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Social psychiatry

The 1967 meeting of the American Psychopathological Association was devoted to social psychiatry. It elicited a wide range of views on the nature and compass of the subject. George Rosen (1968), who has made the most illuminating contributions to the history of its development, selected for approval the broad view that it is 'any work which deals with the relationship of social and individual variables', but suggested that 'social psychiatry can be considered still more broadly by thinking of it as a facet of social medicine, which may be defined as the study of the relationships between health phenomena and social factors and contexts'.

Such claims on behalf of social psychiatry have been attacked from two flanks: from clinicians who deny the need for departure from their traditional role in dealing with individuals, and from social scientists who see in it an extension of medicine's pretensions. The latter view was outspokenly expressed at the 1967 meeting by Barbara Wootton, who planted arresting 'No Trespass' notices on what she regarded as moral, ethical and legal territory, calling to her aid the extravagant contortions of Dr Thomas Szasz whose 'onslaught', she says, 'on the expansionists seems to me to be timely and salutary' (Wootton 1968).

It is noteworthy that Lady Wootton offered no grounds for her contention that social psychiatry has a legitimate field of operation. While many of her strictures will receive the endorsement of wide psychiatric opinion, the suspicion that the baby has disappeared with the bath water undermines much of the value of her cleansing enterprise. In a later discussion of the same issue (Wootton 1977) she very clearly states the dilemma which, she implies, is insoluble. By what criterion, she asks, taking up clinical issues, do we judge whether affective function is healthy when 'everyone who falls in love experiences emotional disturbance — are they therefore mentally sick?'; again '. . . the difference between deficiency of intelligence *per se* and the severe condition is purely social . . . based on ability to satisfy the demands of . . . society. But that capacity is inextricably related to the state of the economy . . . Thus it is the instability of social conditions . . . which elevates or depresses his mental categorization'; and, taking up a broader question, 'any glib assumption that mental health depends on . . . adaptation of the mind to its physical or social environment founders on the double question of what is to be adapted to what . . . On the one hand, adaptation to the social environment inevitably involves judgements of value . . . on the other hand man has a unique capacity . . . to modify both his physical and social environment'.

Quite so. The inescapable social dimension in psychiatry is here clearly revealed and, although the author puts her questions rhetorically, they must nevertheless be answered by the psychiatrist, as best he may, in many aspects of his regular work.

The sharpest dissection of the social element in the physician's task of distinguishing health and disease has been provided by the founding father of social psychiatry in Britain, Sir Aubrey Lewis, in his challenging essay 'Health as a Social Concept' (Lewis 1953). He demonstrates that in both common usage and formal definition the notion of health contains the conception of fulfilment of social function or social well-being; that the physician, whether judging a patient's subjective report, the objective evidence of disturbed function and structure, or the physiological and psychological equilibrium of the body working as a whole, will, explicitly or implicitly, at each stage appeal to norms conditioned by the widely differing geographical, climatic, cultural, occupational and other environmental conditions of human life. These considerations apply *a fortiori* to mental health where 'there must be adjustment of functions within the organism, keeping its internal milieu steady; there must be adaptation of this integrated organism to its surroundings so that it remains unharmed, in spite of changing conditions'. When social adaptation is assessed 'value judgements

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must be made and adaptation is distinguished from maladaptation according as a particular valued state is favoured, or jeopardized. Social adaptation, by itself, is therefore an empty term: it must be qualified by an indication of the state desired'. Conformity, the disparity between an individual's conception of his social role and society's version of it, is a varying but inescapable ingredient of a judgment of the integrity or impairment of mental health. It is in this area that acute difficulties arise in distinguishing mental illness from other forms of deviant behaviour (e.g. criminal behaviour) and in delimiting the legitimate sphere of psychiatry.

Ten years later Lewis drew attention to the origins of social psychiatry (Lewis, 1962) and, taking account of the systematic expositions of psychiatry early this century, he contrasted the scant attention paid to social issues by British authors compared with their European colleagues. He pointed out that Aschaffenburg's 'Handbuch der Psychiatrie' (1915), a representative of the period, considered occupational problems of adolescence; the effects of unemployment; the varied incidence of mental illnesses in different occupational groups; the bearing of psychiatric problems on military service; the psychiatric peculiarities of different ethnic groups; the effect of war and other major catastrophies on the incidence of mental disorder. In France, Auguste Marie's multi-volume 'Psychopathologie Comparée' (1912) dealt extensively with historical changes in the forms of mental illness, the mechanism of the effect of immigration and industrialization on the incidence of mental breakdown; with communicated mental disorder, mass psychiatric phenomena and similar questions which arise when the psychiatrist looks beyond bedside and interview and sees what he learns there mirrored in the larger events of life around him.

By articulately identifying the social dimension of psychiatry, which has its roots in the concept of health but has fluctuated in medical awareness at different places and times, Lewis prepared the ground for his major contribution to the field; a practical demonstration that it could be evaluated, quantified and, with the adaptation and development of appropriate method, subjected to a scientific rigour comparable to that by which, in medicine, the laboratory forms a mainstay of clinical practice and public health. He seized his opportunities from the exigencies of the times in which he lived: unemployment in the early 1930s, the upheavals of industrial and social life in World War II and the post-war forging of the Welfare State.

In the more settled period of the 1950s, Lewis turned to the more lasting problems of prolonged disability following psychiatric illness and, in founding the Medical Research Council (MRC) Social Psychiatry Unit, of which he became the first director, secured for them sustained attention from a socially orientated multidisciplinary team. Its subsequent development formed his most influential legacy to social psychiatry in the form of young professionals attracted to the field, trained in and influenced by his leadership to devote their subsequent careers to its problems. In addition to the list of workers in psychology, psychiatry, sociology, social anthropology and linguistics, contained in a recent account of the development of social psychiatry in Lewis's thought and work (Shepherd 1979), one may here include K Rawnsley, a member of the Social Psychiatry Unit before his appointment to the Chair of Psychiatry in Cardiff; the MRC Unit of Clinical Psychiatry in the workaday psychiatric setting of Graylingwell Hospital under P Sainsbury; the MRC Unit for Research on Epidemiology of Psychiatric Illness, in Edinburgh, under M Carstairs and later N Kreitman; the continuation of the MRC Social Psychiatry Unit under J K Wing, pupil and successor to its founder; and the creation of a Chair of Epidemiological Psychiatry held by M Shepherd, today's most vigorous exponent of Lewis's ideas.

The application of epidemiological principles to social psychiatry has been the major innovation of psychiatry during the past three decades. A substantial textbook surveys its contributions in a systematic and compact form (Cooper & Morgan 1973) under three headings. 'Planning Mental Health Services' is the most obvious of these and has the longest history. National and local statistics, the composition, movement and fate of hospital populations, the extent and severity of morbidity and distress in the general population, give the bearings by which services should be launched, steered or have their course changed. The traditional but unwarranted restriction of the field of epidemiology to infectious diseases makes 'Clinical Applications', including problems of identification, delimitation and classification of psychiatric disorders, a less familiar field. Within general medicine, however, epidemiology in cardiovascular disease has been notably productive, while in psychiatry its application to genetics, alcohol and drug addiction, for example, offers equal promise of an extension to the clinical study of individuals. Aetiology comes under the last heading. 'The Search for Causes', and it is here that most is looked for because most is needed in psychiatry. The attribution of causes to pellagra, a classic of epidemiological research (Shepherd 1978), and general paralysis in the manner now widely familiar in medicine, has removed these serious psychiatric disorders from

the scene, but the more intractable problems of neurosis, subnormality, dementia, manic-depressive illness and schizophrenia remain. Cooper & Morgan (1973) give several examples of concomitant, precipitating and predisposing factors contributing to the causation of psychiatric illness,uncovered and clarified by epidemiological method: the association between schizophrenia and social class and between psychiatric and physical illness; the mechanism of psychiatric breakdown in combat troops and in puerperal mental illness; the role of genetics, perinatal and early environmental risk factors in liability to psychiatric illness. Although achievement in the field of the 'functional' psychiatric illnesses has been less striking than in those disorders where a single organic cause is predominant, epidemiology has notably strengthened the drive to clear the ground and extend its borders by the indispensable antecedent operations of defining terms, improving the reliability of diagnosis, establishing the extent and limits of disease entities, and importing more rigorous methods to the answering of such clinical questions as the assessment of therapeutic effect.

The evident tension between the polarizing tendencies of psychiatric thinking may be illustrated on the one hand by the disparaging use of the term 'medical model' by sociologically or psychologically orientated professionals, and on the other by the recent onslaught in the correspondence columns of this journal (Hemmings 1979) on an exposition of the social aspects of psychiatry (Wing 1979). After delineating the stance of the opposing views, a recent commentator concludes: '. . . social medicine like medicine itself) and medical sociology share two basic sciences, biology and sociology; the only difference being that most theorists and practitioners start from one or other base, since very few are (or need to be) trained in both, (Wing 1980). Applying this premise to the particular problem of schizophrenia, he continues: 'but it is frequently forgotten, or denied, that this condition can be preceded, or accompanied or followed by chronic impairments which can certainly be exacerbated or maintained by social factors . . . The only danger is that such impairments may not seem sufficiently "medical" to physicians or sufficiently "social" to social workers'. To keep both viewpoints in focus is the major role of social psychiatry, and nowhere has it been developed more productively than in the United Kingdom.

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Medical Director, St John's Hospital
Stone, Aylesbury, Buckinghamshire

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The hospice tradition

'It is as natural to die as to be born', wrote Francis Bacon: a long-neglected fact that was aptly paraphrased as 'death is part of life' by Miss Dorothy Summers, the coordinator of studies at the Study Centre of St Christopher's Hospice, during her talk at a meeting of the Open Section of the Royal Society of Medicine on 6 October 1980. Why this fact should have been resurrected as it has been during the last decade or so it is difficult to say, but undoubtedly one of the potent factors in reminding this technologically orientated generation of the truth of the old saying has been the realization that an ever-increasing proportion of the population is living to an age when cancer, with its accompanying pain, takes an increasing toll of life. Inevitably interlinked with this is a growing fear, not only of dying, but also of a painful death.

It was to cope with this problem of how to ensure that the fear, and the pain, of death and dying should be reduced to a minimum that the tradition of the hospice was introduced. Actually, in its present format it dates back to 1905, when the Irish Sisters of Charity founded St Joseph's Hospice in Hackney in the East End of London. Here, three-quarters of a century later, the devoted Sisters, along with their colleagues – medical, nursing and lay – 'provide', in their own characteristically modest terms, 'pain control and final comforts for 600 cancer victims every year'.

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