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THE TROUBLED RELATIONSHIP BETWEEN PSYCHIATRY AND SOCIOLOGY

DAVID PILGRIM & ANNE ROGERS

ABSTRACT
The alienated relationship between psychiatry and sociology is explored. The two disciplines largely took divergent paths after 1970. On the one side, psychiatry manifested a pre-occupation with methodological questions and sought greater medical respectability, with a biomedical approach returning to the fore. Social psychiatry and its underpinning biopsychosocial model became increasingly marginalised and weakened. On the other side, many sociologists turned away from psychiatry and the epidemiological study of mental health problems and increasingly restricted their interest to social theory and qualitative research. An interdisciplinary void ensued, to the detriment of the investigation of social aspects of mental health.

INTRODUCTION
This paper has three aims. First, an indicative description will be given of the current alienation between psychiatry and sociology. Second, a brief historical account will be given about the emergence of the distance and distrust existing between the disciplines. Third, some negative consequences of the interdisciplinary void will be explored and some positive suggestions made about its repair.

Space does not permit a full content analysis of psychiatric texts and their recent position about sociology. Nor is there space to explore the ongoing fruitful dialogue between psychiatry and anthropology, where some overlapping interests with sociology can be found (e.g. Kleinman, 1988; Littlewood & Lipsedge, 1997). With these constraints of space in mind, our focus will be on psychiatry’s relationship with sociology, not the whole field of social science. Since 1970, the relationship between psychiatry and sociology has been distant and often hostile. Prior to that, as we will explore later, practitioners in the two disciplines were often active collaborators.

The position offered in a recent prestigious textbook of psychiatry will be taken as indicative of the inter-disciplinary alienation we wish to explore in the paper. Gelder et al. (2001), in the Shorter Oxford Textbook of Psychiatry, allocate over 23 pages to discussing ‘the contribution of scientific disciplines to psychiatric aetiology’. Of these, 17 pages are allotted to discussing aspects of bio-determinism (covered under headings of genetics, neuropsychology, neuropathology, physiology, endocrinology, pharmacology and biochemical studies). Sociology is mentioned in just two paragraphs of the 23 pages, with an accompanying
Many of the concepts used by sociologists are relevant to psychiatry [that is, the five topics listed above]. Unfortunately, some of these potentially fruitful ideas have been used uncritically, for example in the suggestion that mental illness is no more than a label for socially deviant people, the ‘myth of mental illness’. This development points to the obvious need for sociological theories to be tested in the same way as other theories by collecting appropriate data. (Gelder et al., 2001, p. 120–1, author’s comment in square brackets)

This passage is from an eclectic and comprehensive textbook, not one dedicated narrowly to biological psychiatry. Its authors are not, in principle, opposed to sociology making a contribution to psychiatry, as they make clear in the first sentence. However, the barely veiled sub-text, given the fraction of space allocated and its content, is this: ‘for the time being, sociology is of little use to psychiatry’. We now trace some historical reasons for this disappointment. This will begin to open up a scrutiny of each discipline and the difficulties created for and within the older bridging multi-disciplinary arena of social psychiatry.

THE IMMEDIATE PAST

During the past thirty years, psychiatric epidemiology and medical sociology have become, what Fenton & Charsley (2000, pp. 110–123) have called, ‘incommensurate games’. That is, the theoretical and methodological preferences of the two approaches to mental health problems in society have become discrepant. Moreover, the epidemiological wing of the profession only reflects a more widespread divide from sociology. Rogers & Pilgrim (2003) provide two examples that point up this divide.

The first is in relation to differences between the disciplines over the nature of mental health and illness. Criticisms of psychiatric theory and practice from sociologists have focussed on: the weak construct validity of diagnostic categories; the relative absence of longitudinal studies in psychiatric epidemiology; the dominance of empiricism at the expense of theoretical development; a lack of explicit reflection on the ideological nature of psychiatric theory and practice; and the interest work of the drug companies in the mental health industry.

The second major difference between the disciplines is in relation to service contact. Sociological analysis is more inclined to problematize this, whereas psychiatrists emphasise the inherently beneficent role of services. As a consequence, the emphasis of psychiatric epidemiology has been on mapping the need for early intervention or on equitable service access. Services are viewed as sites of an uneven right to treatment, rather than as a threat to well being and citizenship.

This leads to the epidemiological study of ‘need’ (i.e. numbers of identified diagnosed cases) in order to plan ‘appropriate’ services, inviting socio-political questions such as: ‘Who are they “appropriate” for?’, ‘whose “needs” are being met by mental health services?’, and ‘are notions of “access” or “service” meaningful, when coercion is involved?’ Sociological interest in the new social movement of disaffected patients ensures that these questions are
raised (Rogers & Pilgrim, 1991). In response, psychiatry limits its social policy interest to stigma, and only considers itself as part of the solution, not as part of the problem (Sayce, 2000).

Psychiatry, with good reason, has lost its trust in sociology. During the 1970s, sociologists from the Marxian and Weberian traditions began to use medicine as an object of sociological understanding or to illustrate a social theory (Reid, 1976). By the 1970s, medical sociologists had promoted themselves from handmaiden to ‘observer status’ (Illsley, 1975). After 1970, sociologists, increasingly saw themselves as providing a sociology of medicine. Prior to that, they had largely been content to make a sociological contribution to medicine.

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

These theoretical shifts within sociology disrupted a prior inter-disciplinary compatibility, by focusing on social phenomena being concept and context specific and by emphasising subjectivity and inter-subjectivity in their field of inquiry. Meanings, not just causes, were now considered to be important – the task for sociology was increasingly descriptive and interpretive (verstehen) rather than explanatory (erklären). The most extreme rejection was to come from post-structuralism, especially the work of Michel Foucault (1973), with its abandonment of causal reasoning, truth claims and any confidence in an independent reality, culminating in a focused exploration of ideas, language and ‘discursive practices’. With it came a concomitant abandonment of faith in quantitative methods, such as the survey techniques of epidemiology and the randomised controlled trial approach to testing treatment methods (including psycho-social interventions).

Prior to this trend, symbolic interactionism, a Weberian derivative from the Chicago School of sociology, was to make its mark in the study of people with mental health problems (e.g. Goffman, 1961). Lemert (1967) made a distinction between primary deviance (multifactorially caused) and secondary deviance (socially amplified by the reactions of others). 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.

Whereas the previous relationship between psychiatry and sociology had been built on cooperation, these newer studies were explicitly critical not only of the social control role of psychiatry but also of its knowledge base (Pilgrim & Rogers 1994). Moreover, the co-operation had worked previously, largely because sociology was co-opted by medicine to help solve its problems; a convenient advantage of the empiricist legacy of Durkheim after the Second World War. By the 1980s, the sociological attack on psychiatry, and the defensive reaction it provoked, led not to a prolonged and creative debate but instead to a breakdown in interest on both sides. Some organisational pressures then amplified this divergence. For example, the rules of the research assessment exercise in British higher education meant that sociological scholarship was less valued in medical schools, where empirical papers, not books, especially ones preoccupied with social theory, were privileged. In this context, sociology rather than psychiatry departments may have been more desirable work sites in the academy for sociologists.
The general trend of sociological criticism of psychiatry after 1970, understandably, was met with defensive counter-argument. Tetchy reactions from psychiatrists depicted sociological critics, with some justification, as being part of an international oppositional movement, which aimed to denigrate and discredit their profession (‘anti-psychiatry’) (Hamilton, 1973; Roth, 1973). This resentment against sociology was particularly evident from some who had previously gained much from collaboration between the disciplines (Wing, 1978).

The complex field of ‘anti-psychiatry’ was not inhabited solely, or even mainly, by professional sociologists. The key high-profile ‘anti-psychiatric’ critics, such as Ronald Laing, David Cooper, Thomas Szasz and Franco Basaglia, were dissident members of the psychiatric profession, though their critical products were largely sociological or philosophical in character. Moreover, a more recent generation of dissidents have become evident in the growth of ‘critical’ or ‘post’ psychiatry (Thomas, 1997; Bracken, 2003). Also anti-racist critiques within the profession continued to problematize psychiatric knowledge (Fernando, 1988; Sashidaran, 1993). The technocratic approach of bio-medical psychiatry was challenged by some psychiatrists, who emphasised the over-determining role of social factors in both aetiology and recovery (Warner, 1985; Ross & Pam, 1995) and the distorting effects of drug company interests on clinical practice (Breggin, 1993; Kramer, 1993; Healy, 1997).

This unbroken pattern of internal dissent suggests that many substantive problems about psychiatric theory and practice are both inherent and unresolved. These problems were not invented by mischievous sociological critics. Nonetheless, the sociological character of ‘anti-psychiatry’ meant that even internal critics of the psychiatric profession were tarred with the sociological brush. (Note the allusion in the passage quoted at the outset from Gelder et al. to the ‘myth of mental illness’, as if this notion constitutes an external attack from sociology. Thomas Szasz is a professor of psychiatry.)

Having characterised the last thirty years, which included the turbulence of ‘anti-psychiatry’ and intimations of a break down in inter-disciplinary collaboration (enjoyed by social psychiatry) in its wake, we now turn to the longer historical story of the alienation between the two disciplines.

**VICTORIAN ORIGINS**

In the Victorian period, under the influence of, and as a constituent of, eugenics, psychiatrists and Lunacy Commissioners used epidemiological methods. This first version of psychiatric epidemiology began with a preoccupation with counting cases of mental disease, not with mapping definitively known aetiological sources of psychopathology. Whereas infectious agents were the concern of medical epidemiologists, psychiatrists wanted to count and regulate mad bodies. In the eugenic view of Victorian psychiatry, the latter were both the victims of mental disease and its aetiological source. The sequestration of patients from society and their subsequent sexual segregation, in asylums, logically followed from this assumption.

Psychiatric epidemiology was bound up with a broad eugenic social policy of segregating an assumed ‘tainted’ gene pool, in what Marx called the ‘lumpenproletariat’. This gene pool was depicted as the source of various forms of deviance, including, but not limited to, madness (Scull, 1979; Porter, 1989; Forsythe, 1990; Marshall, 1990;). This eugenic period was medically dominated and not inviting to sociologists, even though more widely, in main-
stream 19th century medical epidemiology (social medicine), sociology was finding a significant practical role. Indeed, the roots of medical sociology can be traced to social medicine (Rosen, 1979; Kleinman, 1986).

Dohrenwend (1998) points out a shift in the eugenically-driven consensus by the 1930s and 1940s:

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, p. 224)

Economic and war conditions were undoubtedly influential in shaping the production of psychiatric knowledge. One clear example, earlier in Britain, was the environmentalist challenge to the eugenic, asylum-derived, bio-deterministic legacy, which came from the shellshock doctors returning from the First World War (Stone, 1985). Another was the impact of observing concentration camp inmates, which inspired the development of the concept of ‘institutional neurosis’, in the British asylums of the 1950s (Barton, 1958). These examples highlight the post-Victorian emergence of mutual sympathy between environmentally-orientated social psychiatrists and sociologists.

**THE SALAD DAYS OF COLLABORATION**

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

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

The collaborative period was particularly influenced by the development of human ecology, a theoretical trend within the Chicago School of sociology (Pilgrim & Rogers 1994). A seminal study based on this human ecology approach (*Mental Disorders in Urban Areas*) was published by members of the Chicago School (Faris & Dunham, 1939). In exploring
the influence of poverty and deprivation, the authors 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 focussed on social isolation as a possible aetiological factor, Hollingshead & Redlich (1958) reflected the popular appeal of Freudian ideas, which were prevalent in the USA at that time, in their subsequent study.

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

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

**MUTUAL DISILLUSIONMENT**

Given the obvious common concern for ‘the social’, in both medical sociology and psychiatric epidemiology after the Second World War, a trajectory was set for long term inter-disciplinary collaboration. But this did not happen. The reasons for the breakdown in the relationship are complex but, for the purpose of this article, can be grouped into three. First, there were shifts of emphasis and theoretical preference inside sociology. Second, there were also shifts inside psychiatry. Third, some of the alterations within each discipline were a function of the negative interaction of these shifts. Mutual suspicion and disdain occurred, which lead to a vicious circle of shrivelling positive interest in the other party’s concerns. These three groups of points will be unpicked here.

**Theoretical shifts in sociology**

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

Psychiatry accepted that, as its disease categories were so tenuous and not generally marked by physical signs, the sociologist’s concepts of impairment or disability marked by social dysfunctions could be the key to unravelling the rates of mental illness. (Lawson, 1989, p. 38)

Note how the notion of ‘mental illness’ remained in tact but psychiatrists were able to accept alternative views than an illness model. Moreover, in relation to secondary and tertiary prevention, strong alliances were made with sociologists. For example, this included research into the role of adverse and alienating conditions within mental hospitals, which demonstrably maintained and amplified pre-existing psychiatric disability- ‘institutionalism’ (Brown & Wing, 1962).

After 1970, this reliance on a Durkheimian view in sociology and the Freudian influence on continuum models in psychiatry was changed radically. Sociologists (and psychologists) increasingly attacked the growth of neo-Kraepelian psychiatry, with its rigid pre-occupation with categories, for confusing the map with the territory. For example, psychiatrists assume that ‘schizophrenia’ is a non-problematic fact, when it is simply a codification of ordinary judgments about madness and provides little or no additional scientific value to these lay ascriptions (Coulter, 1973; Bentall et al., 1988; compare with Wing, 1978). Moreover, what psychiatrists now call ‘schizophrenia’ is not what was originally described by Kraepelin and Bleuler (Boyle, 1990). With psychiatric categories being such easy targets for criticism, scepticism about the reality of mental illness, sometimes reached nihilistic proportions. Radical constructivists rejected mental illness as a total error of reasoning (a ‘myth’ or a ‘metaphor’ not a fact (Szasz, 1961)).

After Szasz, the radical internal critic of psychiatry, and under the sway of Foucauldian critiques of psychiatry, more and more sociologists depicted mental illnesses as social representations or epiphenomena produced by psychiatric activity utilising preferred reified categories (Miller & Rose, 1988; Prior, 1991; Parker et al., 1997). By 1980, most sociologists had neither the theoretical inclination, nor the practical competence, to support social psychiatric research. They became deskillled as social psychiatric collaborators.

**Shifts (and continuities) in psychiatry**

By the end of the 20th century, far less consideration was being given to social psychiatry, which was contained increasingly on the margins of the profession (Moncrieff & Crawford, 2001). The biopsychosocial model (Engel, 1980), favoured by many academic psychiatrists, was being displaced by the ‘decade of the brain’, which inspired expressions of biological triumphalism in its advocates (Shorter, 1997; Guze, 1998; compare with Clare, 1999).

Despite the environmentalist phase in epidemiology and the growing confidence of social psychiatry after the Second World War, the biological aetiology of madness was deemed to be confirmed in the core of the profession by the apparently dramatic impact of the phenothiazine group of drugs. These were now connoted by their producers and prescribers as...
‘anti-psychotic’ agents, implying curative capability, rather than them being crude symptom-control adjuncts for some patients, some of the time (Moncrieff, 2002). With hindsight, critical psychiatric historians have demonstrated that the ‘pharmacological revolution’ was, if not a total myth, a considerable uncertainty (Scull, 1979). The policy of de-institutionalisation was the product of a variety of fiscal and ideological forces; these drugs had little or no impact on this policy trend (Warner, 1985; Rogers & Pilgrim, 2005).

However, more conservative accounts continued to depict madness as a biochemical brain disturbance, pre-determined by a genetic fault but increasingly amenable to medicinal remediation (from first the ‘old’ and now the ‘new’ ‘anti-psychotics’). For example, Csernansky & Grace (1998) remained committed to the ‘pharmacological revolution’ view and claimed that subsequent neuroscientific research provides us now with unequivocal evidence of ‘schizophrenia’ as a genetically pre-programmed brain disease (compare with Boyle, 1990).

The negative impact of the interaction
The impact of the shifts in the two disciplines was very clear. Mutual hostility developed, with sociological critics turning away from psychiatry. Eventually there was even a diminishing interest in mental health as a sociological topic of inquiry. Many promising beginnings, for example in labelling theory and in the ethnographic study of psychiatric patients, petered out and were displaced by other more pressing concerns in the sociology of health and illness (Cook & Wright, 1995). After 1980, sociologists still researched mental health. For example, some new work appeared on modified labelling theory (Link et al., 1989), users’ views of psychiatric services (Rogers et al., 1993), problems with psychiatric nosology (Kutchins & Kirk, 1997) and race and mental disorder (Nazroo, 1998) but the extent of this interest was notably less than in the 1970s. Moreover, this work rarely attempted to re-build broken bridges with psychiatry; usually the opposite applied or was implied.

As for psychiatry, it retreated into ‘methodologism’ and ‘quantitativism’, after 1980, unchecked by critical reflection about its reified diagnostic categories. It did not deal comprehensively with the philosophical attacks on its knowledge base, let alone abandon categorical reasoning as a lost cause. Instead, psychiatrists aspired, to attain better construct validity, akin to improving the measurement of other epidemiological variables, such as hypertension (Fryers et al., 2000).

At the very time when many sociologists were retreating into philosophical forms of anti-realism, within a wider trend of post-modern social science, psychiatry retrenched and became pre-occupied with defending its methods and its claims to medical respectability and objectivity – what Hoff (1995) calls ‘medical naturalism’. There was a ‘return to medicine’, with an increasing interest in linking epidemiology to neuroscience and genetics (Wittchen, 2000). In clinical psychiatry, discredited pharmacological solutions did not lead to therapeutic pessimism and a return to the social. Instead, faith was re-stated in a biomedic approach, supported by the pharmaceutical industry producing and profiting from new agents. Many in one discipline naively took the reality of mental illness for granted and looked forward to the next breakthrough in biological treatments (the pharmacological revolution became permanent). Many in the other readily abandoned reality as unknowable. A breakdown of trust and comprehension between the disciplines inevitably ensued.

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

Thus, this most recent phase in psychiatric epidemiology, since 1970, has been characterised by greater diagnostic specificity and case identification, which accord with the ‘medical necessity’ for intervention. This can be contrasted with the collaborative phase of research, which was more concerned with the identification of the social causes of, or dominant influences on, mental health problems.

Currently, policy and practice imperatives remain firmly rooted in a concern with identifying rates of diagnosed mental illness in populations in order to provide sufficient specialist services. This has largely displaced the community and environmental focus of studies during the phase of collaboration, although in some recent studies both strands of interest can be found (e.g. Ostler et al., 2001). Overall though, it is fair to say, in summary, that psychiatry seems to have gone full circle over a century, from eugenics to environmentalism and then back to genetic determinism and the service need it implies. This pattern can be seen in the theoretical changes in psychiatric nosology.

The categories of DSM-I were heavily influenced by both psychoanalytic theory and wartime social psychiatry (Carpenter, 2000). Later shifts in DSM and the section on mental disorders in the International Classification of Diseases brought about major changes in case identification and classification. DSM-II, whilst not adhering to what may be viewed as explicit social aetiology, nevertheless incorporated psychoanalytically influenced ideas about causal antecedents. By contrast, the specific aim of moving to DSM-III was to expunge causality from diagnosis in favour of behavioural description:

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

The ‘a-theoretical’ position about aetiology, far from signifying non-committal eclecticism, had the effect (if not the intention) of eliminating confidence in social causation. Subsequent changes from DSM-III to DSM-IV represented a further elimination of patient subjectivity and their biographical and social context, in favour of an anti-holistic model of mental illness, compatible now with biological psychiatry (Mishara, 1994; Wallace 1994). This emphasis on behavioural criteria and the silencing of social causation hypotheses may signal a normative North American ideology.
Carpenter (2000) views the trend of promoting standardised categories of normality and disorder in DSM as part of a US-inspired ‘MacDonaldisation’ of social and economic life. For Carpenter, DSM-IV represents ‘the psychiatric equivalent of the World Trade Organisation (WTO), promoting the principles of American Universalism as objective standards that are beyond reproach’ (Carpenter, 2000, p. 615). Certainly one of the consequences of this focus on measurement and ‘objective’ criteria has been a negation of the consideration of social context and personal experience (the routine concern of medical sociology), as a core part of the psychiatric research endeavour.

Whilst more robust methods and credible diagnostic constructs have been the product of recent activity in 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 low 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 psychiatric epidemiology after 1980.

THE PROBLEM STATED RE-VISITED

Now that an historical account has been given of the breakdown of trust and cooperation between psychiatry and sociology, where does it leave the social investigation of mental health problems and mental health services? There are a few answers which are evident and some have been noted already. Sociologists have become deskilled in epidemiology. Psychiatrists have become weary and defensive about philosophical attack, so that wholly legitimate questions about the role of their profession in society or their dubious knowledge base are pre-emptively dismissed by allusions to ‘anti-psychiatry’. A blocked dialectic has occurred, so the disciplines either do not talk or they talk past each other.

Despite the multiple sources of evidence about the social origins and consequences of mental health problems, they have been weakly represented in recent health research, which has placed a greater emphasis on social inequalities in physical morbidity and mortality (Muntaner et al., 2000). In health inequality research, mental health status has been afforded a central role as a mediator but has been studied less often as an outcome of social forces (Wilkinson, 1996; Rogers & Pilgrim, 2003). One factor in this relative lack of recent scrutiny of mental health outcomes is the loss of collaborative synergy, which had previously existed, between psychiatrists and sociologists.

The mutual distrust between sociology and psychiatry over the past thirty years may reflect an entrenched and irreversible alienation. If this conclusion is accurate and prescient, then only a small rump of neo-Durkheimian sociologists will remain within the fold of social psychiatry and conduct traditional epidemiological research (e.g. Kessler et al., 1994). A more optimistic scenario is that of a greater (re-)engagement between the disciplines. For this to occur, some compromises are probably needed on both sides. Psychiatrists would need to concede the epistemological problems they inherit and the professional self-interest, which has driven the most recent version of epidemiological research.
Turning to sociologists, they too would need to step out of their disciplinary boundary and re-appraise their potential contribution. Post-modern social theory, in particular, has left many sociologists antithetical to, and de-skilled in, empirical projects. A consequence is that the deconstruction of psychiatric knowledge has become a well-trodden but inadequate substitute for considered and detailed explorations of mental health inequalities. The sociological curriculum may need to re-introduce more robust training in epidemiology to complement current preferences for social theory and qualitative methods.

The recent orthodoxy of sociology may need to shift back to some version of realism rather than of constructivism before a bridge with psychiatry can be re-discovered. There are some signs of this where critical or sceptical realism is challenging social constructivism. Critical realism accepts a weak version of social constructivism (that knowledge is socially constructed and interests are at work in particular contexts) but does not reject the possibility of discovering how a web of material reality causally impacts on psychological functioning (Bhaskar, 1989; Greenwood, 1994; Sayer, 2000; Rogers & Pilgrim, 2005).

Ironically, some psychiatrists, influenced by constructivism, make similar pleas for methodological pluralism and multiple theorisations and they encourage sociological inquiry into the practical world of their profession (Bracken, 2001). Thus, points of engagement between constructivism and realism are evident or possible. Sociologists, hamstrung by the nihilism of postmodernism, could discover that it is possible to be empirical without necessarily being naively empiricist. Psychiatrists might discover the advantages, not just the disadvantages, of making their discipline an object of critical sociological inquiry. There are already signs that some social psychiatrists are willing to take the risk of inviting sociological contributions of this kind (e.g. Thornicroft & Szmuckler, 2001).

If some form of rapprochement is not negotiated between the two disciplines then sociology will be reduced to the type of small, grudging and distrustful concession permitted by psychiatric textbooks cited at the start of this paper. The risk will be created of a whole raft of topics not finding a professional psychiatric audience related, for example, to: the role of psychiatry in society; the sociology of psychiatric knowledge; the social antecedents and consequences of mental health problems; the social aspects of service contact; the role of the drug companies in shaping psychiatric theory and practice; the new social movement of disaffected psychiatric patients; the social conditions engendering or inhibiting personal well-being; and the relevance of race, class and gender, when understanding people with mental health problems and the services they encounter. Ground would need to be given, on both sides, to achieve this ambition of re-discovering a collaborative relationship between psychiatry and sociology. Until this happens, social psychiatry may continue to exist as a fractured and precarious bridge between the two disciplines.

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