially descriptive and intuitive, but it hits home on many issues and it is extremely beneficial to see ourselves as Goffman sees us even if he is somewhat jaundiced. A more experimental approach is represented by Wing and Brown's (1970) study of three different psychiatric hospitals. This is a natural rather than a contrived experiment, but it shows the formative effect the social atmosphere in an institution can have on the symptoms of the inmates, and confirms some of Goffman's insights.

A more recent attempt to exploit a natural experiment is the survey by Brown *et al* (1977) on the island of North Uist in the Outer Hebrides. This area was chosen because it retains a traditional culture but is likely to undergo rapid change as a consequence of the exploitation of North Sea Oil. Their survey provides a baseline for the later assessment of social change and its psychological concomitants. However, the initial survey itself has suggested that there are interesting links between the form of neurotic symptoms and the respondants' social position. Women occupying a traditional place in island society exhibited predominantly anxiety symptoms, whereas the 'outsiders' suffered more commonly from depression, which was rare in the 'integrated' women. Durkheim rules, O.K.?

Social psychiatry, like astronomy, has only recently moved into the field of artificial, as opposed to natural, experiments. An example is Orford and Edwards' (1977) comparison of comprehensive psychiatric and social work care with a single session of counselling for married male alcoholics. Their findings provide further evidence for the importance of family relationships in determining the outcome of psychiatric disorders. Scientific studies of social intervention pose knotty methodological problems, but these have to be solved if social psychiatrists are to advance beyond interesting speculations to the identification of social causes of psychological symptoms.

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