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EDITORIAL

The contributions of sociology to psychiatry

In the past two decades sociologists have carried out a wide variety of studies examining factors related to the occurrence and course of psychiatric and behaviour disorders, reactions to illness and deviance in the population, the help-seeking and help-giving process, the organization and functioning of psychiatric facilities, community processes affecting the provision and character of mental health services, and the larger moral and institutional influences affecting definitions of mental health and mental illness and the social uses of psychiatry.

The strengths and weaknesses of the sociological contribution are in large part a product of the ambiguities of psychiatric practice itself, and particularly existing confusion concerning concepts of psychiatric disorder, diagnostic variabilities, and problems of reliability (Jahoda, 1958; Sells, 1968; Dohrenwend and Dohrenwend, 1969; Mechanic, 1970). Epidemiological approaches in social psychiatry have depended on varying concepts of disease, disorder, and disability, and it has been difficult to achieve comparability across studies and among nations having varying diagnostic approaches. Existing epidemiological studies provide data on a variety of dependent variables that are in no sense comparable, including such diverse indicators as happiness (Bradburn and Noll, 1969), psychophysiological complaints (Srole, Langner, Michael, Opler, and Rennie, 1962; Leighton, Harding, Macklin, Macmillan, and Leighton, 1963; Langner and Michael, 1963), psychotic symptomatology (Cooper, 1970), behaviour problems (Robins, 1966), and social functioning (Freeman and Simmons, 1963). Despite the difficulties of these investigations, they have clearly given evidence of the importance of such variables as social class, age and sex roles, residence, social mobility, ethnic and cultural differences, and community networks for psychiatric efforts, although the precise role of each of these factors in various disorders remains an issue requiring continued research (Dohrenwend and Dohrenwend, 1969). Although awareness of such factors presently informs the psychiatrist's perspectives and practice, future efforts must be organized around more precise conceptions of psychiatric phenomena and more adequate and sophisticated case-finding. More attention must be given also to the interactions between genetic, biological, and social influences (Rosenthal and Kety, 1968; Rosenthal, 1970), and the work in each of these areas can be enhanced by awareness of the contributions and limitations of each perspective.

Although efforts in psychiatric epidemiology have been limited by difficulties in measurement of disorder, sociologists have had wider scope in the study of community definitions and reactions to mental illness (Clausen and Yarrow, 1955; Eaton and Weil, 1955; Foucault, 1965; Mechanic, 1968) and the performance of psychiatric institutions (Caudill, 1958; Goffman, 1961; Grob, 1966; Wing and Brown, 1970). It is clear from a wide variety of investigations that social, cultural, and situational factors affect the recognition and response to illness (Mechanic, 1966), the inclination to seek psychological assistance, and choice of practitioner (Kadushin, 1969). Existing evidence suggests that the impact of such variables is most pronounced in situations where the symptoms are less dramatic but declines with increasing severity and disruption of activity (Mechanic, 1968). Although mental patients generally perform poorly in instrumental roles and maintain a relatively low level of social functioning, hospitalization is dependent much less on these factors than on the manifestation of bizarre, disruptive, and frightening behaviour (Freeman and Simmons, 1963; Brown, Bone, Dalison, and Wing, 1966; Michaux, Katz, Kurland, and Gansereit, 1969).

A major aspect of sociological effort deals with the social processes through which patients are identified and treated and the consequences for the patient's self-identity and future social performance (Lemert, 1951; Scheff, 1966). The impact of labelling has been exaggerated at times (Gove, 1970), but work in this area has served to sensitize practitioners and administrators to the importance

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of the environment and regimen on self-confidence and patients' potentialities for future performance. We have learned that social expectations in treatment can have important effects in encouraging inactivity and dependency or activity and attempts to cope more effectively. In particular, the debilitating effects of long periods of inactivity have been shown to have substantial effect on motivation and future social adaptation (Pasamanick, 1967; Wing and Brown, 1970).

One of the most consistent themes over several decades concerns the observed relationship between social stratification and mental illness, and particularly the association between social class and schizophrenia (Kohn, 1968). The observation of a disproportionate number of schizophrenics in the lowest social strata noted in studies undertaken throughout the world has generated a variety of conceptions concerning the role of social structure in the occurrence and course of mental illness (Dunham, 1965; Kohn, 1972). Although the evidence is not fully consistent and is much debated, it suggests that the disproportionate occurrence of schizophrenia in the lowest social strata is a consequence of genetic selection and downward mobility or failure to move upward as a result of the debilitating consequences of the disorder (Turner and Wagenfeld, 1967; Mechanic, 1972). Social class also appears to have a major effect on the course of the condition by exposing lower-class schizophrenics to treatment and community conditions that exaggerate the debilitating effects of the disorder (Hollingshead and Redlich, 1958; Myers and Bean, 1968). The MRC Social Psychiatry Unit has taken the lead in contributing to our understanding of hospital and community conditions conducive to limiting such debilitating effects, although much remains to be done in this area.

There have been some social epidemiological investigations in recent years describing the course of specific symptoms and syndromes. Although such studies are difficult, they are of high priority, since they help distinguish more transitory conditions from those that are persistent and result in continuing disability (Rutter, 1972). They help specify needed interventions and a more effective distribution of treatment resources. An important and provocative finding of one such prospective study is that antisocial behaviours in childhood are more persistent and disabling in adult life than earlier occurring neurotic symptoms (Robins, 1966).

Increasingly, psychiatrists have taken a more expansive view of mental health, and much sociological research is devoted to types of distress and behaviour that go beyond more limited concepts of mental illness. Considerable effort has been devoted to studying self-esteem (Rosenberg, 1965; Coopersmith, 1967), general well-being (Bradburn and Noll, 1969), and social stress and coping (Lazarus, 1966; Hamburg, 1970). General well-being, in contrast with more classical symptoms, is highly responsive to situational events and is a joint product of two independent factors: lack of psychological distress and positive life events. Although there is considerable research suggesting some relationship between social stress and psychiatric disorders as well as a variety of other diseases, results in these areas have been less consistent from one study to another (Mechanic, 1968). There is growing evidence that social stress is a factor contributing to a medical consultation, and thus it is essential to separate the role of distress in the aetiology or persistence of a condition from its influence on contacting a doctor (Mechanic, 1972).

The management of personal distress in general medical practice has received little scientific study in relation to either its prevalence or importance (Shepherd, Cooper, Brown, and Kalton, 1966). Related issues concern the very high failure among patients to conform to medical regimen and means to best promote patient cooperation (Davis, 1966). There is a developing body of research on communication in patient–doctor relationships and on the role of specific instructions on moderating patient distress (Leventhal, 1970). Existing research suggests that, while reassurance may moderate the patient's level of fear, clear and specific instructions are required to achieve a reasonable level of conformity to medical expectations. Reassurance without specific instructions may be of little value if the patient does not develop behaviours that facilitate coping with his problems.

As sociologists have devoted greater efforts to measuring psychiatric concepts, the relevance of social and cultural orientations for psychiatric practice has become more apparent. The willingness of populations to report certain behaviours and feelings, and probably even the prevalence of these, is related to perceptions of social desirability (Dohrenwend and Dohrenwend, 1969). Behavioural

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outcomes are dependent on the expectations and responses of significant others, and these may vary substantially from one group to another.

At the levels of institutions and communities, sociologists have studied how persons' capacities, skills, and defences have been conditioned by the social networks to which they belong, societal incentives, and the quality of social and cultural preparation for the life problems they must face (Sykes, 1958; Cohen, 1966; McGrath, 1970). Failures stem not only from personal incapacities but also from the failure of social organizations to adapt to changing technology and social and cultural change. Complex organizations are instruments to achieve various goals and must be examined from this perspective (Etzioni, 1964; Perrow, 1965; Thompson, 1967). The failures of large custodial hospitals and penal institutions in rehabilitating clients have been well documented, but less attention has been given to a balanced examination of the gains and liabilities of community care under varying conditions. Organization of community care and ambulatory services, like organization of more total institutions, requires a carefully developed system of resources that establishes the necessary assistance to meet objectives and minimizes social costs to family and community (Mechanic, 1969).

In the future, as sociological research efforts develop on matters relevant to psychiatric practice, greater attention must be given to: improved concepts and measurement of psychiatric disabilities; clearer specification of the factors intervening between social and environmental change and individual pathology; clearer separation between the factors causing illness, the process of seeking help, and factors affecting the course of illness and disability; and greater cooperation between the relevant behavioural disciplines. As we realize how much there is to be known about the aetiology and course of psychiatric conditions and effective modes of intervention, it is more readily appreciated that psychiatry cannot be parochial in its scope or perspectives. It must develop as a scientific and investigatory field that builds on basic knowledge, analytic perspectives, and methods from both the behavioural and biological sciences. The practice of psychiatry and its utility as a helping profession ultimately depend on the scope and integrity of its basic sciences.

DAVID MECHANIC

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