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COMMENTARY TO SPECIAL ARTICLE

What should we do to promote a social perspective in psychiatry?

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Commentary on: Priebe S (2016). A social paradigm in psychiatry – themes and perspectives. *Epidemiology and Psychiatric Sciences*. doi:10.1017/S2045796016000147.

The special paper by Priebe (2016) is a stimulating and brilliant narrative review of some of the evidence on the social determinants of mental health, on some of the conceptual conundrums of the field and on the importance of the social context in shaping mental ill health, mental disorders and psychiatric practice. The paper reviews fields of work that may help advance our knowledge on mental suffering, psychiatric disorders and mental health care using a social perspective or paradigm, and it covers sub-headings such as the historical aspects of the social paradigm (late 18th and 19th century history having decisively shaped the history of psychiatry both as a science and a field of mental health care practice), the theme of social determinants of mental ill health and what could be called the 'political mission' of psychiatry. The special paper focuses on social integration of people with mental illness, the issue of social isolation, social networks and social interventions, which are upheld by very strong evidence (regarding their weight in causing, shaping, helping overcome and treating mental disorders). Social context and social interactions and the social construct aspect of diagnostic concepts in psychiatry are all addressed, and in the reflection of the 'way forward' for the field collaboration with partners (beyond sociology and psychology) such as geography, economics, philosophy, linguistics and the arts is considered to provide a promising path for social psychiatry research as a project in advancing our knowledge on how to understand and alleviate mental suffering.

Commenting on Priebe's paper we briefly outline a modified or additional perspective. There is ample reason for a 'technical' professional discourse on specific illness-related themes such as psychiatric nosology and diagnosis, psychiatric therapeutics ranging from individual interventions all the way to milieu aspects in treatment and the overall configuration of the mental health care system. Different from the approach developed by Priebe, we would argue that, along with an overwhelming process of modernization in post-World War II European societies there has been an enormous growth in our knowledge on mental illness pathogenesis and the wealth of the therapeutic armamentarium. This growth of knowledge and evidence applies to pharmacological interventions (with a lot of the work not being ground-breaking but implying steady growth in differentiated evidence), a more substantial knowledge of the potential and limitations of treatment algorithms and an amazing growth of research on psychological interventions. Research into cognitive behavioural therapy, cognitive remediation, meta-cognitive training, solution-focused psychotherapy and social skills training has been helpful and, as rightly pointed out by Priebe, we have seen great advances in what we know about the 'grand' factors of effectiveness in psychotherapeutic interventions. Also, there has been high-quality work on evidence-based psychotherapy interventions for people with psychotic disorders. We do agree with Priebe that there is no solid evidence of a tidal change in the prognosis and long-term outcome of people with severe mental illness going along with this historic modernisation of the mental health care field but we would argue that these various threads of modernisation have altogether changed mental health care in high-resource countries (i.e., where and to whom it is available). As the paper rightly points out, care systems have improved in terms of resource input, and staff is currently more highly qualified than they were in the 1960s. However, we think the change in therapeutic approaches, with a host of new technical interventions and a more community-oriented set-up of the care system does reflect major change in the way mental health problems are being addressed. Adopting an optimistic view, we could speculate that approaches focusing on the biological understanding of mental illness on the one hand and on social interventions on the other hand are not only at odds or conflicting (e.g., due to competition

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for scarce research funding and mutually exclusive paradigms), but may also complement and cross-fertilise each other. Admittedly, there is little empirical support for this optimism, but anecdotally some proponents of biological psychiatry in the post WWII era were also engaged in social psychiatric reforms and recent conceptualisations try to integrate neurobiological and psychosocial aspects of mental illness (Fuchs, 2005).

We would further argue that today's research efforts on gene-environment interactions (or, more broadly, on interactions of individual disposition and environmental agents) substantiate a position reminiscent of early Marxian philosophy, e.g., that epigenetic mechanisms link socioeconomic status to depression-related brain function in high-risk adolescents (Swartz *et al*. 2016), in other words that the brain is socially shaped and that social forces impinge directly on 'nature' (the brain being part of 'nature'). We can thus state that poverty, social inequality, social class and the onslaught of socioeconomic adversity shape the very human brain, its function and the way genes are expressed. Thus, the brain itself is 'social', and social adversity produces a 'footprint' in the human body/brain. Thus, the social is everywhere, it is in the treatment 'algorithms', in the systems and routines of 'evidence-based medicine', it is in rehabilitation and in amygdala function (Swartz *et al*. 2016).

It is true that we lack the evidence that this hypothesised modernisation process has changed the long-term course of psychotic disorders. However, we can have the impression that the potential for socially integrated living outside institutions has improved for people with severe mental illness and care systems have moved in the direction of community arrangements. In agreement with Priebe, we could say that all the psychiatric 'technical' innovation has been part of societal change favouring social integration (and inclusion) of people sharing various types of minority status. These changes, in countries of Western Europe such as Italy, have spanned diverse groups and societal conflicts such as the unemployed and trade union organisations, women's rights issues, gay and lesbian minority group issues and the situation of people with mental illness with a tidal wave of societal reform movements beginning in the 1960s and gaining momentum throughout the 1970s in Capitalist welfare state societies that were experiencing long-term economic growth (and the first petrol crisis in 1973). Thus, the reform movement in the mental health care field was contingent upon wider societal change but with no natural or 'set' link between the agenda of societal reform and mental health care improvement.

We believe one way towards moving forward psychiatric research today is to engage in high-quality research on poverty in rich Western societies, and on the role of societal inequality and migration. We would argue that the questions of how to advance the modern 'social state' and of how to formulate welfare policies in the 21st century are pertinent to the field of social psychiatry research (as to many other fields). Of course, these issues are important not only for those with mental health problems and severe mental disorders but they are important to many subgroups in society who grapple with the current set-up. Very aptly, the paper by Priebe points to the wide range of humanities, social sciences and linguistics that may contribute to advancing the field of social psychiatry research. But we would suggest that the field should be defined more broadly than by just looking at the situation of people with mental illness, i.e., the societal/cultural/scientific subsystem of psychiatry and mental health services. The question is raised of how mental suffering will be framed in coming decades, to what extent societal solidarity with those suffering from schizophrenia will persist or grow (or dwindle), whether and how neo-liberal thinking will link with the paradigms of empowerment and recovery, and what fields of work mental health professionals and researchers will concentrate on. Also, the question will be whether wider societal reform movements will join forces with the mental health care sector or take interest in psychiatric issues and to what extent mental health issues will shape the discourse on and our coping with international mass migration that is currently shaping the face of Europe. Using the thrust of the paper by Priebe, we should turn to social science and wider societal movements in our attempt to understand where psychiatry and mental health care will be moving and where social psychiatric research should be heading to better understand mental health issues in the world around us that is undergoing rapid change.

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