# Introduction to Special Issue: Psychiatry as Social Medicine

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## Introduction

This issue of *Culture, Medicine, and Psychiatry* proposes a historical reevaluation of the relationship between psychiatry, medicine, and the field of social medicine. Specifically, we ask how the concept of "the social" in relation to mental health took on very different meanings by different historical actors over the course of the last century. The seven essays that comprise this special issue focus on the formation of a self-conscious field of social psychiatry, the tacit and explicit role of social categories in the definition of diagnostic categories and therapeutic goals, the relationship between psychiatry and social medicine in colonial and postcolonial contexts, and the medicalization and demedicalization of severe mental illness over the course of the twentieth century. As psychiatry has become rebiologicized over the past half century, they argue, historical analysis has become a crucial means of recapturing attention to the social world in the field of mental health—as both a category used by the historical actors themselves and as a category of analysis.

Read together, these articles present a dynamic analysis of the changing understanding of "the social" within the field of psychiatry in the twentieth century, and its relationship to the evolving field of social medicine. Social psychiatry and

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social medicine are not synonyms, but they overlap in important ways. Social medicine has a long and complicated history, and is concerned with the social, historical and structural forces that produce illness and directs its care, as well as relations of medicine and social justice. It has shaped the development of national and international health services for most of the twentieth century, and both influenced and been influenced by developments in social psychiatry during the last 100 years.

The social history of psychiatry has been a subject of extensive professional and popular attention for decades, partly because psychiatry appears as one of the branches of medicine whose diagnostic and therapeutic categories can be most easily critiqued as "social" and therefore not natural (and, in some of the most critical antipsychiatric interpretations, not really "medicine" at all) (Szasz 1961). In the late twentieth century a series of historical analyses extended the critique of social control as a concept in mental health beyond the walls of the mental hospital or asylum to engage a broader analysis of how social and societal changes have influenced the creation of disease categories (Kirk and Kutchins 1992; Metzl 2009; Noll 2011) and therapeutic approaches, (Braslow 1997; Gijswijt-Hofstra, et al. 2005; Healy 1997; Herzberg 2009; Killen 2006; Smith 2012; Tone 2009). In a series of studies ranging from Foucauldian analyses of the role of state and para-state apparatuses in social discipline, to more Marxist analyses of markets in relation to the professionalization of expertise, historians, sociologists, and anthropologists have described very different means by which social control can take shape (Grob 1983; Rothman 1971; Scull 1979). Standard social histories of psychiatry also detail how the field has evolved in the context of political ideologies, from ideals of social reform and progress to threats of degeneration and race, and how these categorizations have depended on contemporary societies' perceptions of deviance.

In recent decades, historians of psychiatry have examined in greater detail the contestation of diagnostic and therapeutic categories inside and outside of institutions of mental health, by a wide variety of actors outside of the medical profession (Grob 1991; Eghigian 2011). These textured accounts of the social worlds contained within the history of psychiatry and the mind sciences pay closer attention to the intersections of gender, class, and race (Burch 2016; Hirshbein 2009; Lunbeck 1994; Metzl 2009), using methodologies drawn not only from social and cultural history (Pietikainen 2007) but also broader analytics drawn from environmental studies, disability studies, and postcolonial studies (Doroshow, et al. 2019). As the field of psychiatry has become increasingly biologicized in the late 20th and early twenty-first centuries, these social histories have worked to complicate the universalism of biomedical categories, and to emphasize how diagnostic and therapeutic practices are also shaped by those who live within these categories and navigate these institutions as nurses, patients, and family members (Braslow 1997; Sadowsky 2017; Harrington 2019; Smith 2020).

The essays of this volume suggest much can be learned by positioning the history of psychiatry alongside the field of social medicine, an emerging field that countered the increasing dominance of biomedicine in clinical practice in general over the late nineteenth and twentieth centuries. From a social medicine perspective, no form of medicine can ever be a pure biological science: there is always a mutual imbrication

of biological and social concerns in any domain of medicine, from atherosclerosis to oncology to the microbiology of tuberculosis or COVID-19. Social medicine engages social as well as biological determinants of health and disease (Alegria et al., 2018). Social medicine encourages health practitioners to develop a keen understanding of how social structures like poverty, racism, stigma, and economic marginalization shape patterns of illness in individuals and populations (Metzl and Hansen, 2014), and how healthcare providers can be more effective advocates for the health of their patients (Kirmayer et al., 2018). Psychiatry played an important role in the formation of the field of social medicine, but the insights from this field apply to somatic as well as mental health. To view the history of social psychiatry in relation to social medicine is to ask—as Sadowsky does in the first essay of this issue—what it means to separate "psychiatry" from "medicine" in the title of this journal, and how does each relate similarly, or differently, to the question of "culture"?

## Forgetting Social Psychiatry

The biomedicalization of psychiatry in the second half of the twentieth century is typically narrated alongside the fall of Freud and the heyday of psychodynamic psychiatry. Yet the rise of biological psychiatry has also largely erased the collective memories of the crucial field of social psychiatry, a field grounded simultaneously in the liberalizing discourse of pragmatic social policy and the moralizing discourse of social hygiene movements. The concept of "social psychiatry" first appeared in Germany in the first decades of the twentieth century in the writings of psychiatrists interested in harmful factors influencing the mental health of the population and how they could be prevented (Schmiedebach and Priebe 2004; Kritsotaki et al., 2019). Tied to a broader agenda for preventive health, it spread widely in other parts of Europe and the United States. Psychiatry in the beginning of the twentieth century was strongly hereditarian, and leading social psychiatrists increasingly, and particularly after the Great War, would also address the concerns of "the nation", or "the race", arguing for the surveillance of the mentally ill also outside of the walls of the asylum in order to impede marriage and procreation to prevent its spread. In fascist regimes in the 1930s, social psychiatry was often reduced to the concept of prevention based on biological interventions, such as incarceration, sterilization and euthanasia (Burleigh 1994; Porter 2018; Schmiedebach and Priebe 2004; Weindling 1989). The retrospective identification of the term "social psychiatry" with Nazism had long-term consequences for the field: there could be no going back to the practices and language of pre-war social psychiatry in Germany and the expression was avoided for many years (Schmiedebach and Priebe 2004).

Yet the mental hygiene movement only represented one strain of this emerging field. When the concept of social psychiatry reappeared in the 1950s and 1960s in Germany, it had a different and more patient-centered and individualized meaning. In the Netherlands, "social psychiatry" came to mean care outside the asylum, and was deployed during the interwar years largely as a response to asylum

overcrowding (Oosterhuis 2004). This model had been anticipated (and explicitly promoted) in the Dutch East Indies decades beforehand, rooted in principles of moral treatment, and served as an explicit model for the French in Indochina, as Claire Edington shows in this issue. Social psychiatry took shape in colonial Southeast Asia as international health authorities tried to solve the problem of asylum overcrowding. In Edington's analysis, regional knowledge about psychiatry produced in colonial institutions became part of new "social psychiatry" approaches to health care in rural areas which emphasized deinstitutionalization rather than institutionalization. As colonial psychiatry became involved in local networks of care and economy in looking for alternatives to institutionalized care, this coincided with a turn of emphasis in international health from technocratic and expensive solutions towards educational improvement, economic and social development, and care in local communities planned in tandem with indigenous communities (Edington 2019). The Bandung conference of the League of Nations, taking place in 1937, introduced perspectives that have been described as forerunners to the Alma Ata conference in 1978 (Brown and Fee 2008). A subsequent Bandung summit in 1955, as Edington notes, became a powerful expression of anti-colonial and Global South solidarity in the emerging Cold War order.

In the wake of the Nazi atrocities committed in the name of social hygiene, international efforts to reconsider mental health in social context took on new impetus in the immediate postwar years. Actors in the World Health Organization and other U.N. bodies tried to locate a new definition of 'common humanity' in a new post-colonial field of transcultural psychiatry. As Ana Antic argues in this issue, this field alternately challenged and reframed some racist paradigms of pre-war colonial psychiatry, while allowing for others to persist in new forms. Antic traces a history of how transcultural psychiatrists sought to separate local from global, social from biological, as they characterized -emic and -etic distinctions in global mental health. In her analysis, Antic shows that Western psychiatrists mostly worked within a Universalist framework, where cultural difference to a certain extent was reified nevertheless. In contrast, leading non-Western psychiatrists used an emerging language of social psychiatry to challenge some of the Eurocentric tendencies of transcultural psychiatry, and thereby contributed to re-imagining cross-cultural encounters in fruitful ways.

By 1959 a WHO Expert Committee on Mental Health defined social psychiatry as "the preventive and curative measures which are directed towards the fitting of an individual for a satisfactory and useful life in terms of its own environment'" (Packard 2016). In the United States, where social psychiatry was much less tainted by an association with Nazism, the growth of the field was explicitly related to practices concerned with the treatment and recovery of patients outside the walls of the asylum. Confronted by the social world outside of the asylum walls, psychiatry increasingly turned its attention to social factors. Social psychiatry increasingly became an umbrella term covering an emphasis on treatment in the "community", and focused on the familial and social origins of mental illness (Davies and Dyck 2016; Kritsotaki, et al. 2016). One of the most significant social psychiatry projects to emerge following the Second World War, the Midtown Manhattan Study,

endeavored to test the general hypothesis that "biosocial and sociocultural factors leave imprints on mental health which are discernable when viewed from the panoramic perspective provided by a large population" (Srole et al 1962). This large-scale, interdisciplinary project that surveyed the mental health of 1,660 white Upper East Side residents, became a crucial touchstone in the policies of de-insitutionalization in the middle to late twentieth century, as states steeply contracted the inpatient population of mental hospitals and invested (or failed to invest) in the community-based models of care supported by researchers in social psychiatry.

The decline of social psychiatry has often been explained by reference to the rise of the antipsychiatry movement, the decrease in funding for state-based mental health institutions, and the increasing appeal of biological psychiatry (Shorter 1997; Torrey 2014). However, as Matthew Smith argues in this issue, tensions developing within this study, both interdisciplinary and personal, suggest a more complicated legacy of the study and altered the potential impact of social psychiatry as a field. In order to understand the potential contemporary relevance of Midtown and other studies in social psychiatry, Smith argues, we need to understand them on their own terms, and not judge them retrospectively based on the systemic failures that became apparent after the policy of deinstitutionalization.

The groundswell of support for deinstitutionalisation and the turn towards community-based psychiatry in the late twentieth century were associated with a turn towards recovery as a focus of treatment. In recent years, focus on recovery from mental illness has led to significant changes in policy and service provision, and has been hailed by many as a welcome alternative to the prevailing biomedical regime. As Michael Healey shows in his essay in this volume, the recovery model has longer roots which can be traced to the beginning of the twentieth century in the biopsychiatric approach of Adolf Meyer, which made explicit space for the social world in the definition of disease and approach to treatment and recovery. Meyer, one of the most influential American psychiatrists of the first half of the twentieth century, was deeply engaged with American pragmatism, and opposed the ontological approach to mental health diagnoses embraced by his contemporary Emil Kraepelin. In place of Krapelin's fatalistic definition of dementia praecox (and later schizophrenia) as an invariably morbid state, Meyer built a more flexible nosological entity, "parergasia", suggesting that severe psychosis only made sense in relation to social context, and that within this context substantial recovery was possible. As Michael Healey describes in his contribution, there is an important link between the Meyerian use of the social world in the categorization of disease and the Midtown Manhattan Study: a shift towards equating mental health with the ability to participate actively and responsibly in the community life and consequently the increasing social reintegration of patients with severe mental disorders.

Many factors connect the history of social psychiatry to the history of deinstitutionalization, including new research on psychiatric rehabilitation supported by the National Institute of Mental Health's Community Support Program, and increasing demand by psychiatric patients to take part in medical decision-making, and be accorded autonomy and respect like other medical patients (Myers

2015) Yet deinstitutionalization reforms also spread because they suited new turns in governance in the late twentieth century, which aimed to reduce people's dependence on public mental health systems in favor of models supporting their self-sufficiency and the consequences of individual behaviors (Braslow 2013).

As a consequence, many people living with severe mental illness in countries with and without national health systems have since become trapped in an endless cycle of homelessness, incarceration and fragmentary care (Hopper 2003). As Joel Braslow shows in his contribution in this issue, psychiatrists have unintentionally helped to rationalize and reinforce a system in which individuals with severe mental illness are caught in endless and unrelenting cycles between homelessness and incarceration. Examining patient case files from California state hospitals of patients treated between the 1950s and 1980s, Braslow investigates the ways in which contemporary psychiatric practice reproduces and reinforces a kind of "blindness" to psychiatric disease which was once a core part of psychiatric pathology—namely social suffering. If a homeless patient with evident psychosis presents at an emergency department in twenty-first century Los Angeles, they are now more than likely to be turned away at the door as their problems can be categorized as "social" but not "medical". Where the social world was once a core province of psychiatry, "social issues" are now used to displace responsibility for care for severe mental illness within a broken system of care.

## Remembering Social Medicine

In recent years, a revitalization of the field of social medicine in multiple sites around the world has worked to revisit the field in global perspective. Informed by histories of colonial psychiatry and anticolonial psychiatry such as Edington's contribution to this volume, this framework of social medicine did not merely diffuse outward from Western Europe and North America but instead found many key sites of theoretical and pragmatic development in Eastern Europe and Latin America, in South Africa and South Asia, and in Southeast Asia and East Asia as well (Pentecost et al., 2021). Examining the histories of social medicine is deeply connected to its reconception in the present and role in the future of medicine and public health.

The architects of the constitution of the World Health Organization, for example, were social medicine proponents who saw the relationship between social, economic and biological factors as crucial when they formed their broad definition of health (Packard, 2016). Yet social medicine after the Second World War has taken different forms in different parts of the world (Porter 2006; Porter and Porter 1988). Most practitioners identifying with the term would agree that social medicine means understanding health and delivering care around an understanding of the sociality of the mental as well as somatic health.

To demonstrate the importance of this intersection, consider one form of psychiatry which would not fall under the term "social psychiatry," but is now clearly associated with social medicine: the field of transgender psychiatry. As Ketil Slagstad recounts in this issue, trans healthcare in Norway from the late 1970s

throughout the 1980s, a field explicitly unrelated to mental hygiene or community psychiatry movements, was rooted instead in the principles and practices of social medicine, especially as they took shape in Scandinavian contexts. Psychiatrists and other medical doctors with a special interest and training in social medicine created a new diagnostic and therapeutic model where the social aspects of transitioning took center stage. In sex change therapy in Norway in the 1980s, psychiatry and social medicine became inseparable, as social aspects constituted an integral component of both the diagnostic evaluations as well as the therapeutic regime. Yet this approach could also be used to reproduce the prevailing gender norms, as social context was wielded as a tool to help patients adjust to society rather than change the very conditions that produced illness in the first place.

Social medicine, like social psychiatry, is a field of critical analysis and critical interventions. In the year that this special issue has taken shape, the world was disrupted by a pandemic whose social and biological effects have demonstrated perhaps too clearly how vital social medicine perspectives are to medical and public health. The Covid-19 pandemic has also shown how deeply interwoven the epidemiology of mental illness and access to mental health services are to both social factors and somatic health. A single emergent virus can create vast repercussions across social, economic, biological and medical fields. A WHO survey showed in the autumn of 2020 that the pandemic had disrupted or halted critical mental health services in 93% of the countries worldwide in a situation where the demand for mental health was increasing. Grief, isolation, loss of income and fear are exacerbating existing mental illness or creating new ones. This pandemic has demonstrated for all—however briefly this realization lasts—that the biological and social dimensions of medicine and public health are inextricably linked.

We end this introduction by turning again to the opening themes of the first essay of this issue. As Jonathan Sadowsky argues in his contribution to this volume, one reason why social psychiatry has not been considered in relation to social medicine is that many social scientists who study psychiatry continue to separate it from the rest of medicine. In a far-reaching historiographical engagement with the field, Sadowsky asks why historians of psychiatry over the course of the twentieth century have been so reticent to accept the field that they study as a part of medicine in general, and social medicine in particular. How, he asks, could the relationship between culture, medicine, and psychiatry be restructured in the twenty-first century to encourage more parity among all three terms? We leave it to readers of *Culture, Medicine, and Psychiatry* to answer this question.

**Declarations**

**Ethical Approval** This article does not contain any studies with human participants or animals performed by any of the authors.

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