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Epidemiology and its limits

Introduction

In this chapter, we present some of the evidence about mental health inequalities generated by mainstream epidemiology. We do so principally to draw attention to the controversies which have surrounded the relationship between social conditions and mental health problems rather than to provide a comprehensive review of the evidence about inequalities and mental health.\(^1\) We suggest, as others have done, that whilst traditional epidemiological approaches have illuminated relationships between social and psychological factors, explanations of causation are still weakly developed. This is because the development of knowledge in this area has been hampered by a number of tensions within psychiatric theory and practice and between psychiatry and social science. This tension has led over time to a gradual distancing of psychiatric epidemiology from other social scientific disciplines. This distancing has been a function of the development of distinctive disciplinary practices which have shaped restricted forms of scientific endeavour. We argue that this has undermined an adequate basis for mental health research. Our view is that psychiatric epidemiology has played an important part in producing evidence about the topic of this book but that its dominant role has left many unanswered questions and a poverty of theory about mental health inequalities.

Socio-economic status and social class

Epidemiology has furnished evidence about social class,\(^2\) gender\(^3\) and ethnic differences\(^4\) in mental health status. The main methods of
psychiatric epidemiology have been the case series, the case-control study, the cross-sectional survey, the cohort study and the randomised controlled trial (RCT).

Despite changes in measures of both mental health and socioeconomic status (SES), the finding that higher prevalence rates for a range of mental health problems are to be found amongst those in the lowest social classes is firmly established. This cumulative evidence suggests that a strong inverse relationship with social class exists for those with diagnoses of ‘schizophrenia’, ‘depression’ (in women), ‘antisocial personality disorder’, ‘alcoholism’, ‘substance abuse’, and ‘non-specific distress’. Evidence about the relationship between lower social position and mental health is indicated by a recent systematic review of psychiatric epidemiology which echoes findings over the last 80 years. Fryers et al. (2001) found:

- A positive relationship between less privileged social position and mental health from five out of nine studies, with no studies showing an inverse relationship.
- A high income and material standard of living are associated with low rates of mental health problems, whilst low income and a poor material standard of living are associated with high rates.
- Poor education is associated with higher rates of common mental health problems in four out of six key studies.
- Unemployment, particularly recent unemployment (for both sexes), is associated with common psychiatric symptoms.

Most research on social inequalities and mental health has been conducted using measures of social stratification. Two broad conceptualisations have underpinned structural approaches to the study of social inequalities and mental health – social stratification and social class (Muntaner et al. 2000). Social stratification studies use measures of inequality which focus on disparities in social resources, such as years of education, occupation and income (Bartley et al. 1998). Social class research tends to refer to class locations originating from ownership and control over different types of asset (e.g., property and credentials). Aspects of the former approach include occupational, employment and housing status, income and wealth, and composite indicators. Occupational stratification is associated with differences in prestige, wealth, skills and working conditions (Blane 1995). Box 1.1 elaborates this point.
Occupational status

The use of occupational status in the UK was originally based on the 1911 Registrar General’s Classification of Occupations which used the following definitions:

i. Higher professional and managerial;
ii. lower professional, technical and managerial;
iii. skilled-non-manual workers and clerical workers;
iv. skilled manual workers;
v. semi-skilled workers and labourers;
v. unskilled workers.

Classification of jobs by level of skill and social status is taken as an indicator of similarities across cultural, economic and environmental experience. Married women measured by men’s occupation are also considered to share the same experiences. The use of classifications devised so long ago is problematic in establishing changes over time as structures and the status ascribed to particular jobs have altered considerably.

Box 1.1 Definitions and methods of measurement of socio-economic status

Employment status

Employed in economic activity and unemployment, which includes those seeking work, those not seeking work because of long-term sickness and/or disability, retirement. Divisions into period and duration of unemployment and those never employed.

Changes in employment over time best measured by longitudinal design (cohort studies).

Education

Education is measured either as years of education (length of full-time education or age of completion of full-time education) or credentials (qualifications achieved). Its stability over adult life and reliability of measures are the reason for its popular use in psychiatric epidemiology. International comparisons are limited because qualifications and length of education are country-specific.
Housing

Housing status is considered to reflect wealth, income and social status. Housing status has been classified by: having a home or not (e.g., homelessness); type of house (flat, maisonette, terraced house, semi-detached, detached) and ownership status or tenure (social renting ‘council’ or owner-occupation). Area of residence and features of housing conditions (e.g., over-crowding) are also used in epidemiological studies.

Income and wealth

Broad income bands are used to measure individual and/or household income. The latter is considered the best indicator of material status for women. Material possessions are a common proxy for wealth and include home-ownership, access to a car and possession of domestic items.

Composite indicators

Indicators that reflect the multidimensional nature of social class, which encompass family income, personal educational achievement and occupational status.

Other factors associated with mental health symptoms and socio-economic status:

Disadvantaged life course status (e.g., being a single parent, having young children at home). Presence of absence of social support; life events; physical illness; activities of living include perceived loss of activity.

The relationship of disadvantaged social position to mental health differs according to the type of measure used. The strength of the relationship is weakest when using occupational grouping as the basis of comparison. A strong and consistent relationship between occupational status and mental health was evident up until the early 1980s (Dohrenwend 1990a). There has been less consistency in this finding since, which, in part, may be due to the decreasing relevance of traditional occupational status measures as an indicator of social position. Taken overall, studies indicate gender differences with a notably weaker connection evident between social class status and men’s mental health (Fryers et al. 2000). There are stronger relationships between other indicators – education, unemployment status and income and mental health status. Box 1.2 summarises evidence
about the relationship between class and mental health. However, the Fryers et al. review found that specific markers of social exclusion, such as being a single parent or having multiple illnesses, were better indicators of poor mental health than more general descriptions of social class or socio-economic status.

**Box 1.2** Studies showing the strength of the relationship between occupational social class and common mental health problems in the UK (Fryers et al. 2000)

- **Health Survey of England 1998** (positive weak) A limited and inconsistent trend for mental health (measured using the GHQ12) to improve with increasing occupational social class (SCPR 1999)
- **National Psychiatric Morbidity Survey 1993** (positive) A clear social class gradient for neurosis amongst women (15% in SC I-II to 25% in SC IV-V) but far less for men, where all classes were similar except for SC I. (Weich et al. 1998)
- **Health and Lifestyle Survey** (mixed, contradictory) No clear social class distribution: mixed results by gender and age (Hubbert and Whittington 1993)
- **British Household Panel Survey** (positive) A clear negative gradient of measure of mental health with social class: those in lowest social class have highest prevalence. (Buck et al. 1994)
- **1946 Longitudinal Cohort Study** (mixed, inconsistent) Higher rates of mental health problems in SC V compared to all others but not for men at age 36. (Fryers et al. 2000)
- **1958 Cohort** (positive) Lower social class in both sexes show poorer mental health scores at age 23. Between ages 23–33 social class differences in scores diminish for men and increase in women (Manor et al. 1997)

Most studies summarised in Box 1.2 are of community surveys. Recently, a service-based sample was used instead (in primary care) (Ostler et al. 2001). From this study of 18,414 patients from 55 GP practices in Hampshire, England, the relationship between the siting of the practice and depression scores (age- and gender-adjusted) shows a clear relationship between depression and degrees of local deprivation. The importance of locality and services for mental health inequalities is returned to in Chapters 2, 3 and 4.

**Causal models for mental health problems**

Two main causal hypotheses have been put forward to explain the relationship between low SES or social class and poorer mental health: social causation theory and social selection theory.
Social causation theory

Environmentally oriented theorists (e.g., Bebbington et al. 1981; Brown and Harris 1978; Faris and Dunham 1939) suggest that higher rates of mental health problems amongst those of lower social class are due to a greater exposure to environmental and social stress. This includes living in poverty and deprivation, particularly in disintegrated communities characterised by social isolation, high crime and fragmented communication. In these communities, individual and community coping resources are both limited and chronically tested. A combination of external stressors with internal demoralisation and lack of personal control are offered to account for raised levels of madness and distress in conditions of poverty. Recent analysts have paid significant attention to relative deprivation and a gap between normative aspirations and the restricted avenues for realising these aspirations (Dohrenwend et al. 1998; Thomas et al. 2001).

Social selection theory

This suggests that social class is affected by mental disorder. Genetic and/or early environmental factors may be implicated in explaining the association between low socio-economic position and high rates of mental illness, either by increased vulnerability at times of stress or by simple biodeterminism (a biological ‘time bomb’). It is important to note, then, that selection models do not focus only on genetic determination (see below).

A number of lines of inquiry have been pursued in order to explain the social class gradient in mental health, including experiences of family disadvantage in childhood, specific social-psychological and biological factors, and generalised vulnerability acquired through exposure to widespread adversity (Sacker et al. 1999). Explanations deriving from these broader categories have included class-based differences in foetal damage, genetic differences, stress, limited or inflexible conceptions of social reality and differences in coping mechanisms – all of which have been linked to ‘lower social class’ position.

Current debate

There has been an ongoing controversy about the social causation and social selection explanations. Although there has been some
recent suggestion that processes of social selection and causation differ according to diagnostic type – for example, more persuasive evidence for social selection in relation to ‘schizophrenia’ and for social causation in relation to depression and anxiety (Dohrenwend et al. 1998) – in general terms there has been no definitive adjudication that one position is more compelling than the other. This is particularly the case in relation to the uncertainties about which variables (if any) are implicated in putative individual vulnerability.

Although sometimes the selection hypothesis has been mainly linked to genetic theories in psychiatry, logically social selection could occur as a result of early or aggregating psychosocial variables causing mental ill-health, which then culminates in individuals being socially disabled or incompetent. Hence, a neat dichotomy cannot be assumed, with the social selection hypothesis simply equalling a genetic position and the social causation hypothesis an environmental or social stress position.

This poses another problem in the debate, which is that vulnerability implies a relationship across time (from the embryo or childhood depending on whether a genetic or social learning position is favoured): a ‘diachronic relationship’. By contrast, some social causation models emphasise moment-in-time adversity or trauma: a ‘synchronic relationship’. Logically, of course, both diachronic and synchronic factors may have a causal relevance – hence the common consensus about ‘stress-vulnerability’. Even within this inclusive logic, it still remains problematic to disaggregate the relative weighting or salience of different current and past variables.

The debate about social selection and social causation, being unresolved, has brought with it a set of uncertainties about mental health inequalities:

(1) **Construct validity**

The consistency of the social class gradient in relation to different psychiatric diagnoses appears to be less strong compared to physical illness (Sacker et al. 1999; Stansfield et al. 1998). Notwithstanding the increasing recognition of conditions which have inextricably linked components of psyche and soma, this may in part reflect the lack of construct validity of mental illnesses compared to physical illness. Even for those who do not dismiss mental illness as a myth and emphasise instead the functional criteria being present for illness (Szasz 1961; cf. Pilgrim and Bentall 1999), the construct validity and
predictive validity of the major illnesses studied in psychiatric epidemiology, such as ‘schizophrenia’ and ‘depression’, are not robust.

(2) Longitudinal studies

With a few notable exceptions (e.g., Brown and Moran 1997; Johnson et al. 1999; Miech et al. 1999), a demonstration of the strength of the relationship between social position and mental health has been restricted by the dearth of prospective longitudinal population-based studies. These are necessary for an understanding of the development, interaction and impact of likely causal factors. For example, the likely presence of cumulative adversity through exposure to life events and stressful situations needs to be taken into account in making accurate assessments about mental health risk (Bartley et al. 1998).

(3) Psychiatric epidemiology

Despite a range of postulated causal explanations and some attempts, such as that by Brown and Harris (1978), which incorporate diachronic and synchronic factors, to provide sophisticated theoretical models, psychiatric epidemiology has remained underdeveloped theoretically, compared with other types of medical epidemiology and with predictive models in social science about social problems. There has been a tendency to engage in ‘circular epidemiology’, which is the replication of descriptive findings without attempts further to understand causation (Kuller 1999). Analyses which shed light upon the nature and meaning of the relationship between social class and mental health and illness have remained nascent or rudimentary compared to the study of physical health inequalities, and deviancy more generally, where causal theories have been more robust and there have been attempts to identify mediators of effect within a ‘web of causation’ (Kreiger 1994). For example, in criminology, which has also examined social selection and social causation processes as explanatory frameworks, there has been a substantial development of mixed selection-causation models. In support of social selection, low self-control in childhood was found to be predictive of disruptive social bonds and criminal offending later in life. In support of social causation, adolescent delinquency predicted later adult crime, and the impact of self-control on crime was mainly mediated by social
bonds (Wright et al. 1999). In the mental health field there has been a tendency to attribute depression to social causation and for schizophrenia to be viewed as a result of social selection or ‘drift’. However, analysis of SES as both a consequence and cause of mental health problems has only recently been seriously considered (Miech et al. 1999).

(4) Ideological difference

A major ideological difference between the social selection and social causation theorising is that the latter approach has been responsible for producing a more elaborate relationship between social influences and mental health than one concerned with social selection. This is associated with a greater optimism with a strong environmentalist assumption that changes in social conditions can influence mental health outcomes. Thus, the two positions are implicitly connected to political ideology – with the selection position being more conservative in intention, function or consequence.

Social processes implicated in mental health outcomes

The interconnection between low income, financial hardship, unemployment, poor housing and lack of education, which we can collectively call ‘socio-economic adversity’, could be corrected by political action. This recognition supports one of the ideological positions just noted. Traditional ‘structural’ approaches to mental health inequalities, such as the community studies of the impact of the environment on mental health conducted in the 1950s and 1960s (e.g., Hollingshead and Redlich 1958; Myers and Bean 1968), suggested links between socio-economic adversity and psychiatric morbidity. More recent research into the prevalence of mental disorder amongst women and the impact of poor employment, unemployment and a poor standard of living point to the importance of macro-structural variables and environmental causes in determining mental health (e.g., Warner 1985; Lewis et al. 1998).

In recent years, structural approaches to the study of mental health inequalities from the social causation perspective have been complemented by a literature on psychosocial factors, concerned
with changes in, and the experience of, life events; the social world of individuals; and the way in which social environmental demands generate psychological stress (a precursor of distress and dysfunction) (Dohrenwend and Dohrenwend 1982; Elstad 1998).

The ‘psychosocial perspective’ refers to a number of related approaches which place a correspondingly greater emphasis on precipitating rather than predisposing factors. This offers potential policy cues for a reduction of the prevalence (rather than the incidence) of mental health problems. Take the example of poverty reduction as a mental health promotion policy. Although all social classes experience distressing negative life events, poorer people experience fewer positive life experiences to buffer them against these ubiquitous existential challenges. As the ratio of positive to negative life events is different in different social classes, a reduction in class differences would also reduce levels of psychological distress in a society (Phillips 1968).

Elstad (1998) distinguishes between approaches which examine the direct influences on psychological distress versus those where the influence is more indirect (e.g., when stress is expressed in health-damaging behaviour, such as violence or excessive consumption of alcohol and drugs). One of the most developed theories of negative stressors is the life events model, which encompasses the work of George Brown and his colleagues in relation to depression (Brown and Harris 1978). In mapping the social origin of depression, attention is drawn to three groups of interacting factors that produce depression (vulnerability factors, provoking agents and symptom formation factors).

There has been some recent recognition of the need to view psychosocial influences as embedded in, rather than separate from, material influences (Stansfield et al. 1998). A link between personal agency and wider structural determinants of mental health is evident in a self-efficacy approach characterising the work of a number of social scientists interested in mental health (Aneshensel 1992; Mirowsky and Ross 1984; Pearl 1989; Thoits 1995). An example is provided by an empirical study which explored people’s responsiveness to specific environmental opportunities through highlighting the achievement, or blocking, of personal goals in maintaining mental health (Maas 1998).

Rather than viewing people as passive recipients of external circumstances (good or bad), the centrality of concepts, such as
‘mastery’, ‘goal seeking’, perceived control of the environment, and opposite notions, such as ‘fatalism’, and ‘powerlessness’, are important to examine in relation to changing ‘opportunity structures’. The ‘differential vulnerability’ hypothesis proposes that not only are ‘lower-class’ individuals exposed to greater stressors, they are also more susceptible to their pathogenic effects because of a lack of resources such as social support and personal coping strategies. However, such theories have failed to adopt a context-specific approach in which aspects in the immediate environment might influence mental health outcomes. These are explored in greater detail in Chapter 3.

**Gender and race differences**

Whilst sex, like age, was frequently included as a variable in early epidemiological studies, race and ethnic differences were not and, in the main, analyses of data focused firmly on social class differences. From the late 1960s attention turned to exploring gender and race and mental health as well as social class. Results on gender are tied closely to other key variables, such as social class, educational background and social circumstances.

As with more recent studies of social class, community studies have been used to explore gender and race and mental health. Community studies aim to provide information by measuring the level of mental disorder in society at large, independently of any contact people have had with services. The findings of these studies have been used to suggest that women experience relatively high rates of depression and other psychiatric disorders compared with men. Ground-breaking work was undertaken by Walter Gove and his colleagues (e.g., Gove 1972; Gove and Tudor 1972) focusing on the higher female rates among married women than men and a number of studies since that time have identified differences in female rates of mental health problems compared to men. As a result of this and subsequent work (e.g., Kessler *et al.* 1994; Pearlin 1975), one of the most consistent epidemiological findings is that of a greater prevalence of depressive disorders and ‘non’ specific psychological distress in women.

A 1958 cohort study suggested that between the ages of 23 and 33, social class differences in mental health scores diminished for men
and increased in women (Manor et al. 1997). Additionally, the First UK National Household Psychiatric Survey has shown that women have a higher rate of neurotic disorder. This was highest in social classes IV and V and lowest in social class I (see Chapter 5).

A recent systematic review attributed gender differences in mental health scores to a range of social, familial and personal factors. These included: adverse experiences in childhood and adolescence creating anxiety and depression; socio-cultural roles and associated adverse experiences; psychological attributes which predispose individuals to negative life events and individual differences in coping skills (Piccinelli and Wilkinson 2000). Despite the findings of the review, explanatory factors focusing on social-psychological aspects are far from agreed. For example, a dedicated study set up to explore social role differences between men and women found that neither the number, or occupancy, of traditional ‘female’ caring or domestic roles accounted for gender differences in depression between men and women (Kessler et al. 1994; Weich et al. 1998).

Whilst there has been considerable interest in drawing out the differences between men and women, this tends to underestimate the similarities that remain between men and women in relation to mental health status. The latest Health Survey for England (1993–1998) showed that there was a tendency for mental health scores (using the General Health Questionnaire (GHQ)) to be correlated with social class in both men and women. Similarly, levels of functional psychosis reported in the First UK National Household Psychiatric Survey showed very high rates in social class V in both sexes. Some research shows the reverse in relation to gender. Analysis of findings in the 1946 cohort study PSE, last followed up in 1991, found that the highest PSE scores were in men not fully employed, from the lowest occupational social class, and renting their own home (Fryers et al. 2001).

In general terms, the specific discussion of male mental disorder is rare compared with the literature on women’s mental health problems. An exception is the literature on male unemployment. The focus on female mental health problems also has the effect of underestimating the prevalence and content of male mental health problems and of the relationship between men and women more generally. The overrepresentation of women in depressed populations is well reported in the literature but the fact that unmarried
men are also overrepresented and the possible origins of this finding are not widely discussed in epidemiological research.

The tendency in the literature for depression to be portrayed as an essentially female problem is also problematic. There are a number of studies which seem to provide evidence in absolute terms of higher rates for women. However, male depression is comparatively underexplored. There are reportedly high rates of suicide in young men, which is likely to be one outcome of psychological distress (the rates of suicide being higher in those with severe depression and psychosis) (Appleby et al. 1999). Higher suicide rates in young males may in part be due to their lack of ability or willingness to articulate distress (compared to young women). We examine suicide further in Chapter 6.

Gender differences in reporting may also account for a bias in the research of depression, with women being more ready than men to disclose the symptoms of depression to researchers. For example, in their ground-breaking work, Brown and Harris (1978) were quite explicit that their choice of a female-only sample stemmed from a gender assumption ‘that women, who are more often at home during the day, would be more willing to agree to see us for several hours’ (Brown and Harris, 1978: 49).

The gendered nature and relationship of mental health problems differ according to history, diagnostic category, cultural context and political origins and are reviewed elsewhere (Barnes and Maple 1992; Pilgrim and Rogers 1999; Russell 1995). The focus on female psychopathology within psychiatry has been viewed as a reflection and extension of oppressive patriarchy; the concern with redressing this imbalance has feminist origins. Feminist analyses focused on illuminating the way in which assumptions about gender-infiltrated constructs of mental disorder are commonly attributed to women and the role of patriarchy in sustaining an oppressive system of psychiatric control over women (Chesler 1972; Penfold and Walker 1984; Showalter 1987). These theorists in turn have influenced the tendency in recent years for the sociology of gendered health inequalities to focus on female rather than male disadvantage and the term ‘gender’ has tended to mean ‘women’.

The relationship of ethnic and racial status to mental disorder has, like the relationship with gender, been inconsistent and less established and studied. There are a number of studies in the UK and the Netherlands which suggest that racial differences in mental health
have been found for diagnoses of schizophrenia, substance abuse and depression (Eaton and Harrison 2000). However, these have been subjected to vigorous methodological criticism and more recent comprehensive community studies of race and mental health seem to contradict the picture painted by earlier studies.

In Britain variations between ethnic groups, reported in studies carried out some time ago, reported lower rates of depression for people originally from the South Asian sub-continent than the white majority population (Cochrane and Bal 1989) and higher rates of psychosis for people of Afro-Caribbean origin. A more recent, and the largest, systematic population-based study undertaken of the prevalence of mental health problems among ethnic minority groups in the UK does not fully support earlier work. This larger study suggests that Caribbean men do not have higher rates of psychosis than the white majority (Nazroo 1998). These findings resonate with US evidence of the association of race with mental health inequalities in two of the biggest epidemiological studies, the Epidemiologic Catchment Area Programme Study (Robins and Reiger 1991) and the National Co-morbidity Study (Kessler et al. 1994). These found neither a strong nor consistent relationship between race and mental disorder. Similarly, recent evidence for race, class and ‘common’ psychological problems (anxiety and depression) is more contradictory than earlier studies suggest. As with gender, this is a hotly contested area which is bound up with the constructs and methods that are used as well as the latent assumptions of psychiatric knowledge.

In the UK literature, there is a bias towards studying psychosis amongst Afro-Caribbean people and a lack of focus on the study of anxiety and depression. Moreover, within psychiatric epidemiology specifically there has been a tendency to conflate variables such as race and socio-economic status (i.e., treating race as a proxy for SES) or towards artificially isolating race, class or gender by testing only their independent effects. Such an approach has the effect of underestimating the separate contribution of either racial discrimination or socio-economic privilege to inequalities or of exploring synergistic effects of race, gender and social class (Schwabe and Kodras 2000).

However, for our purposes the important point is that patterns between social variables, such as race, class or gender, are only that. Moreover, findings about these patterns change over fairly short
periods of time. Additionally, whilst there has been considerable success in identifying patterns (albeit changeable ones), explanations for why such differences exist remain contested.

**The role of knowledge in the mental health inequalities literature**

The failure to develop a more context-specific explanatory framework discussed above resides, in part, in the changing knowledge base of social science and psychiatry. Studies tracing the relationship between social disadvantage and mental illness implicitly accept the legitimacy of psychiatric knowledge, treating diagnostic categories such as ‘depression’ or ‘schizophrenia’ as unproblematic and focusing on the social causes of mental illnesses. Yet the question of what is being identified has also pervaded the contested nature of knowledge about mental health. From one perspective, the difficulties have been seen in methodological terms as trying to attain better construct validity akin to the difficulties of, say, measuring other epidemiological variables, such as hypertension (Fryers et al. 2001). Others have reflected on the influence of external social and economic factors on the content of explanatory models. Dohrenwend (1998) for example comments that the

belief in the paramount role of genetic inheritance began to change, especially in the United States, under the impact of two major events: the stock market crash of 1929 followed by the Great Depression, and the US entrance into World War II in 1941. The Great Depression made it clear that a person could become poor for reasons other than inherited disabilities and research conducted during World War II showed that situations of extreme environmental stress arising out of combat and imprisonment could produce serious psychopathology in previously normal persons, some of it long lasting. (Dohrenwend 1998: 224)

Dohrenwend suggests here that economic and war conditions shape the development of psychiatric knowledge. We return to the shaping influence of warfare on psychiatric knowledge in Chapter 6.

Peacetime conditions between the two ‘World Wars’ of the twentieth century largely witnessed ‘business as usual’ with a biomedical approach in psychiatry returning to the fore. The shift from a biological to an environmental emphasis in the period Dohrenwend addresses went into reverse eventually. In the same year that Dohrenwend was
making his historical point, we find the following confident statement from biological psychiatrists about their postwar triumphs in relation to ‘the pathophysiology of schizophrenia’:

The discovery of anti-psychotic drugs, such as chlorpromazine and haloperidol, in the early 1950s, had a tremendous impact on the treatment of schizophrenia. Long-term inpatient stays became increasingly uncommon, and the challenges of treating patients with schizophrenia began moving from the inpatient to the outpatient arena. However, the discovery of anti-psychotic drugs also had a major impact on our conceptualisation of schizophrenia. For the first time firm evidence [sic] existed that schizophrenia had a physical basis and that physiological models of intervention could be employed to treat the disorder. (Csernansky and Grace 1998: 185)

Here, we find a set of interlocking assertions and assumptions about biological causation and biomedical authority. Such assertions have been disseminated more broadly in the public domain by commentators such as Edward Shorter (1997), who pronounced at the beginning of his book, entitled *A History of Psychiatry*:

if there is one central intellectual reality at the end of the twentieth century, it is that the biological approach to psychiatry – treating mental illness as a genetically influenced disorder of brain chemistry – has been a smashing success. (Shorter *ibid.*: vii)

And yet, by the 1990s, *contra* Shorter, most psychiatric historians had come to a consensus that the ‘pharmacological revolution’ was, if not a myth, a considerable uncertainty (Scull 1979; Warner 1985). The examples cited above from Dohrenwend, Csernansky and Grace, and Shorter highlight why psychiatric epidemiology has not merely been a technical, or methodological matter, it has also been an important site of ideological struggle.

Turning to assumptions and constructs within social psychiatric research, the questioning of objectivity and neutrality of central concepts of race, class and gender have in themselves become the focus of substantial critique. The latter has consistently pointed to the way in which these categories are ‘socially constructed’ or framed, which may result in the exacerbation, as well as the measurement, of inequalities in mental health. This is most evident in the study of differences in race and mental health where reification and the
amplification of racist assumptions about different ethnic groups have permeated the inequalities in mental health literature. The way in which ‘race’ and ‘culture’ are inextricably bound up in the construction of disease categories is illustrated by a number of past and contemporary examples. For example, ‘drapetomania’ was defined by an American psychiatrist, Cartwright, in 1851 as a disease which made slaves run away:

The cause in the most of cases, that induces the Negro to run away from service, is as much a disease of the mind as any other species of mental alienation, and much more curable, as a general rule. (cited in Ranger 1989: 354)

More recent examples are constructs of ‘cannabis psychosis’ and, for some, even the ubiquitous ‘schizophrenia’. Until recently, ‘cannabis psychosis’ was a label attached selectively to Afro-Caribbean people when psychiatrists were perplexed by their behaviour (Ranger 1989). Psychosis was defined by the Royal College of Psychiatrists as a mental illness which ‘cannot be understood as an exaggeration of ordinary experience’. Fernando (1988) points out the rise in racist categories is bound up with the institution of slavery and social control. Pilgrim and Rogers (1999) have suggested that the interest in dualistic reasoning between ‘black and white’ characterising race and mental health acts to accentuate and polarise differences. This is further accentuated when consideration is given to how the variables of depression and psychosis and their measurement are currently constituted.

In contrast to a traditional medical emphasis on diagnostic categories, a number of prominent social psychiatric researchers have advocated a dimensional view, in which there are gradations of psychological distress (Goldberg and Huxley 1992). This has filtered down into common tools such as the General Health Questionnaire (GHQ) commonly used in primary care and community population surveys. The relevance of this for race is the reinforcement of a dichotomy between a negative highly stigmatised and medicalised category, such as ‘schizophrenia’, and its association with ethnic identity at the same time as a rapidly demedicalised and normalised view of anxiety and depression and its measurement has emerged which is relatively less frequently associated with race.
Conducting and appraising isolated epidemiological studies can distract us from the way in which disciplinary knowledge takes shape, consolidates and changes over time. ‘Methodologism’ inherent to the recent norms of much epidemiology can generate a version of ‘superficial empiricism’ which is neither theorised nor reflected on. Avoiding this distraction or tunnel vision, and standing back from the field, Dohrenwend (1998) identifies three distinct generations of mental health inequalities research that have been accompanied by ‘dramatic changes in psychiatric nomenclature’ (Dohrenwend *ibid*).

First-generation studies covered the period up until just after the Second World War in which hospital samples and clinical diagnoses were used to describe the patterning of mental illness. Mental health and public health reform movements originating in the nineteenth century were imbued with a moral and reforming thrust aimed at the poor. The division between the way in which the social and environmental causes of physical health were dealt with contrasts with the attention given to mental health. In the former, the connection between poor living conditions and ill-health was a salient feature of the origins of epidemiology and public health as a medical discipline.

The identification of the relevance of structural, environmental and social conditions is vividly conveyed by the accounts of Rudolph Virchow in 1848 identifying the poor living conditions of the people of Upper Silesia as the cause of illness (Tesh 1990). Another illuminative event was of TV reporter John Snow removing the handle from the parish pump to eliminate an epidemic of cholera. Important public health measures mirrored this concern with the introduction of population-based interventions, which were overlaid by the pursuance of policies characterised by social justice. Water and sewerage were regulated, factory and housing conditions improved through legislative action, and child labour was abolished.

The focus of Victorian psychiatric epidemiology was, in a major respect, different from mainstream medical epidemiology, being concerned not with removing a pathogenic source of community contagion but with institutional populations and segregation. Psychiatric epidemiology began (and in many ways continues) with a preoccupation with counting cases of mental disease, not with
mapping sources of pathology (as these are predominantly unknown). Whereas infectious agents were the concern of medical epidemiologists, psychiatrists were more concerned with the assumed genetic threat of pauper lunatics. In the late nineteenth century, Lunacy Commissioners used the epidemiological approach in mapping and commenting on the distribution of insanity across populations in their efforts to construct a separate psychiatry for the poor. The massive expansion of the lunatic population was fed almost totally by the pauper insane. Over the same period, private patients hardly increased in numbers at all. Psychiatric epidemiology was bound up with a broad eugenic social policy of segregating an assumed ‘tainted’ gene pool (see Porter 1989; Scull 1979).

The demographic analysis of an institutionalised mentally ill population reached its peak in the USA during the 1920s. It was not until the late 1930s and 1940s that greater importance was assigned to social inequalities in psychiatric and social epidemiology. In these early studies, investigations depended, in large part, on key informants and agency records. Studies based on direct interviewing produced low prevalence estimates. Armed with advances in epidemiology, including the use of new statistical and sampling techniques, subsequent studies turned their attention to surveying broader groups in the population and examining the role of environmental variables and the incidence and prevalence of mental illness in the community (Dohrenwend 1998).

The second phase of epidemiological studies involved the development of human ecology as a theoretical trend within the Chicago School of sociology (Pilgrim and Rogers 1994). At the outbreak of the Second World War, a prominent study based on social ecology and entitled Mental Disorders in Urban Areas was published by members of the Chicago School (Faris and Dunham 1939). Keen to show the influence of poverty and deprivation, they 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 reflected the popular appeal of Freudian ideas, which were prevalent in the USA at that time, in their subsequent study. They suggested the influence of social factors that spanned the life course and emphasised the experience of early infancy.
This second generation of research on inequalities in mental health began to follow those evident in mainstream public health with a focus on environmental conditions and the quality of interpersonal relationships in different parts of society. Subsequently, a range 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 (e.g., Hollingshead and Redlich 1958; Srole and Langer 1962). Consistently reported findings were that the diagnoses of schizophrenia and personality disorders 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 (see below). The trend for affective psychoses (e.g., ‘manic depression’ now called ‘bi-polar disorder’) was towards greater prevalence in ‘middle-’ and ‘upper-class’ populations.

Over the past thirty years, the third generation of studies has returned to its original focus – the mental institution and the mapping of population need to match service provision. The emergence of a policy of community care (very slowly from the 1930s) brought with it the need to enlarge surveillance associated with the increased medical management and risk reduction in those considered most vulnerable. This, most recent, phase has been characterised by greater diagnostic specificity and case identification which accord with the ‘medical necessity’ for intervention. This can be contrasted with the preceding phase which had been more concerned with the identification of the root causes of mental health problems in social environments. 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 environment focus of studies in the second generation, although in some studies both strands of interest can be found.

The relationship between sociology and psychiatric epidemiology

The broad professional aspiration of social psychiatrists has been to join a wider project of medical epidemiology. According to Williams
The attraction of epidemiology is that it seeks to address the problem of disease in the context of the community as a whole. Traditionally, the aims of psychiatric epidemiology have been identified as being concerned with definition, etiology, natural history, treatment and outcome of disease. In particular, the following functions are emphasised:

- The completion of the spectrum of diseases
- The establishment of outcome
- The actuarial assessment of morbidity risks
- The evaluation of the efficacy of treatment
- The conceptual construction of diagnosis/classification.

During the second generation of research noted above, a strong alliance with sociology was evident in pursuing the above agenda, and social scientists were active members of academic departments of psychiatry (Klerman 1989). This close association between epidemiology and sociology is traceable to nineteenth-century social medicine (Kleinman 1986; Rosen 1979) which grew in the twentieth century, with sociologists joining psychiatric epidemiologists in seeking to identify the causes of mental health problems and linking these back to social and material conditions. The growth in legitimacy of psychoanalysis in the 1930s and 1940s, and the consequent acceptance of ‘continuum’ models to add to, rather than wholly displace, the traditional categorical approach in medicine, made the lack of precise classification acceptable to both psychiatry and sociology. Moreover, in relation to secondary and tertiary prevention, fruitful alliances were made with social scientists that tied the subject of mental health firmly to the social. For example, this included research into the role of adverse and alienating conditions within mental hospitals in exacerbating or amplifying existing mental health problems – ‘institutionalism’ (Brown and Wing 1962). This phenomenon had been identified earlier as ‘institutional neurosis’ (Barton 1958) and now tends to be called ‘institutionalisation’.

Such studies ensured that sociological knowledge, with its direct connection to inequality and the social nature of mental health problems, permeated the discipline of psychiatry. A mutual and fruitful relationship characterised the relationship between sociology
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and psychiatric epidemiology, 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 unravelling the rates of mental illness. (Lawson 1989: 38)

Whilst sociological work grounded in epidemiology has continued, there has also been a retreat from the relationship with social psychiatry. After the late 1960s, there was a redirection of sociology away from positivism and a broad openness to other orientations. This was important in two respects. The tradition of symbolic interactionism (from another part of the Chicago School) and newer trends such as 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.

A set of different studies with a radical departure emerged. This included work inspired by the distinction Lemert (1967) had made between primary and secondary deviance and its elaboration in the ‘social reaction’ theory of Thomas Scheff (to be better known imminently as ‘labelling theory’). From this point on, psychiatric illness was treated with suspicion by sociologists and their interest turned to the social processes which led to labelling and diagnosis and the social consequences of psychiatric practice.

A further sociological project emerging after the late 1970s was represented in the study of changes in the discursive practices of psychiatry attributed to a postmodern society, a branch of work considerably influenced by French poststructuralism (Foucault 1965; Prior 1991; Rose 1990). Whereas the previous relationship between psychiatry and sociology had been built on cooperation or common understanding, or at least an ability to ignore or tolerate epistemological differences, these newer studies were explicitly critical not only of psychiatry but also of the constructs which constituted the subject matter of psychiatry and epidemiology (Pilgrim and Rogers 1994). Such a shift was understandably met with counter-arguments and resentment from psychiatrists who had previously gained much from their collaboration with sociology and from the analysis of social forces (e.g., Wing 1978).
Another effect of this change from within sociology was pragmatic rather than ideological. Psychiatrists had previously accepted that social scientists had particular methodological expertise (Lawson 1989). In its Durkheimien form, sociology presented itself as an objective project whose purpose was to study social problems and produce knowledge which could be used to further policy objectives. However, later sociologists wished to show how mental illness was socially negotiated, constituted or constructed, as well as exploring its connectedness with everyday norms and values of society and the deployment of psychiatry as a means of social control. By contrast, social psychiatry became increasingly concerned with establishing invigorated and technically robust constructs of mental illness and elaborating methodological rigour. Sociology was in many ways undermining the professional credibility of psychiatrists, at the very time when they were becoming more entrenched in a medical–scientific paradigm.

This diverging agenda brought a substantial distance into the relationship between sociology and social psychiatry. Wing, an eminent social psychiatrist who had worked closely with sociologists (e.g., George Brown), chided psychiatry for a failure of scientific practice in the face of the onslaught of criticism that came from labelling theorists such as Scheff. Writing in 1979, Wing argued for the establishment of a narrower set of scientific categories of disease, which he saw as essential for psychiatry to distance itself from lay constructs of madness and popular contemporary critiques of the legitimacy of the concept of mental illness and the role of psychiatry in society. Wing suggested:

One reason why medical practices have come under criticism in recent years is that some psychiatrists use a term like schizophrenia in a non-technical, virtually a lay sense and make and act on a diagnosis when there is not reason to suppose that a disease theory can usefully be applied. The broader their concept of ‘schizophrenia’ the more liable they are to make such mistakes. (Wing 1978: 164)

This concern expressed by Wing pointed up a long-standing epistemological problem for epidemiological studies in psychiatry, which was the imprecision of classificatory systems (nosologies) compared to other medical specialities. Earlier, Elfkind (1938) had commented in a leading American epidemiology journal that data
based on psychiatric diagnostic categories implicated ‘more or less intangible concepts, because psychiatry, dealing so much with the mind, must perform concern itself with subjective experience, which is so difficult for scientific study and analysis’. Later, Eaton emphasised this inherent contradiction, namely:

Epidemiology is a branch of medicine and thus the assumptions of the medical model of disease are implicit. The most important assumption is that the disease under study actually exists. In psychiatry this assumption is assuredly more tenuous than in other areas of medicine, because psychiatric diseases tend to be defined by a failure to locate a physical cause, and a validation of a given category of disease is therefore more subtle and complex. (Eaton 1986)

Screening measures used in second-generation population surveys recorded aspects of non-specific distress or, as Dohrenwend termed it, ‘demoralisation’. This included a response to chronic physical illness, recent life events, or being in a low-status social position. Dohrenwend and colleagues estimated that non-specific distress occurred with a frequency approximately equal to that of ‘diagnosable psychiatric disorder’. If social psychiatry aligned itself with social scientists and retained an allegiance to the notion of mental distress as a continuum of vulnerability (typical of second-generation studies), this was not a problem. However, it did become an issue when social psychiatry and epidemiology became estranged from sociology during the third generation of research.

In recent years, psychiatric epidemiology has been preoccupied with description and measurement of mental disorder, which has been viewed as a precursor to the future project of advancing analytical and experimental epidemiology. The development of reliable and valid structured diagnostic interviews, deployed in cross-national surveys of the prevalence and correlates of mental disorders, have featured strongly in this agenda.

From the 1980s onwards, there was a concern with developing more robust measurements and categorisation of mental health problems. In particular, there was a greater use of survey interview methods designed to diagnose a variety of ‘mental illnesses’ leading to accurate population estimates of the prevalence and incidence of specific disorders (Kessler et al. 1994). More recently, epidemiological research has been seen as a means for strengthening the links
psychiatry has with the neurosciences, clinical research and public health. In other words, the emphasis has been on medicalising the project of psychiatric epidemiology.

Extending the range of design and methods beyond the emphasis on large-scale cross-sectional and general population studies, according to some, will allow a broader spectrum of psychopathology to be studied. The latter is intended to include an inquiry into ‘etiopathogenic’ processes (genetic, neuroscientific and psychological factors) for the onset and persistence of psychopathology (Wittchen 2000). This speculative biopsychological emphasis stands in opposition to both the previous focus on the social conditions of individuals and the concern with levels of demoralisation amongst community populations.

A preoccupation with standardising and refining descriptive diagnostic categories also replaced the tendency of previous generations of research to pioneer their own methods and procedures for case identification. Whilst this might have meant that little attention was given to problems of validity, it had allowed the proliferation of psychoanalytic and other biographically inspired models. These allowed personal experience and inner life to become windows into the social world. The categories of DSM-1 and 2 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 (10th revision) brought about major changes in case identification and classification. DSM II, whilst not adhering to what may be viewed as explicit social aetiology, nevertheless incorporated psychoanalytically influenced ideas about aetiology. 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 atheoretical 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. (DSM III 1980: 7)
Subsequent changes from DSM III to IV represent a further progressive elimination of patient subjectivity and their biographical and social context, in favour of an antiholistic model of mental illness compatible with biological psychiatry (Mishara 1994; Wallace 1994). Above, we noted Dohrenwend’s observation about the history of psychiatric epidemiology, that models of mental health inequality research represent an interaction of the internal focus and the dynamics of the discipline of psychiatry with the zeitgeist of the wider social economic and political milieu. Echoing this, Carpenter (2000) views this trend of promoting standardised categories of normality and disorder in DSM as part of a US-inspired ‘MacDonaldisation’ of social and economic life.

From this perspective, DSM IV represents ‘the psychiatric equivalent of the World Trade Organization (WTO), promoting the principles of American Universalism as objective standards that are beyond reproach’ (Carpenter 2000: 615). Certainly one of the consequences of this focus on narrowing measurement and objective criteria has been a negation of the consideration of context and experience as part of the epidemiological endeavour. Whilst qualitative sociology in studies of disadvantage in other areas have shed light on issues of cultural identity and discovered highly complex sets of social relationships, in epidemiological work about mental health this has been a missing element and in the UK is only just starting to be reconsidered.

A crisis in the study of mental health inequalities

Despite the multiple sources of evidence about the social origins and consequences of mental health problems, by the end of the twentieth century inequalities in mental health research were weakly represented in a research context where greater emphasis was being given to social inequalities in health as a whole (Muntaner et al. 2000). At present, not only is there less research (compared to the study of physical illness) but causal explanations and frameworks about the inverse relationship between mental health and social position remain underdeveloped. We have argued above that this current poverty of theorising has been driven, in part, by a historical legacy which took sociology and psychiatry down different paths. The mutual project of social psychiatry and sociology which mapped the
social causes of mental pathology collapsed when sociological concerns turned towards showing the way in which traditional psychiatry and mental health services contributed to the marginalisation of those labelled as being ‘mentally ill’. These criticisms also focused on the way in which constructs of mental illness central to the enterprise of psychiatry were imbued with stigmatising, coercive and ideological intent.

Whilst social psychiatry turned its attention to issues of ensuring greater validity and reliability for the diagnostic constructs, which were construed as central to its lack of scientific credibility, sociology turned its attention to the social and political nature of psychiatric practices. One partner became introverted and the other more hostile, creating a vicious circle. Only those sociologists (and psychologists) who were prepared to accept psychiatric knowledge uncritically remained within the inter-disciplinary alliance, which had become ‘social psychiatry’.

Whilst more robust methods and credible diagnostic constructs arguably have been the product of recent psychiatric epidemiology, they have been at the expense of a more sophisticated understanding of the social nature of mental health inequalities. For example, a recent study found that the subjective rating of quality of life for individuals in a residential population was associated with levels of distress which would not normally be counted as constituting either a major or minor mental illness (Thomas et al. 2002). This important reminder of low-grade unhappiness and demoralisation as part of a continuum of distress and dysfunction can be contrasted with an emerging rigid categorical world of the third generation of psychiatric epidemiological studies. In this third generation of research, social psychiatry may have raised its credibility in the eyes of medical colleagues in other specialities but it has taken it away from social science and the rich potential offered by the latter.

The bias towards a medicalised view of the relationship between mental illness and social position has also demoted or obscured a view of what the levels of psychological distress in a society suggest about its character. The level of distress amongst community populations is a marker of social progress, levels of current alienation and the success, or otherwise, of social policies designed to improve the quality of life of its citizens. Levels of psychological distress are also markers of the extent of relative deprivation in a society and its political health. The third generation of an overly medicalised form
of epidemiology obscures rather than illuminates our social and political life world.

Take the example of recent changes in Eastern European societies. Massive rises in suicide, alcohol consumption and violence have been brought about by social and economic upheaval in their social orders. There is a consensus in public health quarters that these are essentially social in nature (Tkatchenko et al. 2000) and that inequalities in physical illness are mediated by psychosocial factors (Wilkinson 1996; Williams 1995). Mental health states, in themselves, are also worthy of separate consideration as the outcome of social processes, influences and context and, conversely, as reflections of social advantage and disadvantage in a society. In the next chapter we examine the increasing importance of understanding neighbourhood when understanding social divisions and inequalities in mental health.
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