Social psychiatry could stem the rising tide of mental illness

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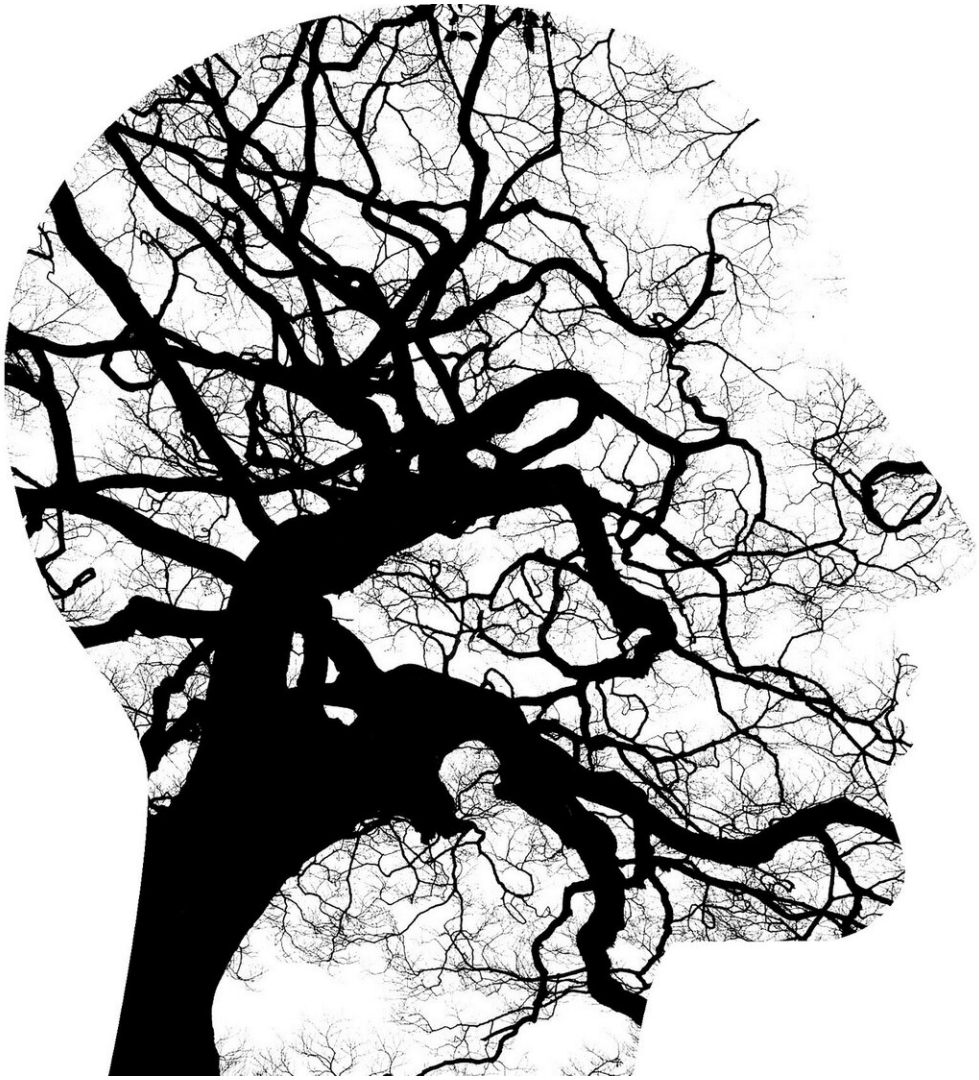

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Nearly 400 million people are affected by mental illness, according to the World Health Organization. Depression, alone, afflicts nearly 300 million people. It is no surprise that concern about mental health is sky high. But what should we do about it?

Talking helps, but it isn't enough. We need to focus on prevention. This means identifying the factors that contribute to mental illness and tackling them. A good place to start is social psychiatry.

Social psychiatry was a preventive approach to mental health that was highly influential in the US after the second world war. It focused on identifying the social factors believed to cause mental illness. These included poverty, inequality and social exclusion. It was also an interdisciplinary approach. Psychiatrists worked closely with social scientists, especially sociologists and anthropologists, to determine the relationship between society and mental illness.

The roots of social psychiatry can be traced back to the mental hygiene and child guidance movements of the early 20th century. Both mental hygiene and child guidance emphasised prevention and the role of the social environment. They also introduced new mental health professionals, including psychiatric social worker, in order to tackle mental illness.

Social psychiatry became even more influential because it was supported by a strong research base. It benefited enormously from the blossoming of social science during the 1920s and 1930s. But it also relied on the willingness of psychiatrists to listen to social scientists.

Indeed, the first significant social psychiatric research was done by sociologists. These were Robert Faris and H. Warren Dunham of the Chicago School. Their book, Mental Disorders in Urban Areas (1939) established a link between poverty and mental illness.

Faris and Dunham analysed 30,000 hospital admissions in Chicago and used maps to demonstrate how different disorders were associated with different parts of the city. For example, paranoid schizophrenia was associated with people living in "Hobohemia", which fringed the central business district.

Hobohemia residents were often homeless, resorting to stealing, begging and charity. As well as being extremely poor, Hobohemians lived "unstable" lives. Their transient and anonymous existence isolated them socially. It could also render their personality "confused, frustrated, and chaotic".

Faris and Dunham summed it up neatly: "Although spending their time in the most crowded parts of the city, these homeless men are actually extremely isolated." Other studies would show similar paradoxes.

While paranoid schizophrenia was most common in Hobohemia, catatonic schizophrenia was found in poor areas with higher numbers of foreign immigrants and African Americans. Manic depression, in contrast, was found in somewhat wealthier areas.

The pair's findings were replicated in other American cities. But some argued that the "downward drift" of the mentally ill to poor neighbourhoods explained their results.

Faris and Dunham disagreed. They argued that the parents of patients in poor districts rarely came from more wealthy backgrounds. They also claimed that younger patients had not had time to "drift" downwards.

Troubled people with mental health problems do "drift" to poorer areas. And poor neighbourhoods are not always bad for mental health. But Faris and Dunham's study showed that poverty, combined with stress, chaos and isolation, was likely to lead to poor mental health.

Chicago during the 1930s was a fairly new city. It had experienced rapid growth, buoyed by Eastern European immigrants and African American migrants. The next city researched by social psychiatrists was very different.

New Haven, Connecticut traced its roots to 1638 when it was founded by English Puritans. It was also much smaller than Chicago. Its entrenched class structure was the focus of Social Class and Mental Illness, by August Hollingshead and Fritz Redlich.

Hollingshead, a sociologist, and Redlich, a psychiatrist, were a truly interdisciplinary team. Their book began memorably: "Americans prefer to avoid the two facts of life studied in this book: social class and mental illness."

The pair divided New Haven into five class divisions. Class one consisted of "Proper New Haveners", the wealthy elite. These people's ancestors had lived in New Haven since the 1600s.

People in class five were "lower class slum dwellers", and had low-skilled, often transient, occupations. While some of them were immigrants from Europe and Quebec, others were so-called swamp Yankees. Swamp Yankees had existed on the fringes of New Haven society for centuries.

Hollingshead and Redlich's analysis of class and mental health revealed stark inequities. People from class five were three times as likely to be treated for mental illness than classes one and two combined. This was despite the fact that many people in class five lacked access to psychiatric treatment and were not included in the figures.

Also, patients in the lower classes were more likely to receive invasive, somatic therapies. These included drugs, electroshock therapy and

lobotomy. Patients from higher classes were more likely to receive psychoanalysis.

Along with poverty and inequality, social psychiatrists implicated social isolation in mental illness. One study that addressed social isolation examined rural Nova Scotia in Canada. Led by psychiatrist and anthropologist Alexander Leighton, the Stirling County Study found that social isolation led to depression and anxiety.

But social isolation was also a problem in cities. Mental Health in the Metropolis (1962) first gained notoriety for reporting that only 19% of New Yorkers had good mental health. But its main finding was that social isolation mattered as much in cities as in rural areas.

The Midtown Manhattan Study conducted two-hour interviews with 1,660 white residents of the Upper East Side, aged 20-59. It found that better mental health was correlated with higher socioeconomic status. But "the loneliness, the isolation, the lostness … of urban life" was also problematic.

Identifying the social factors involved in mental illness was one thing. Prescribing a solution was another.

An ounce of prevention

Social psychiatry showed how poverty, inequality and social isolation impaired mental health. But was there any political will in the US to do anything?

For a short time following the second world war, there was. That's because—as with today—there was intense concern about mental health during these years. The US military was among the first to raise the alarm.

When it entered the second world war, the US military was determined to reduce the number of psychiatric casualties. They were particularly eager to prevent shell shock, which had emerged as a major problem during the first world war.

Their initial approach was to screen out recruits who were thought to be mentally vulnerable. Using methods devised by psychiatrist Henry Stack Sullivan, the US military rejected 12% of recruits – two million men—on psychiatric grounds. It's worth noting, however, that some of these recruits were probably homosexual – then regarded as a mental disorder.

The two million rejections hinted that mental illness was more prevalent than previously thought. And, despite screening, there were one million psychiatric hospital admissions of US military personnel.

Mental illness, therefore, was in the spotlight after the second world war. And prevention quickly became central to how it was to be tackled.

Prominent psychiatrist William Menninger said in 1947 that prevention promised "unlimited opportunity" and could provide psychiatrists with the equivalent of a "vaccination". The focus on prevention gave the impetus to social psychiatry.

Social psychiatry was buoyed by the creation of the National Institute for Mental Health (NIMH) in 1949. NIMH's early focus was on prevention, and it funded many social psychiatry studies. It also funded the Joint Commission on Mental Illness and Health, which stressed the role of prevention.

But the biggest boost for social psychiatry came from the very top. Inspired by personal tragedy, a progressive agenda and the 600,000 Americans in asylums, President John F Kennedy became a proponent

of prevention.

In February 1963, Kennedy stressed the role of prevention in a speech to Congress. Americans "must seek out the causes of mental illness and of mental retardation and eradicate them". In psychiatry, "an ounce of prevention was worth more than a pound of cure".

By "causes" Kennedy meant "harsh environmental conditions". But the primary solution he recommended did not address these conditions. Instead, he proposed creating a national network of community mental health centres (CMHCs) to replace the asylum system.

Funding was provided for the construction of 789 CMHCs. They were staffed by psychiatrists, social workers, psychologists and sometimes mental health aides from the local community.

The shift to community mental healthcare was revolutionary. It ended the asylum era and helped reduce the stigma of mental illness. But it was not without problems.

The fall of social psychiatry

CMHCs were also meant to be preventive. But by 1970, few of their activities were focused on prevention. Instead, most of their efforts were spent on treating the chronically mentally ill.

This backwards step symbolised a broader malaise within social psychiatry. Within five years of Kennedy's speech, hopes for a preventive approach to psychiatry were flagging. Problems were emerging both within social psychiatry and in the broader political context.

By 1968, the political sands were shifting to the right. Kennedy's

successor, Lyndon Johnson, decided not to seek re-election. Republican Richard Nixon went on to defeat Democrat Hubert Humphrey.

The post-war economic boom that fuelled Kennedy's New Frontier and Johnson's Great Society programmes was also ebbing. As John Gardner, secretary of health, education and welfare, stated in 1968, there was "a crunch between expectations and resources". The Vietnam War also distracted from domestic policy.

Internally, social psychiatry was also at an impasse. Many large studies had been conducted. But many argued that more research was needed to cement the link between social factors and mental illness.

There were also debates about what action should be taken. Urban renewal proved to be a sticking point. Some argued that slum clearances would result in better mental health. But others, including sociologist Herbert Gans, argued that such neighbourhoods were not all bad.

Gans' book The Urban Villagers studied the Italian community in Boston's West End, which was cleared during the late 1950s. After spending eight months conducting participant observation, he concluded that the state of the West End did not justify clearance. Middle-class, educated urban planners had mistakenly interpreted it as a hopeless slum when—from the perspective of its residents—it was a functional and valued neighbourhood.

Others debated the extent to which radical change was needed. Harry Brickman, who led community mental health in California, wondered where the balance should be set between "ultra-safe" and "daring", "more ambitious" approaches. Was mental health merely providing clinical services? Or was it about creating a more humane and emotionally healthy community?

For Matthew Dumont, who worked for NIMH on urban mental health, the answer was clear. What was required was "a redistribution of the wealth and resources of this country on a scale that has never been imagined". Not all social psychiatrists agreed with such bold statements, however.

And social psychiatry was only one of many approaches within psychiatry. On the one hand were more traditional approaches. These included psychoanalysis and biological psychiatry.

Both psychoanalysis and biological psychiatry focused on treatment, rather than prevention. Whereas psychoanalysts provided psychotherapy, biological psychiatrists emphasised the prescription of drugs.

Caught in the middle

On the other hand, some approaches were arguably more radical than social psychiatry. These included radical psychiatry and antipsychiatry.

Both radical psychiatry and antipsychiatry critiqued the notion of mental illness itself. Mental illness, to some, was an instrument of social control. Or it was merely a myth.

In this way, social psychiatry was caught in the middle. It was more radical than psychoanalysis and biological psychiatry. But it also conceded ground—and possible supporters—to more radical approaches.

In 1980, the third edition of the Diagnostic and Statistical Manual of Mental Disorders was published. DSM-III, the American "psychiatric bible" signified a new focus on diagnosis and treatment. DSM-III showed that social psychiatry's time was long gone. The emphasis on prevention declined with it.

Instead, biological psychiatry was in the ascendancy. It emphasised neurological, rather than social, explanations for mental illness. Drug treatment, rather than prevention, came to dominate.

The shift to biological explanations was accompanied by a focus on individuals, at the expense of the population. Instead of improving population mental health, the focus was on diagnosing Americans with an increasing list of mental disorders. Most of these disorders were treated with drugs.

During the past few years, however, concerns about rising rates of mental illness have put prevention back on the agenda. Although social factors—especially in light of COVID-19—have been mentioned, there is not enough discussion of policy changes that could make a difference. This was also a problem during the heyday of social psychiatry.

My research on social psychiatry has convinced me that introducing universal basic income could improve mental health. But other progressive policies, ranging from reducing the working week to ensuring we all have ample time to commune with nature, could also make a difference.

The history of social psychiatry compels mental health professionals, charities and policymakers to put prevention at the heart of mental health policy. Doing so would reduce mental illness, but also help us all enjoy life a bit more.

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