BJPsych | The British Journal of Psychiatry (2016)
209, 1–2. doi: 10.1192/bjp.bp.115.175349

Editorial

Why do we need a social psychiatry?

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Summary
Human beings are social animals, and familial or social relationships can cause a variety of difficulties as well as providing support in our social functioning. The traditional way of looking at mental illness has focused on abnormal thoughts, actions and behaviours in response to internal causes (such as biological factors) as well as external ones such as social determinants and social stressors. We contend that psychiatry is social. Mental illness and interventions in psychiatry should be considered in the framework of social context where patients live and factors they face on a daily basis.

Declaration of interest
D.B. is President of the World Psychiatric Association.

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For centuries, psychiatry was known as alienism and psychiatrists as alienists. Treatments have been aimed at making patients behave in a way acceptable to society since society generally defined behavioural deviance (abnormalities). Patients (the aliens) were locked away in distant institutions hidden from public gaze although people visited these asylums to gawp at patients. Although there has always been an emphasis on aetiology and biological aspects of mental illness, we believe that psychiatry is social and needs to focus more on social determinants and consequences of such illnesses, according to the biopsychosocial model.

There is increasing evidence that social determinants of health play a major role in the genesis of both physical and mental illness.[1] Human beings grow up and develop within society and specific cultures and their upbringing and learnt interactions define their behaviours that in turn affect brain structures leading to dysfunctions.

What is health?

The widely accepted World Health Organization's definition of health, which focuses on the 'absence of diseases', has been criticised arguing that it does not include the social domain and individuals' ability to manage one's life by fulfilling their potential and obligations with a degree of independence.[2,3] This is particularly important now in that people are living longer with comorbidities, and with many conditions people can be well at times and ill at others. For example, an individual with bipolar disorder can continue to function effectively between illness episodes. Thus, the question arises, when are they to be seen as healthy? It can be argued that health is a dynamic balance between opportunities and limitations, directly affected by social and environmental conditions. In addition, we believe that the social domain is highly pertinent in our understanding and management of psychiatric disorders, and can be seen as a crucial aetiological factor.[4] Current advances such as mirror neuron systems reflect the importance of social cognition that governs human social interactions.

Development of the mind, empathy and mentalisation abilities are affected by psychosocial interactions and social environment, and difficulties at these levels can lead to psychopathological and behavioural dysfunctions. Social stressors can lead to changes in the cerebral structure and affect neuro-hormonal pathways.[5] Even organic conditions such as dementia are said to be related to life events and social factors such as economic and educational status.[5]

Virchow[6] maintained that illness (of any kind) was an indictment of the political system and that politics was nothing other than medicine on a large scale. This remains apposite even now. The idea that medicine is social is not new or recent[7] but it keeps being ignored when it is argued that changes in brain structure are needed to demonstrate the existence of a psychiatric diagnosis.[8]

The social medicine model is much more applicable to psychiatry as this aids our understanding of what is considered behaviourally normal and what is construed as deviant. Of course, definitions of what is seen as deviant change according to social norms and consequently the criminal justice system becomes involved in dealing with deviance. Psychiatrists as managers of society's concerns and expectations need to continuously evolve in their professional development and through regular updates and training.[9]

McHugh & Slavney[10] offer a very helpful perspective in explaining mental disorders, including disease, dimensional, behavioural and life-story perspectives. A disease perspective focuses on clinical entity, pathology (perceived or real) and aetiological factors. For psychiatric disorders both dimensional and behavioural perspectives are more likely to be socially determined as well as influenced by cultural and social values. The patient's functioning is seen within a tight framework of 'social functioning' as determined by the culture or society. Many previously commonly diagnosed disorders such as catatonia, hebephrenia, hysteria or conversion disorders have dwindled in the West over the past few decades. The shift from decline in hysteria to an increase in self-harming behaviour, eating disorders, post-traumatic disorder and substance misuse then begs the question whether symptoms have simply altered in response to changes in social expectations on the individual within a rapidly changing social structural system.

The key components of any therapeutic encounter in psychiatry belong to the patient–doctor interaction and are strongly influenced by patient perspectives and expectations. Patients' and carers' beliefs, explanatory models, past experiences, culture of the healthcare system and the profession itself within which psychiatry is practised are some of the key aspects of patient engagement. Disparities in rates of psychiatric disorders are the result of ethnic, racial, cultural and social determinants. Also,

biological vulnerabilities play a large role in psychosocial development and disorders, and set off social determinants that in turn can influence biological factors.

Social patterns and brain structures

Malekpour[11] points out that infants upon birth are far more competent, social, responsive and more able to make sense of their environments than previously assumed. Thus, early social interactions start to build individual identity and modify underlying brain structures. The brain being more plastic at this stage responds well to social interactions leading to structural changes.

Insel & Fernald[8] noted that even for rodents, housing has profound effects on their brain structures and that such behavioural and genetic manipulations can be affected by rearing conditions. It is of interest to see that even within animal experiments often the focus shifts to biological and structural changes ignoring the 'social' factors such as overcrowding.

There have been recent suggestions that genetic mutations, for example, may be influenced by stressors to push individuals towards developing psychiatric disorders. Maric & Svrakic[12] postulate that genetic defects ('first hit') by themselves may not lead to illness but this may be expressed following interaction with another genetic, biological or psychosocial environmental variable ('second hit') leading to expression of pathological mutation and brain changes.

Epigenetics is a relatively new field that involves understanding how environmental influences modulate gene activity. Stress–vulnerability response psychosis models have existed for quite some time but epigenetics focuses on vulnerability at micro-levels and greatly supports understanding of this process. Epigenetics plays a mediating role in the onset of schizophrenia. Poor maternal nutrition and physical health, infections and psychological status affect child psychosocial development, factors often linked to social deprivation, poor social support and healthcare systems. Social and cultural factors such as poor parenting, adverse childhood experiences (abuse, neglect and bullying) affect brain and social development increasing future vulnerability to various severe mental disorders, including schizophrenia.[12]

Thus, social factors are important at every stage of human development starting from the prenatal stage or even earlier when wider environmental factors are considered. Importantly, they may provide us with clues towards more preventive public strategies in reducing psychiatric morbidities. The impact of globalisation on the human brain is yet to be fully comprehended. With a rapidly shrinking world and changing social relationships through an ever increasing use of social media is already bringing about changes in perception of self-esteem and self-image.

The way forward

We propose that sociocultural dimensions of individual experiences and distress as life story narratives are incorporated better into diagnostic and management frameworks. The practice of medicine as a whole, but psychiatry in particular, has to be seen in the context of social milieu. This may help patients' understanding of their own distress and balance clinicians' emphasis on the biological model of explanations. There needs to be better integration of various complex strands of biological, psychological and social psychiatry with the developments in the evolving field of neurosciences and social cognition. Social interventions are crucial for the prevention of psychiatric disorders and clinicians need to lead on the agenda for public mental health. Social and cultural aspects of illness need to be included from an early stage of the medical undergraduate curriculum. Psychiatry has a moral responsibility to speak for its patients and their needs, to take its role and responsibility in public mental health more seriously and highlight the impact of social inequalities and resulting inequalities as a result of mental illness. The profession needs to acknowledge the importance of social aspects of medicine and its sequelae, but equally importantly speak for and advocate for those who are most vulnerable and may not have a voice or may not be heard.

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First received 8 Sep 2015, final revision 9 Feb 2016, accepted 7 Mar 2016

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