Chapter 2
Medical Sociology and Its Relationship to Other Disciplines: The Case of Mental Health and the Ambivalent Relationship Between Sociology and Psychiatry

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Introduction

Within the subfield of the sociology of health and illness, mental health is a well-established and major area of sociological inquiry and interest. This prominent interest has necessarily brought sociologists into contact with other disciplines concerned with research and practice in the area of mental illness. The most notable of these has been the discipline of psychiatry. As Norman Elias noted nearly 40 years ago, this relationship necessarily involves difference and tensions because whilst sociology and psychiatry are both dealing with human behaviour, their explanatory frameworks are different[1] and each needs to protect their professional and theoretical autonomy (Elias 1969).

At times, the relationship between psychiatry and sociology has been characterised by mutual co-operation and interest, but at others points, boundary disputes have erupted and epistemological differences about the nature of mental illness have emerged. The aims of this chapter are to examine the nature and extent to which sociology has been successful in asserting its disciplinary authority and interests in the mental health field and in doing so explore something of relationship with psychiatry as a specialty within medicine. We do this through exploring the recent history of the connexions and disputes between sociology and psychiatry mainly but not exclusively focusing on the UK. Our intention is to illuminate the nuances, interests and outcomes in knowledge and disciplinary positions that are relevant to understanding boundary disputes and collaborations between sociologists of health and healing in the area of the study of mental illness using three case examples: social psychiatry, stigma and psychoanalysis. In the final section, we explore the prospects for future collaborations with psychiatry.

Sociology and Mental Disorder

Traditionally, the topic of mental disorder has been well represented within medical sociology both in the US[2] and in the UK (although by comparison in recent time the latter has had a less prominent

[1] Sociology, he points out, might focus on social factors of anomie and status differentials with psychiatry even at the social end referring more to personality traits and sibling rivalries.

[2] The lineage of the symbolic interactionist wing of the Chicago School of sociology has ensured a strong emphasis on deviancy theory (Cooley 1902, Mead 1934, Goffman 1961, Becker 1963, Lemert 1967, Scheff 1966).

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position in the UK). To talk of 'the' sociology of any topic is to suggest that the boundaries between knowledge are rigid and mutually exclusive. We begin this chapter from the premise that there is no absolute distinction between social knowledge claims produced by sociologists and that offered from outside its disciplinary boundaries. Good examples of this point are academic contributions provided from historians and philosophers and from clinical psychology and general medical practice (e.g. Richard Bentall's *Madness Explained* (2004) and Christopher Dowrick's *Beyond Depression* (2004)). These contributions from outside of sociology provide illuminating ways of exploring psychological abnormality in its social context by emphasising historical analysis and a close attention to the meaning of the personal accounts of people with mental health problems. Moreover, sociology itself relies for its legitimacy on lay expertise. Indeed, there exists a paradox that sociological models, such as ethnomethodology (Coulter 1973) and symbolic interactionism, celebrate and utilise ordinary language accounts of social life, whilst at the same time wanting to claim a privileged role for the sociological codifications or meta-accounts generated.

Another body of knowledge, psychoanalysis, outwith sociology, has also been used as a resource to temper sociological assuredness. For example, Craib (1997) examines the shift towards social constructivism 'as if it was a client presenting itself for psychoanalysis' and argues that sociology (unlike the mental health professions it critically documents) has no mandate to change the lives of others. As a result, instead of entering the 'depressive position' of that disempowerment and probable irrelevance, it manifests a grandiose manic defence, with sociology offering expert knowledge claims (discourses on discourses) on anything and everything. In our third case study below, we examine psychoanalysis as a bridging resource between psychiatry and sociology. Additionally, there is simple empirical evidence that sociology cannot claim any privileged and unique understanding of mental health matters. Below we demonstrate this when examining the history of social psychiatry. Moreover, more recently, shifts in the academy about knowledge production indicate that the disciplinary boundaries of sociology and other singular disciplines are now blurred and leaky (Gibbons et al. 1994). The richness of sociological analysis has been helped by the examination and incorporation of work in other disciplines. Sometimes, this has involved using empirical findings of their studies to build up an argument, and at others, it has applied a sociological approach to their production. It is common for sociologists to co-author work with collaborators from other disciplines. The outcomes then appear in non-sociological journals. Although disciplinary silos are still often jealously protected in the academy, research in an applied and broad area like mental health invariably leads to a range of interdisciplinary outcomes.

However sociological interest in mental health has not been sustained uninterrupted within sociology. At the end of the 1980s, sociological debates about mental health and psychiatry were not as salient as they had been during the 1960s and 1970s. During those earlier decades, mental illness had been subject to considerable scrutiny and was used as an exemplar in mainstream theorising on deviance and social control. The popularity of sociological work about psychiatry during that 'countercultural' period was also fuelled by radical critiques from some mental health professionals, who questioned their own traditional theory and practice. While a thriving sociological interest in mental health continued in North America, in Britain, the 1980s witnessed sociological interest turning more towards mainstream topics of physical and chronic illness. At the same time, the identity of sociology has in some quarters been characterised by a shift towards a post-modern orthodoxy in social theory. Post-modern theorising has brought distinct advantages to the subdiscipline, and Pescosolido and Rubin (2000) suggest that a major contribution of this perspective is capturing rapid social change and the uncertainty that characterises contemporary social life. However, such a perspective has tended to problematise empirical knowledge claims (thus undermining empirical sociology) and the post-modern turn has brought with it a distinctive bias against realism, critical or otherwise. Instead of lay accounts offering insights into something of the reality of material social relations, they have now been offered up exclusively as 'representations' or aspects of this or that 'discourse'.

A further bit of empirical evidence of the disruption in sociological authority has been the incursion of new disciplinary forms, such as gender and cultural studies and applied social studies. The association of these applied disciplines with a-theoretical and social administrative accounts, for example in health services research, also provokes sociological wariness. Disciplines (and sociology is no exception here) jealously guard their boundaries and want to claim esoteric expertise. In this light, Strong (1979) pointed out the dangers three decades ago of 'sociological imperialism'. Similarly, Hammersley (1999) has claimed that sociology is no more than a source of specialised factual knowledge about the world, with quite a limited practical value. However, it is also the case that sociological self-doubt in the face of blind medical confidence may not offer the healthiest solution to the problem of sociological imperialism identified by Strong. Below we point out this trend when discussing psychiatric claims of privileged knowledge about stigma. Before that, we will consider the relationship between sociology and social psychiatry.

Case Study One: Social Psychiatry

Since 1970, the relationship between psychiatry and sociology could be described as distant and often hostile. They have become 'incommensurate games' (Fenton and Charsley 2000). However, prior to this time, practitioners in the two disciplines were often active collaborators. Here, we trace the rise and fall of that interdisciplinary synergy.

The Heyday of Collaboration

In nineteenth century, medical epidemiology (social medicine) sociology found a significant practical role. Indeed, the roots of medical sociology can be traced to social medicine (Rosen 1979). However, it was not until the middle of the twentieth century that mutual sympathy between environmentally orientated social psychiatrists and sociologists emerged fully.

Around the Second World War, an environmentalist period was ushered in which was characterised by a strong alliance with sociology and was given expression in the pursuance of a common agenda. Social scientists, including sociologists, were active members of academic departments of psychiatry (Klerman 1989). In its Durkheimian form, sociology presented itself as an objective project, whose purpose was to study social problems and produce knowledge to further social policy objectives. This chimed with the goals of socially orientated psychiatrists.

Eventually, an interdisciplinary collaboration was to emerge and 'social psychiatry' was formalised. This was characterised by notable collaborations of psychiatrists with both clinical psychologists (Falloon and Fadden 1993) and psychiatric social workers in the UK (Goldberg and Huxley 1992). Some of its methodological leaders were even sociologists (Brown and Harris 1978). Social psychiatry has been closely associated with a bio-psychosocial model of mental illness; an inclusive anti-reductionist approach, with a wide potential appeal to both patients and mental health workers (Engel 1980; Pilgrim 2002).

The collaborative period was in both the UK and USA particularly influenced by the human ecology of the Chicago School of Sociology (Pilgrim and Rogers 1994). In exploring the influence of poverty and deprivation, Faris and Dunham (1939) contrasted the prevalence of 'manic depressive psychosis', which appeared to be randomly distributed across the city of Chicago, with the numbers of people diagnosed with 'schizophrenia', found predominantly in poorer areas. Whereas Faris and Dunham focused on social isolation as a possible aetiological factor, Hollingshead and Redlich (1958) reflected the popular appeal of Freudian ideas, which were prevalent in the USA at that time, in their subsequent study.

This environmentalist phase of psychiatric research on inequalities in mental health began to follow those evident in mainstream public health, with a focus on social conditions and the quality of interpersonal relationships in different parts of society. A spate of influential studies identified the relationship between mental health and social class and demonstrated a consistent social patterning of mental disorders. These studies showed that rates of mental health problems were more prevalent amongst those in the 'lower' classes (Hollingshead and Redlich 1958; Srole and Langer 1962).

Consistently reported findings were that the diagnoses of 'schizophrenia' and 'personality disorder' were inversely related to social class. For so-called 'common mental health problems' (anxiety and depression), a link between social disadvantage and mental health was also established, although this appeared to be less consistent than the finding for 'schizophrenia'. The trend for 'affective psychoses' was towards greater prevalence in 'middle' and 'upper class' populations. Social class also predicted treatment type deployed by the psychiatric profession. Lower class people received drugs and ECT, whereas richer clients received versions of psychotherapy.

Given the obvious common concern for 'the social', in both medical sociology and psychiatric epidemiology after the Second World War, a trajectory was set for long-term interdisciplinary collaboration. But this failed to stabilise. The reasons for the breakdown in the relationship are complex but, for our purposes here, can be grouped into three. First, there were shifts of emphasis and theoretical preference inside sociology. Second, there were shifts inside psychiatry. Third, some of the alterations within each discipline were a function of the negative interaction of these shifts. Mutual suspicion and ambivalence occurred, which lead to a vicious circle of a declining interest in and acceptance for the other party's concerns. We now expand on these.

Theoretical Shifts in Sociology and Psychiatry

Two bonds between the disciplines had been evident in the collaborative phase – from Freud and Durkheim. With the growth in legitimacy of psychoanalysis in the 1930s and 1940s came an acceptance of 'continuum' models of psychopathology. We are 'all ill' to some degree, according to psychoanalysts. This made the lack of precise classification acceptable to those psychiatrists, who shared an over-riding commitment with their collaborating sociologists to the investigation of social conditions. The ambiguity created in Anglo-American psychiatry of psychoanalysis, and the consequent role of continuum models, defused potential tensions and cleared the way for a shared focus on the social antecedents of mental health problems. Tolerant mutuality characterised the relationship between sociology and psychiatry, as indicated here by Lawson (1989), a sociological contributor to social psychiatry:

> 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)

It seems that the notion of 'mental illness' remained in tact but psychiatrists were able to accept alternative views other than an illness model. Moreover, in relation to secondary and tertiary prevention, strong alliances were made with sociologists. This included research into the role of adverse and alienating conditions within mental hospitals, which demonstrably maintained and amplified pre-existing psychiatric disability – 'institutionalism' (Brown and Wing 1962).

After 1970, this reliance on a Durkheimian view in sociology and the Freudian influence on continuum models in psychiatry began to change. Sociologists (and psychologists) increasingly attacked the growth of neo-Kraepelian psychiatry, pointing to its rigid pre-occupation with categories and for confusing the map with the territory. For example, whilst psychiatrists assumed that 'schizophrenia' was a non-problematic fact, others viewed it as a codification of ordinary judgements about madness with little additional scientific value to these lay ascriptions (Coulter 1973; Bentall et al. 1988;

cf. Wing 1978). There was a similar back and forth argument between sociologists and psychiatrists in the US which centred on a challenge to the scientific and ideological validity of the concept of mental illness. Writing in the *Journal of Health and Social Behavior* in 1989, Mirowsky and Ross presented a critical analysis of the use of diagnosis as a form or categorical measurement and representation of psychological problems. This they argued represented poor science influenced by outmoded nineteenth-century thinking and acted to narrow understanding of mental health through the exclusion of the consideration of social structural and other contextual issues. On the bases of their critique, Mirowsky and Ross concluded their argument by recommending 'eliminating diagnosis from research on the nature, causes and consequences of mental, emotional and behavioural problems' (p. 11).

A riposte by a Gerald Klerman in an invited comment bemoaned the loss of the period when psychiatrists and sociologists collaborated, suggesting also that Mirowsky and Ross were overly ideologically committed to a social constructivist position, were ignoring the paradigm shift within psychiatry and re-emphasised the scientific validity of a diagnostic approach to the study of mental illness (Klerman 1989).

With psychiatric categories becoming easy targets for criticism, scepticism about the reality of mental illness sometimes reached nihilistic proportions. Earlier, radical constructivists had rejected mental illness as a total error of reasoning (a 'myth' or a 'metaphor' not a fact (Szasz 1961)). After Szasz, the radical internal critic of psychiatry, and under the sway of Foucauldian critiques of psychiatry, more and more sociologists tended to depict mental illnesses as social representations or epiphenomena produced by psychiatric activity utilising preferred reified categories (Prior 1991).

By 1980, most sociologists had neither the theoretical inclination nor the practical competence, to support social psychiatric research. Compared to an earlier era, they had become deskilled as social psychiatric collaborators. By the end of the twentieth century, possibilities for collaboration were muted because far less consideration was being given to social psychiatry. It was being contained increasingly on the margins of the medical profession (Moncrieff and Crawford 2001). The bio-psychosocial model (Engel 1980), favoured by many academic psychiatrists, was being displaced by the 'decade of the brain'. Biological triumphalism was abroad in the psychiatric profession, within a self-assured 'new-Kraepelin' orthodoxy (Shorter 1998; Guze 1989; cf. Clare 1999).

Mutual agreement about the role of social factors and environment in the cause and trajectory of mental health problems evident in the earlier phase of social epidemiology gave way to discrepant views. These pitted social arguments and explanations against bio-determinism. This was most apparent in relation to the perceived utility and role of psychotropic medication. The biological aetiology of madness, confirmed in the core of the profession by the apparently dramatic impact of the phenothiazine group of drugs, was now connoted by their producers and prescribers as 'anti-psychotic' agents. For some, this terminology implied curative capability, rather than them being only symptom control adjuncts for some patients, some of the time (Moncrieff 2006).

A more critical historical analysis pointed to social forces and events which demonstrated that the 'pharmacological revolution' was, if not a total myth, a considerable uncertainty (Scull 1979). The policy of de-institutionalisation was the product of a variety of fiscal and ideological forces; these drugs had little or no impact on this policy trend (Warner 1985; Rogers and Pilgrim 2005). Social scientists in the US also pointed to similar influences particularly the central role of fiscal factors. For example, William Gronfien pointed out that Medicaid had a stronger impact than Community Mental Health Centre policies of the 1960s and 1970s and it was reimbursement schedules rather than the philosophy of community which was responsible for promoting de-institutionalisation (Gronfein 1985). However, more conservative accounts continued to depict madness as a biochemical brain disturbance, pre-determined by a genetic fault but increasingly amenable to medicinal remediation. For example, Csernansky and Grace (1998) remained committed to the 'pharmacological revolution' view. They claimed that neuroscientific research now provided us with completely unequivocal evidence of 'schizophrenia' as a genetically pre-programmed brain disease (cf. Boyle 1990).

This exemplar of the role of drugs was only one of many differences which accounts for the increasing distancing between these two disciplines. Criticisms of psychiatric theory and practice from sociologists focused on a range of other facets of mental health management. 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 arena.

A further difference between the disciplines relates to the conceptualisation of the nature of service contact. Sociological analysis is more inclined to problematise this, whereas a psychiatric perspective tends to emphasise the inherently beneficent role of 'access' to services. As a consequence, the emphasis of psychiatric epidemiology has been on mapping the need for early intervention or on equitable service access. Services are viewed as sites of an uneven right to treatment, rather than as perhaps a potential threat to well-being and citizenship.

This has led to a pre-occupation with the epidemiological study of 'need' (i.e. numbers of identified diagnosed cases) in order to plan for 'appropriate' services, instead of inviting socio-political questions of interest to sociologists. These might include: who are these services appropriate for?; whose 'needs' are being met by mental health services? and are notions of 'access' or 'service' meaningful, when coercion is involved? Sociological interest in the new social movement of disaffected patients ensures that these types of questions are raised regularly in the sociological literature. By comparison, psychiatry limits its social policy interest to stigma and then only considers itself as part of the solution, not as part of the problem (Sayce 2000).

The distancing of sociology from psychiatry through differences in understanding of key phenomena was influenced by epistemological preferences within sociology more generally. During the 1970s, sociologists from the Marxian and Weberian traditions began to use medicine as an object of sociological understanding or to illustrate a social theory (Reid 1976). By the 1970s, medical sociologists had promoted themselves from handmaiden to 'observer status' (Illsley 1975). After 1970, 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.

Post-1970, sociology increasingly turned away from medical positivism and manifested a broad openness to other orientations. The tradition of symbolic interactionism and subsequent trends, like ethnomethodology and social constructivism, brought distance into the common ideological project of social engineering, which had previously acted to cement the enterprises of medical sociology and social psychiatry.

These theoretical shifts within sociology disrupted a prior interdisciplinary compatibility, by focusing on social phenomena being concept and context specific and by emphasising subjectivity and intersubjectivity in their field of inquiry. Meanings, not just causes, were now considered to be important – the task for sociology was increasingly descriptive and interpretive (*verstehen*) rather than explanatory *(erklaren*).

The most extreme rejection was to come from post-structuralism, especially the work of Michel Foucault, with its abandonment of causal reasoning, truth claims and confidence in an independent reality. This culminated in a focused exploration of ideas, language and 'discursive practices' and the eschewing of faith in quantitative methods, such as the survey techniques of epidemiology and the randomised controlled trial approach to testing treatment methods (including psychosocial interventions). Prior to this trend, symbolic interactionism had made a distinction between primary deviance (multi-factorially caused) and secondary deviance (socially amplified by the reactions of others).

The consequence of treating psychiatric illness with scepticism by sociologists meant that interests turned more to the social processes, which led to labelling and diagnosis, and the social consequences of psychiatric practice.

Whereas the previous relationship between psychiatry and sociology had been built on co-operation, these newer studies were explicitly critical not only of the social control role of psychiatry but also of its knowledge base (Pilgrim and Rogers 1994). Moreover, the co-operation had worked previously, largely because sociology was co-opted by medicine to help solve its problems; a convenient advantage of the empiricist legacy of Durkheim after the Second World War. By the 1980s, the sociological attack on psychiatry, and the defensive reaction it provoked, led not to a prolonged and creative debate but instead to a breakdown in interest on both sides.

The general trend of sociological criticism of psychiatry after 1970, understandably, was met with defensive counter-argument. Reactions from psychiatrists portrayed sociological critics as being part of an international oppositional movement of 'anti-psychiatry', which was setting out to denigrate and discredit their profession (Hamilton 1973; Roth 1973). This disenchantment with sociology was particularly evident from some who had previously gained much from collaboration between the disciplines (Wing 1978).

Whilst the complex field of 'anti-psychiatry' was not inhabited solely, or even mainly, by professional sociologists for more traditional psychiatrists, it was convenient to lump them under a sociological rather than psychiatric umbrella. The key high-profile 'anti-psychiatric' critics, such as Ronald Laing, David Cooper, Thomas Szasz and Franco Basaglia, were dissident members of the psychiatric profession, though their critical products were largely sociological or philosophical in character. A more recent generation of dissidents have become evident in the growth of 'critical' or 'post' psychiatry (Thomas 1997; Bracken 2003).

The technocratic approach of biomedical psychiatry was challenged by some psychiatrists, who emphasised the over-determining role of social factors in both aetiology and recovery (Warner 1985; Ross and Pam 1995) and the distorting effects of drug company interests on clinical practice (Breggin 1993; Kramer 1993; Healy 1997). This unbroken pattern of internal dissent suggests that many substantive problems about psychiatric theory and practice remain inherent and unresolved. Not only did mutual hostility culminate in sociological critics turning away from psychiatry but eventually there was even a diminishing interest in mental health as a sociological topic of inquiry. Many promising beginnings, for example in labelling theory and in the ethnographic study of psychiatric patients, petered out and were displaced by other more pressing concerns in the sociology of health and illness (Cook and Wright 1995). After 1980, sociologists still researched mental health. For example, some new work appeared on modified labelling theory (Link et al. 1989), users' views of psychiatric services (Rogers et al. 1993), problems with psychiatric nosology (Kutchins and Kirk 1997) and race and mental disorder (Nazroo 1997). However, the extent of this interest was notably less than that in the 1970s. Moreover, this work rarely attempted to re-build broken bridges with psychiatry.

A consequence of the distancing from sociology for psychiatry was that it retreated into 'methodologism' and 'quantitativism', unchecked by critical reflection with previous close collaborators of research about the use of reified diagnostic categories. Nor in the 1980s did psychiatry deal comprehensively with the philosophical attacks on its knowledge base, let alone abandon categorical reasoning as a lost cause. Instead, psychiatrists aspired to attain better construct validity. This was akin to improving the measurement of other epidemiological variables, such as hypertension (Fryers et al. 2000). At the very time when many sociologists were retreating into philosophical forms of anti-realism, within the wider trend of post-modernism noted earlier, psychiatry was marked by a 'return to medicine'.

With this professional strategy of re-medicalisation, there was an increasing interest in linking epidemiology to neuroscience and genetics (Wittchen 2000). Questions about pharmacological solutions did not lead to therapeutic pessimism and a return to the social. Instead, faith was re-stated in a biomedical approach, supported by the pharmaceutical industry producing and profiting from new agents. Thus, many in psychiatry naively took the reality of mental illness for granted and looked forward to the next breakthrough in biological treatments (the pharmacological revolution

became permanent). Many in sociology abandoned reality as unknowable. A breakdown of trust and comprehension between the disciplines inevitably ensued.

Even when social psychiatry shifted (partially) from a categorical to a dimensional view of mental illness, this cleavage was sustained. For example, a number of prominent social psychiatric researchers advocated a dimensional view, in which there are gradations of psychological distress (Goldberg and Huxley 1992). This filtered down into tools such as the General Health Questionnaire (GHQ), commonly used in primary care and community population surveys. However, this dimensional view did not fully displace categorical reasoning in psychiatry. In the American Psychiatric Associations' Diagnostic and Statistical Manual (1980), categories and dimensions are preserved together and are not viewed as being incompatible.

Thus, this most recent phase in psychiatric epidemiology, since 1970, has been characterised by greater diagnostic specificity and case identification, which accord with the 'medical necessity' for intervention. This can be contrasted with the collaborative phase of research, which was more concerned with the identification of the social causes of, or dominant influences on, mental health problems. Currently, policy and practice imperatives remain firmly rooted in a concern with identifying rates of diagnosed mental illness in populations in order to provide sufficient specialist services. This has largely displaced the community and environmental focus of studies during the phase of collaboration, although in some recent studies both strands of interest can be found. Overall though, it is fair to say, in summary, that psychiatry seems to have gone full circle over a century, from eugenics to environmentalism and then back to genetic determinism and the service need it implies. This pattern can be seen in the theoretical changes in psychiatric nosology. The categories of DSM-1 were heavily influenced by both psychoanalytic theory and wartime social psychiatry (Carpenter 2000). Later shifts in DSM and the section on mental disorders in the International Classification of Diseases brought about major changes in case identification and classification. DSM-II, whilst not adhering to what may be viewed as an explicit social aetiology, nevertheless incorporated psychoanalytically influenced ideas about causal antecedents. By contrast, the specific aim of moving to DSM-III was to expunge causality from diagnosis in favour of behavioural description.

Because DSM III is generally a-theoretical with regard to aetiology, it attempts to describe comprehensively what the manifestations of the mental disorder are, and only rarely attempts to account for how the disturbances came about, unless the mechanism is included in the definition of the disorder. This approach can be said to be descriptive in that the definitions of the disorder generally consist of descriptions of the clinical features of the disorders. These patterns are described at the lowest order of inference necessary to describe the characteristic features of the disorder. (American Psychiatric Association 1980, p. 7). Although aetiology is bracketed, this induces a spurious confidence in tautological accounts. Symptoms define disorders and disorders are explained by the presence of the symptoms.

Apart from a new era of tautology, the 'a-theoretical' position about aetiology, far from signifying non-committal eclecticism had the effect (if not the intention) of eliminating confidence in social causation. Subsequent changes from DSM-III to DSM-IV represented a further elimination of patient subjectivity and their biographical and social context, in favour of an anti-holistic model of mental illness, compatible now with biological psychiatry (Mishara 1994; Wallace 1994).

This emphasis on behavioural criteria and the silencing of social causation hypotheses may signal a normative North American ideology. Carpenter (2000) argues that the trend of promoting standardised categories of normality and disorder in DSM is part of a US-inspired 'MacDonaldisation' of social and economic life. For him, DSM-IV represents 'the psychiatric equivalent of the World Trade Organisation (WTO), promoting the principles of American Universalism as objective standards that are beyond reproach' (Carpenter 2000, p. 615). Certainly, one of the consequences of this focus on measurement and 'objective' criteria has been a negation of the consideration of social context and personal experience (the routine concern of medical sociology), as a core part of the psychiatric research endeavour.

In the wake of the vicious circle of distrust described above, sociologists have become deskilled in epidemiology, and psychiatrists have become weary and defensive about philosophical attack. As a result of wholly legitimate questions about the role of their profession in society or their dubious knowledge base are pre-emptively dismissed by allusions to 'anti-psychiatry'. A blocked dialectic has occurred, so that the disciplines either do not talk or they talk past each other. Despite the multiple sources of evidence about the social origins and consequences of mental health problems, they have been weakly represented in recent health research, which 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 central role as a mediator but has been studied less often as an outcome of social forces (Rogers and Pilgrim 2003).

One consequence of the gap of understanding between psychiatry and sociology has been the tendency for psychiatry to proceed autonomously about sociological matters. The best of example of this recently has been in the psychiatric framing of stigma.

Case Study Two: The Medicalisation of Stigma

The study of stigma by sociologists emerged was associated with classical labelling theory (Garfinkel 1956; Goffman 1963). Critiques of the theory emerged in the 1970s (Gove 1982; Jones and Cochrane 1981) and it fell out of favour for a while but it was rehabilitated, in a modified form, in the 1980s (Thoits 1985; Link et al. 1989). Labelling (or societal reaction) theory was an important departure in social science, especially in relation to mental health. It was linked to a shift from Durkheimian positivism, with its emphasis on the social causes of illness, to a neo-Weberian examination of the way in which illness was socially negotiated.

Whereas social causationism examined the aetiological role of social factors in mental illness, the study of labelling and stigma suggested that the reactions of others were important. Not only causes were now of interest but so too were the exchanges of meanings attached to illness behaviour and the sick role. Medicine traditionally singled out primary deviance (the 'push behind' of skin-encapsulated pathology), whereas sociology increasingly emphasised secondary deviance; the 'pull from the front' of the reactions of others to perceived difference.

Classical labelling theory focused on stereotyping and the rejecting actions of others but the later, modified, version of the theory emphasised the anticipated need in both parties to avoid mutual social involvement. Both versions drew attention to the demoralisation and social exclusion arising from negative ascriptions. Sociological interest in stigma, as well as modified labelling theory, has returned in recent years, suggesting that the classical work of those like Goffman retains contemporary relevance in the study of illness and disability (Link 2000; Scambler 2005).

Against this backdrop of shifts within the sociology of health, the social reform of mental health services in developed countries was leading not only to people with mental health problems becoming more numerous and visible but also to demands that their citizenship should be protected. As a consequence, both de-stigmatisation and social inclusion became progressive social policy demands for and from a range of interest groups concerned to improve the lives of those with mental health problems. By the 1990s, one of these was the psychiatric profession. This focus of interest is highlighted by an analysis of the interests involved with and expression of interest of an anti-stigma campaign led by the Royal College of Psychiatrists between 1998 and 2003.

The aims and objectives of the campaign were (cited in full) as follows.

The Stigma Campaign

- The Royal College of Psychiatrists believes that society, including the medical profession, has the potential to develop more tolerant and humane attitudes towards people with mental disorders.

- The College's 'Stigma' Campaign will aim to 'de-mythologise' those mental disorders which are currently stigmatised by mounting a wide-ranging educational campaign aimed at many different components of society, including different age groups and people from different social and ethnic backgrounds.

Campaign Objectives

- Raise awareness that mental disorders are very common and touch every family in the land at some time.
- Change attitudes so that mental disorders in general are less stigmatised.
- Demonstrate that both genetic inheritance and the environment contribute to in nearly all mental disorders.
- Show that a holistic approach to treatments is the most effective.

(Crisp A Psychiatric Bulletin 2000)

In the fifth and sixth objectives, the phrase 'more constructive working relationships' may hint at a necessity, borne of experience. (Psychiatrists may not have these already in relation to service users, their significant others or nearby mental health professionals.) The final objective concedes that psychiatry is an imprecise science and that the campaign provides an opportunity to explore 'uncertainties and challenging problems'. Finally, the summary statement rounding off the objectives listed is worth citing:

> By achieving these objectives, it is hoped that people suffering from mental disorders will be enabled optimally to contribute towards their own recovery. (Royal College of Psychiatrists 1998, p. 16)

This summary 'meta-objective' is not actually about stigma but is simply therapeutic paternalism and the hope that rates of patient non-compliance with treatment will decline. Thus, early in the document, a whole series of indicators are present about professional interests, which are separate from the commitment its authors had to the social challenge of de-stigmatisation.

In line with the discussion of the nature of mental health problems, the document from the Royal College framed the reality about mental health problems in a categorical and not in a dimensional or non-committal way. This framing is linked explicitly in the document to the history of asylum psychiatry and its claimed beneficial legacy:

> Within that setting [the asylum], medicine, and psychiatry in particular, set about the task of better differentiating the variety of mental disorders which currently finds expression in the diagnostic criteria of the International Classification of Diseases of Mental and Behavioural Disorders (ICD 10) and the American Diagnostic and Statistical Manual of Mental Disorders (DSM IV). Such classifications of mental disorders have contributed to the development of valuable treatments for many of the identified disorders (Royal College of Psychiatrists 1998, p. 13)

The axiom in the final sentence is open to challenge because the history of psychiatric treatment has tended to proceed in an ad hoc and opportunistic way. There is also little evidence that nosology has systematically and effectively guided treatment innovation. The front of the document summarises the changing minds project as a 5-year campaign to:

> …increase public and professional understanding of mental disorders and related mental health problems; thereby to reduce the stigmatisation and discrimination against people suffering from them; and to close the gap between the differing beliefs of healthcare professionals and the public about useful mental health interventions. (Royal College of Psychiatrists 1998, p. 1)

Thus, an 'uncertainty' or 'challenging problem' (Royal College of Psychiatrists 1998, p. 7) for the profession is not about the existence of 'mental disorders' or the effectiveness of 'mental health interventions'. This lack of self-doubt is not surprising. If any medical specialty put forward policy

suggestions, it is highly likely that its preferred knowledge base would be stated confidently and its therapeutic utility taken for granted.[3]

Returning to the diagnostic categories described in the campaign, these became a way of organising not clinical knowledge but sociological knowledge. Thus, the campaign does not privilege stigma but starts at the other end of the telescope – with particular diagnoses. As a result, different 'stigmas' (sic) not 'stigma' are described in the campaign document. Thus, the social process of stigmatisation is tied down to preferred clinical categories like 'depression' and 'schizophrenia'. The taking of diagnostic categories as natural givens in the campaign is what Hoff (1995) calls 'medical naturalism'. The document adheres to the view that psychiatric diagnosis or categorical reasoning is not only legitimate but that it has been linked to the incremental scientific understanding of mental illness. It is argued that diagnostic categorisation has improved treatment capability over time and ignores the opposite argument which has been made; those categories with poor conceptual and predictive validity have actually impeded our understanding of how to respond effectively to madness and distress (Mirowsky and Ross 1989; Bentall 2004).

Specific diagnostic categories of 'mental disorder' are described ('anxiety', 'depression', 'schizophrenia', 'dementia', 'drug and alcohol problems' and 'eating disorders'). The campaign used these as sections to report work. (Later, 'personality disorder' was added to create seven, not six, categories of stigma.) The website of the campaign puts different categories of mental health problem and stigma into boxes on its pages, and in this way the campaign can be seen as a vehicle to create a sense of certainty for its audience about the nature and prevalence of 'mental disorders'.

The Challenge of the Concept of Stigma for the Psychiatric Profession

Sociological work on the therapeutic impact of psychiatric labelling and treatment suggests that 'closing the gap' between lay and professional views of mental health problems is not self-evidently of value for patients. (The benefit of social regulation on behalf of the wider moral order is another matter.) For example, studies underpinning classical labelling theory, modified labelling theory and social exclusion suggest that psychiatric diagnoses and treatment may have unhelpful consequences for patients. Given this evidence, then psychiatric theory and practice may be part of the problem of stigma and social exclusion not part of the solution (Garfinkel 1956; Goffman 1961; Link et al. 1989; Skinner et al. 1995; Sayce 2000). Therefore, the preferred way of reasoning about stigma in the campaign (yoking particular forms of stigma to particular diagnoses) reflects a form of interest work for the psychiatric profession. It frames knowledge about a social phenomenon in clinical terms. Thus, conceptually, stigma becomes a form of psychiatric (not sociological) knowledge.

Classical labelling theory was held in suspicion by the psychiatric leadership of the 1970s, the predecessors of the document's authors, as part of 'anti-psychiatry' (Roth 1973; Wing 1978). Labelling theory played down the role of primary deviance and emphasised the negative impact of labelling from others, including that from psychiatrists. If psychiatry were to open its doors to a discussion of all of this sociological work, then it risks opening these old wounds. The singularly cited paper from Hayward and Bright (1997) can be viewed a buffer against this eventuality, because

[3] The true nature of mental health problems, according to the campaign, is contrasted with the competing and flawed views held by the general public. An explicit intention discussed under the heading of that name is to 'close the gap' between the psychiatric and lay perspectives and an explicit emphasis on the need for the profession to educate the public to accept a professional conception of mental health problems. This is pro-active attempt at what De Swaan (1990) calls 'protoprofessionalization'. While the benefits to the profession of this opportunity to promote its preferred view of reality about mental health are afforded considerable space, it is not clear what this has to do with stigma or its reversal.

it summarised and filtered a complicated sociological literature, which could then be 'cherry picked' by the College leadership for the purpose of its campaign. In doing so the social became medical.

Case Study Three: Psychoanalysis

The relationship between sociology and psychoanalysis has had a checkered history (Bocock 1976). Psychoanalysis itself is a polyvalent or open textured concept (rather like a Rorschach Card – a projective test of its own making) inviting that mixed trajectory:

- It is a wing of psychiatry but contains non-medical practitioners ('lay analysts').
- Within psychiatry, it is one bulwark against biodeterminism (the dehumanising logic of the biomedical model) but also a form of biodeterminism. Freud was a hoped-for-reductionist, who considered that ultimately human conduct would be accounted for by neuroscience.
- It is a form of biographical psychology but is mechanistic as well as existential in its method.
- It retains diagnostic reasoning – psychoanalysts have been highly influential in the development of the Diagnostic and Statistical Manual of the American Psychiatric Association (Bayer and Spitzer 1985; Wilson 1993). However, it also emphasises the hermeneutic task applied to each unique case.
- It rejects a neat separation of mental illness from normality but also retains the concept of mental illness to describe psychological difference, when arguing that 'we are all ill'.
- It is a social theory that can give comfort to both conservative and radical social forces.

The critical theorists of the Frankfurt School offered a brand of sociology by blending the views of Freud and Marx. The treatment of shellshock in the First World War was a site for this convergence, when external conditions were made manifest in symptoms but mediated by intrapsychic conflict. The intrusion of psychoanalysis into war-torn mental health work raised expectations of voluntarism in mental health services, and it challenged the eugenic assumptions of asylum psychiatry. Those breaking down in the trenches were 'England's finest blood' – officers and gentlemen and working-class volunteers (Stone 1985).

A number of writers attempted to account for the relationship between socio-economic structures and the inner lives of individuals. One example can be found in the work of Sartre (1963) when he developed his biographical progressive–regressive method. The latter aspired to understand the social context in relation to biographical accounts and biography in relation to social conditions. This existential development of humanistic Marxism competed with other elaborate discussions about the relationship between unconscious mental life and societal determinants and constraints.

Within Freud's early circle, a number of analysts took interest in using their psychological insights in order to illuminate societal processes. This set a trend for later analysts, some of whom tended to reduce social phenomena to the aggregate impact of individual psychopathology and offered social theories that were forms of psychological reductionism (e.g. Bion 1959).

However, an alternative and explicitly Marxist group of analyst competed with existentialism on one side and psychological reductionism on the other. These 'critical theorists' who were associated with the Frankfurt Institute of Social Research were led by Max Horkheimer, a German philosopher and sociologist, after 1930. The key difference between the Frankfurt School thinkers and the traditional clinical psychoanalysis was the focus of the interrelationship between psyche and society. The central importance of the interrelationships between the material environment of individuals and their cultural life and inner lives were subsequently explored by Marcuse, Adorno and Fromm (and the more marginal institute members Riech and Benjamin). The group had an explicitly emancipatory intent.

The role of this group of critical theorists in social science marginalised the notion of illness replacing it with the notion of what Fromm termed the 'pathology of normalcy'. Compatible with this the concerns of the group focused on the dialectical relationship between psyche and society through the drawing of connexions between life-negating cultural norms associated with authoritarianism and the capitalist economy and the ambiguous role of the super-ego as a source of conformity and mutuality. The latter were conceptualised as mediated by the intrapsychic mechanism of repression. Critical theory was exemplified in studies of the authoritarian personality (Adorno et al. 1950) and the mass psychology of fascism (Reich 1975) and the psychological blocks attending the transition from capitalist to socialist democracy (Fromm 1955).

An example though of the polyvalent concept of psychoanalysis is demonstrated by a range of other developments in social theory. For example, it was influential in Parson's structural functionalism as the intrapsychic factor in explaining conformity (Parsons 1964). Resonances of it can also be found in Giddens' theory of structuration (Giddens 1976). It was the basis of both left wing (Laing 1968) and right wing (Szasz 1961) 'anti-psychiatry'. It was also the conservative basis for opposing political radicalism and the Marxian developments of Reich and Marcuse (Chassegaut-Smirgel and Grunberger 1986). It was attacked by feminist social theorists (Millet 1971; Oakley 1972) but also used as a vehicle for their arguments (Mitchell 1972; Eichenbaum and Orbach 1982). Indeed, from the perspective of sociology, psychoanalysis seems to have been whatever its range of authors have wanted it to be.

Despite this highly variegated relationship between sociology and psychoanalysis, there has been regular engagement between the two bodies of knowledge. The individualism and empiricism of the latter has placed a fairly permeable boundary between psychology and psychoanalysis. Clinical psychologists have rejected it as therapeutically useless and pre-scientific (because of the un-testability of its propositions). Social psychologists have investigated their topic experimentally and avoided the hermeneutic leaps of group analysis. This gap between psychology and psychoanalysis also applies to the former and sociology. There have been seminal developments from a few social psychologists offering insights beyond that of studying small group interactions – G.H. Mead and Erving Goffman stand out in the context of this chapter. However, their legacy has been claimed largely by sociology not psychiatry or psychology.

Indeed, if we were to discount psychoanalysis as a legitimate form of psychology (as it is so contested), then only recent developments in social contructionism offer a bridge between psychology (and psychiatry) and sociology. This brings us back to the importance of the shift towards post-modern social science discussed early in the chapter, especially that inspired by French post-structuralism (e.g. Parker et al 1997; Bracken 2003; Thomas 1997).

Conclusion: Between Medical and Sociological Imperialism

This chapter has examined the relationship between sociology and psychiatry via three case studies about social psychiatry, stigma and psychoanalysis. The first highlighted the possibilities of co-operation, but these were predicated on two tendencies. On the one hand, sociology had to accept the handmaiden role in psychiatric epidemiology and, on the other, psychiatry had to concede its tenuous knowledge base and be truly open to sociological reasoning. Once sociology refused to continue in the role of subordinate and took a different epistemological turn, there was a 'return to medicine' in psychiatry, and the bridge was seriously weakened.

And once an interdisciplinary void opened up with the weakening of the project of social psychiatry and the association of sociology with 'anti-psychiatry', then this left the medical

profession turning away from sociological insights. This became evident when we turned our attention to stigma. The campaign of the Royal College of Psychiatrists we described proceeded virtually without reference to sociology. Moreover, the medical profession started at the clinical not social end of the telescope.

The third case study of psychoanalysis drew attention to the multiple ways in which it could act as a bridge between psychiatry and sociology. The problem is that these multiple linkages are often internally or mutually contradictory. Nonetheless, we concluded that psychoanalysis, as a form of both psychology and psychiatry remains the one clinical discipline of regular interest to sociologists.

Mainstream academic psychology is caught between the paradigms of social science and natural science, tending to default generally to the latter. As a consequence, the distance in the academy between psychology and sociology has largely arisen from the pre-occupation of the former with empirical matters and the latter with pre-empirical and non-empirical matters (social constructs and social theory). This point is reinforced by evidence of a clear convergence between social psychology and sociology with the post-modern turn across the social sciences – social constructivism in sociology (or social constructionism) in social psychology. With the latter, there are of course cross-cultural differences. In the US Social constructivism, it did not seemingly gain such a grip on sociology and there was a greater acceptance of the legitimacy and possibilities introduced by neuro-psychiatry (Pescosolido personal communication). It appears that in the US, the introduction of a post-modern interest encouraged more of a loosening of a focus on 'status attainment' research suggesting perhaps that American sociological knowledge in the field of mental health is likely to have become a little more open and diverse rather than rejecting of psychiatric knowledge per se.

The history of the divide in a stand-off between strong advocates in each discipline which followed a heyday of early collaboration shows signs of reversing or at least tentative reversal related to two developments. One is related to changes and challenges within the psychiatric profession which has led to internal reflection and critical reflection. Starting in the 1990s, the marketisation and a more managed system in the NHS has meant that in the UK, at least the dominance of psychiatry has not been taken for granted but has resulted in a more fragmented field of mental health care (Samson 1995). An embracing of evidence-based medicine has resulted in a more critical stance towards aspects of psychiatric practice including medication[4] (Tyrer 2008). The psychiatric profession has spawned 'critical psychiatry' 'from within its own ranks.' The latter is a network of British psychiatrists who debate the reform or abolition of their own profession and adopt a critical stance derived from Foucauldian analysis and advocate the adoption of a thorough going bio-psychosocial model (Moncrieff 2006; Bracken and Thomas 2006). The common thread in the network is a willingness of its participants to concede the limits of the profession and to open up debates about how to respond in society to psychological difference. Finally, the relatively new field of health services research and other applied interdisciplinary arenas are rapidly growing which rely on both sociological and clinical talent. It is possible that within this new research environment, new synergies will be found and nurtured between sociology and medicine about the empirical and epistemological study of mental health.

[4] For example a *British Journal of Psychiatry* article stated that: we are reminded by Lewis and Lieberman (pp. 161–163) that the Orwellian chant of 'atypical antipsychotics good, typical antipsychotics bad' is indeed the vacant refrain of sheep-like adherents to an outdated chimera of progress.

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