

The art of medicine

An ounce of prevention

On Feb 5, 1963, President John F Kennedy made a provocative speech to the US Congress. His topic? Mental illness. According to Kennedy, mental health problems affected more people, required longer treatment, drained more financial resources from both individuals and the state, and caused more suffering than any other health conditions in the USA. The situation, he emphasised, could not persist. Claiming that recent public health advances had largely controlled infectious diseases, Kennedy argued that a similar “bold new approach” was required to “attack” mental health problems. He urged that society needed to “seek out the causes of mental illness and of mental retardation and eradicate them. Here, more than in any other area, ‘an ounce of prevention is worth more than a pound of cure.’” What were the causes that Kennedy wished to eradicate? Targeted above all were “harsh environmental conditions”.

Kennedy’s preventive message sounds somewhat strange today. When most people think of mental illness, they tend to think about treatment, whether it be pharmaceutical or psychotherapeutic, the early identification of various disorders, and reducing the stigma associated with mental health problems. The causes of mental illness are also of interest with much recent research concentrated on the neurological origins of mental illness, often thought to be genetic in nature. Prevention does not feature so prominently, with the exception of preventing specific acts, such as suicide. Such lack of interest is perhaps surprising since for most of the 20th century and, indeed, for previous centuries, prevention was believed to be an important part of mental health care. Whether it be avoiding the wrath of the gods and keeping one’s humours in balance, or resisting the urge to masturbate, imbibe, or study too much, mental illness was considered preventable. By the early decades of the 20th century, familial and social causes began to dominate, echoing the theory and influence of Sigmund Freud and Adolf Meyer, among others. Newly described disorders, ranging from neurasthenia to shell shock, also suggested specific environmental factors had a role in these disorders. Meanwhile, the turn of the century saw the emergence of the mental hygiene and child guidance movements, particularly in the USA. Led both by psychiatrists, such as Adolf Meyer and William Healy, and former patients, such as Clifford Beers, these initiatives put prevention at the forefront of psychiatric practice and public mental health policy. While some approaches—for instance, the 19th-century focus on preventing masturbation and over-study in children—now seem absurd, the fact that those involved in mental health care were adamant that prevention was part of their remit should not be dismissed.

Preventive mental health strategies became even more popular in the USA after World War 2. Due to the surprisingly high number of military recruits rejected on mental health grounds, American psychiatrists, such as Robert Felix and William Menninger, grew concerned that they had underestimated the number of people coping with mental illness. If the number of rejected recruits was representative of American society as a whole—and if one took into consideration the hundreds of thousands of people already in psychiatric hospitals, some receiving little treatment and insufficient care—then it was thought to be imperative to take aggressive prophylactic action. The situation was made even more pressing by the dominance of psychoanalysis in American psychiatry, which tended to treat patients using one-on-one, expensive, and time-consuming psychotherapy. The efficacy of psychotherapy, not to mention more invasive surgical or shock treatments (for example, lobotomy, insulin shock therapy, and electroconvulsive therapy) notwithstanding, psychiatrists such as Leon Eisenberg worried that there were “more people struggling in the stream of life than we can rescue with our present tactics”. Concern reached the heights of power in Washington, DC, when the National Mental Health Act was passed in 1946, which led to the foundation of the National Institutes of Mental Health (NIMH), headed by Felix.

The psychiatric approach that dominated the first two decades of NIMH and American psychiatry more generally during this period is one that is scarcely remembered today: social psychiatry. A descendent of the earlier child guidance and mental hygiene movements, but also influenced by new social scientific investigations into mental illness, social psychiatry traced the causes of mental illness to socioeconomic problems, such as poverty, social isolation, overcrowding, poor education, and violence. Address these problems, contended social psychiatrists, and the rising rates of mental illness targeted by Kennedy would be checked.

Although it is true that the definition of social psychiatry became fairly muddy by the late 1970s, during the mid-20th century its definition was quite clear. It was, as the highly influential British psychiatrist Sir David Henderson stated in the introduction to the second volume of the *International Journal of Social Psychiatry* in 1956, “first and foremost a preventive psychiatry. It strives to combat all those causes of social and environmental nature which are manageable”. In other words, when Kennedy highlighted the “harsh environmental conditions” connected with mental illness, he had social psychiatry very much in mind.

Social psychiatry in the USA during the 1940s and 1950s was informed by earlier sociological research, such as that done by Robert E L Faris and H Warren Dunham in Chicago. Faris and Dunham found that a high proportion of people with schizophrenia came from impoverished neighbourhoods, characterised by transience, isolation, and instability, along with other social problems, such as sex work, poor housing, violence and substance use. Faris and Dunham formulated dozens of maps indicating the “schizophrenogenic” areas of the city. Although some questioned their conclusions, often contending that people with mental health problems “drifted” to such areas, thus skewing the results, many psychiatrists were impressed by what insights could be gained from such an approach.

Later social psychiatry projects were even more inter-disciplinary. In 1958, for example, sociologist August B Hollingshead and psychiatrist Frederick C Redlich wrote *Social Class and Mental Illness: A Community Study* (1958), which investigated the epidemiology of mental illness and the provision of mental health care in New Haven. Delving deeply into the history of New Haven, as well as relying on anthropological and sociological methodologies, Hollingshead and Redlich determined that an individual’s position on New Haven’s five-tier class structure had a major effect on whether they succumbed to mental illness and how likely they were to receive treatment. They found that members of the lowest class (class V), who tended to subsist on temporary or seasonal unskilled work, were three times more likely to be treated for

mental illness than the members of class I and II combined, the classes representing the city's elite. The authors wondered, however, whether American society was ready to confront the bitter reality implicit in their conclusions, that if the rising tide of mental disorder was to ebb, the gulf between rich and poor had to be reduced.

Irrespective of how American society viewed such provocative assertions, leading psychiatrists and politicians needed little convincing. Spurred on by additional studies, such as the Mental Health in the Metropolis: The Midtown Manhattan Study (1962), the drive to reduce the number of patients in psychiatric hospitals (to save costs as much as for therapeutic reasons) and the social welfare agenda of Kennedy and Lyndon B Johnson, the social psychiatric agenda took hold in NIMH, in the American Psychiatric Association, and in Washington, DC. After Kennedy's speech to Congress, the Community Mental Health Act was passed on Oct 31, 1963, providing federal funding to build 1500 community mental health centres throughout the nation. Such centres would not only treat mental illness in the community, but also prevent it by early identification and treatment and by working with community leaders to address its social determinants. After Kennedy was assassinated 6 weeks later, pressure grew to extend the legislation to cover the staffing costs of such centres. The amendment, which was passed in 1965, suggested that social psychiatry had blossomed.

And then the bloom fell off. Despite the interest of politicians, psychiatrists, and social scientists, the passage of legislation and escalating concern about mental health issues, by the late 1960s the social psychiatry movement was struggling in the USA. A whole host of factors were responsible, ranging from the cost of the Vietnam War and the election of the sceptical President Richard Nixon to the increasing popularity of psychopharmacology, doubts about the tenets of social psychiatry itself, and the resistance of psychiatrists to become the social actors social psychiatrists expected them to be. A suggestion made in the *American Journal of Psychiatry* that psychiatrists should spend time volunteering in public hospitals and clinics, for example, incited an acidic response. Psychiatrists that suffered from such a "Robin Hood Complex", one respondent argued, denied "elementary economic and political facts of life". More generally, as Secretary of Health, Education, and Welfare, John W Gardener described with respect to all welfare programmes, there was "a crunch between expectations and resources". This "crunch" would be felt heavily by people with mental health problems, who increasingly found themselves homeless or imprisoned as asylums closed.

Given that the chief tenet of social psychiatry was prevention, there is an irony that the American economic situation undermined its progress. After all, social psychiatry emerged largely in response to the sheer cost of treating mental illness. Social psychiatrists might well have overestimated the role of social factors in mental illness, and been overoptimistic about the capacity of the USA to undergo fundamental socioeconomic change, but the link between the social environment—broadly defined—and mental health remains. Rising rates of suicide and depression in recession-hit Europe are but one recent indicator that, although social psychiatry has faded, the issues it raised have not. Whether mental health professionals and politicians are as willing to tackle the issue today as they were in the 1960s, however, is another question.

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