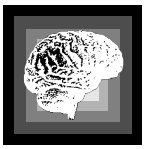

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The 'social' in psychiatry and mental health: quantification, mental illness and society in international scientific networks (1920s–1950s)

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Abstract

The post-World War II international mental health movement placed significant emphasis on the concept of the 'social environment', a true paradigm shift in thinking about the causes of mental illness. Rather than focusing on individual risk factors, experts and policy-makers began to consider the interplay between social context and mental health and illness. Also, during this period, quantification gained prominence within the expanding field of Western psychiatry. Eventually, the concept of the 'social' became fragmented into quantifiable social determinants that could be correlated with mental illness and subjected to systematic neutralization. This trajectory paved the way for the prevailing biomedical psychiatric epidemiology. This broader inquiry challenges us to redefine our understanding of the 'social' in the context of mental health research and practice.

Keywords

Psychiatric epidemiology, quantification, scientific networks, social causes of illness

Introduction

Over the past few decades, the prevalence of mental disorders has gained significant attention in mental health policies and contemporary culture, driven by the dominant paradigm of evidence-based medicine (Lovell, Read and Lang, 2019; Marques, 2017). The media and public spheres in many countries frequently discuss rates of depression and anxiety. While psychiatric epidemiology remains a territory of experts, its impact on our understanding of the social aspects of mental illnesses is undeniable. Long before it became part of our cultural idiom, this discipline delved into the representation of the social and the interplay between social environments and individual mental health.

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To a large extent, during its emergence in the hygienist context and immediately after World War II (WWII), 'mental health' served as a means to address and combat the social problems arising from modernity, and to foster 'healthier societies'. The concepts of 'mental hygiene' and 'mental health' drew on both explicit and implicit notions of the 'social', a term that, in this analysis, refers to the broader context which transcends the individual and can have a significant impact on mental health and illness, alongside the biological and psychological dimensions. Recognizing this historical context, it is important for historians to consider mental health not only as a field related to psychology and psychiatry but also as an integral part of the unfolding history of the 'social question' in industrializing and colonial countries of the nineteenth century (i.e. concerns about the social order stemming from the disenfranchisement of rural and working-class populations (Castel, 2001: 675–745; Castel, 2011; Donzelot, 1980: 170–9; Ewald, 1986; Thomson, 2006: ch. 5). Jacques Donzelot, in his work *L'invention du social*, explored how the concept of the 'social' emerged as a theoretical and practical necessity for political and economic elites governing their countries and managing the so-called 'dangerous classes' (Donzelot, 1994: 21–33; on the 'invention of the social', see p. 139). Additionally, Ian Hacking's historical and epistemological studies shed light on how statistics contributed to the development of a new understanding of society, one that appeared to be more random than nature but seemingly knowable and controllable through statistical methods (Hacking, 1999).

Following World War I, numerous disciplines emerged with the aim of analysing the interactions between the social, biological and psychological aspects in healthy and pathological manifestations. Scientific committees engaged in the development of these disciplines may serve as valuable observation fields, providing rich sources for a historical epistemology of their subjects. Undoubtedly, the international arenas that bore witness to the blooming of mental hygiene, mental health and the globalising psychiatry movements during the period from the 1920s to the 1950s functioned as fertile ground for the construction of discursive frameworks, enabling the circulation of ideas and values. As historians of the field have noted, these spaces provide a valuable vantage point for analysing the conceptual foundations underlying our current understanding of psychiatry and mental health.

This is particularly evident in the case of mental hygiene, which gained global recognition despite the considerable disparities between local and national contexts (Thomson, 1995). Historians have highlighted the importance of mental hygiene as a conceptual framework for disseminating modern psychiatric concepts and practices. For example, building upon Ruth Rogaski's (2004) study on 'hygienic modernity', Howard Chiang has characterized the hygienic movement as a form of epistemic modernity, a discursive cultural apparatus that mediates the relationship between knowledge systems, namely Western psychiatry and local knowledge cultures (Chiang, 2009: 112).

We may argue that the international congresses on mental hygiene laid the groundwork for the post-WWII concept of mental health. It is noteworthy that the term 'mental health' had already found its place in the lexicon as early as the 1930s. For example, the First International Congress on Mental Hygiene, held in 1930, prominently emphasized the vital goals of protecting and conserving mental health. These objectives resonated with the visionary principles championed by Clifford Beers, who, having experienced internment himself, dedicated his life to 'reform abuses, improvement in the treatment of mental patients, and protection of the mental health of the public at large' (Williams, 1932: 2). However, it was in the late 1940s and early 1950s that the concept of mental health flourished and became institutionalized, expanding mental hygiene by incorporating new realms of knowledge, particularly from the social sciences (Wu, 2015: 170–1; 2021: esp. ch. 2). Concurrently, in the field of psychiatry, specifically at the congresses of the newly formed World Psychiatric Association, efforts were made to integrate the social dimension into the understanding of mental illnesses.

The purpose of this article is to address the question of how mental hygiene, mental health and psychiatry incorporated concepts of the 'social' into their scientific projects when presented at the transnational level during the crucial decades of their development in the twentieth century. To tackle this question, the focus will be on analysing the published procedures of the congresses, including speeches, scientific presentations and discussions, as well as participant information, such as their countries, professions, gender and institutional affiliations. Around 1950, two major international scientific networks dedicated to mental health gained momentum through distinct yet interconnected projects. The World Psychiatric Association aimed to unify psychiatric concepts, practices, and institutions worldwide, while the World Federation of Mental Health sought to promote individual and social mental health, simultaneously working towards world peace through mental health initiatives (Wu, 2021: 42–3). These networks and associated projects claimed continuities and discontinuities with pre-WWII mental hygiene. At their international congresses, both organizations traced their origins to the early twentieth century. Although they converged in their goal of reducing mental illnesses through prevention, they differed significantly in their definitions of the scope of action and the relevant social environment to address. Various professionals were involved in shaping these definitions, with psychiatrists primarily engaged in the globalisation of psychiatry, while professionals from diverse backgrounds were committed to the cause of mental health.

Methodology: analysing the quantification and the semantics of the 'social' in international congresses

In this study, I propose an empirically grounded exercise in historical epistemology, focusing on the articulations of the 'social' as a set of factors or determinants influencing mental health and mental illness. Specifically, I examine two significant transnational movements in psychiatry and mental health during the period from 1930 to 1950: the International Committee for Mental Hygiene (later renamed Mental Health) and the association responsible for organising the International Congresses of Psychiatry (which ultimately led to the establishment of the World Psychiatric Association in 1961). To analyse these movements, I draw upon sources that trace transnational developments in mental health and social psychiatry, including the proceedings of International Congresses on Mental Health (1930, 1937, 1948, 1951 and 1954) and the International Congresses of Psychiatry (1950 and 1957). I pay particular attention to the sections dedicated to Social Psychiatry and Epidemiology.

To navigate through the diverse epistemic configurations, I employ a guiding thread: the exploration of calls for quantification and proposed measurements of the 'social' within these contexts. I draw on a rich lineage of studies examining the entanglement of quantification, administration, science, and the construction of modernity. In the footsteps of Foucault, Ian Hacking (1999) analysed the links between practices of counting, measuring, calculating risks and probabilities, and modern science and the modern state. Both Hacking and Nikolas Rose have extensively researched the centrality of quantification to the consolidation of the *psy* sciences in the twentieth century (Hacking, 1986; Rose, 1991, 1996, 1999: esp. chs 13, 14, 15). Their work, alongside that of other scholars, demonstrates the significance of examining what scientists and doctors quantify, as well as how they quantify their objects, across different historical moments and contexts within a discipline. These investigations bring into focus the process of shaping the *psy* disciplines as bodies of scientific knowledge (in particular, Hacking, 1986, 1999: chs 8, 14). Furthermore, drawing from government studies and expanding on Michel Foucault's pioneering research, various authors have shown how quantification played a central role in the 'invention of the social' (Donzelot, 1994: 139),

transforming the 'population' into an object of modern politics (Donzelot, 1980: 179–95; 1994: 140–77; Ewald, 1986: 372–6; Foucault, 1997: 213–35).

The subsequent sections of this article examine how the concept of the 'social' was conceptualized and addressed within each of these movements. The methodology employed for this study entailed an analysis of the congress documentation, which was selected based on its relevance to the research questions at hand. To capture the evolution of the meanings of 'social', I analyse the definitions provided by mental hygiene, mental health and psychiatry at different time periods. This includes an exploration of their objectives, areas of observation and intervention, as well as the professionals involved in their respective fields. By examining the dominant positions within these three epistemic projects, I also consider their intersections with institutions and fields of activity that are invoked to elucidate the causal relationship between the 'social' and mental illness and health. Additionally, I draw upon studies in the history of science that explore the role of quantification in shaping concepts of 'social' (Gigerenzer et al., 1989; Hacking, 1999: ch. 9; Hoskin and Macve, 1994; Miller, 1992, 1994: 5–9 [on 'contexts of accounting']; Miller and O'Leary, 1994: 100–10 [on Taylorism and efficiency and society]; Porter, 1993, 2011]. These studies allow me to posit that, as a working hypothesis, diverse modes of quantification do not just reflect, but also actively contribute to the formation of collective imaginaries surrounding the relationship between society and mental illness. Hence, I approach these sources with the following questions in mind: What social aspects do actors quantify and deem worthy of quantification? How do they undertake these processes of quantification for their respective objects of study?

In the final section of this article, I turn my attention to the evolving meanings of the concepts of the 'social' and 'society' in relation to mental illness and mental health within the history of psychiatric epidemiology. Lastly, in its concluding remarks, this analysis illuminates the different forms of assimilation of the 'social' within the realms of psychiatry and mental health. By engaging in historical epistemology, we may gain insights that can be applied to critique current trends.

Mental hygiene: comparability through quantification

The mental hygiene movement originated in Connecticut, USA, during the early twentieth century and is largely attributed to the efforts of Clifford H Beers. After experiencing a personal crisis that led to his institutionalization in a psychiatric hospital, Beers witnessed first-hand the deplorable conditions and the violations of patients' dignity in asylums and psychiatric hospitals. Motivated by these experiences, he became a staunch advocate for patient rights and he led initiatives to prevent mental illness. The movement initially gained traction through locally based associations, starting at the state level in the USA before expanding to the national and international arenas. The first international meeting took place in 1919, bringing together representatives from Canada and the USA (Williams, 1932: 34). Throughout the 1920s, the movement continued to grow, culminating in the first International Congress on Mental Hygiene held in Washington DC, where delegates from over 50 countries convened (p. 35). The proceedings of these congresses, including the programmes, reports, interventions and resolutions, provide a valuable source for studying the development of mental hygiene.

Mental hygiene encompassed both preventive and prophylactic dimensions, aiming to implement social interventions and improve institutional practices. It focused on enhancing the standards of care within mental health institutions, emphasizing the principles of humanistic approaches, scientific treatment and adequate accommodation for patients (Williams, 1932: 53). The proponents of mental hygiene identified themselves as part of a progressive movement, advocating for improved methods and facilities within psychiatric institutions (pp. 56–7). Additionally, they sought to raise public awareness about the humanity of patients and the collective responsibility

of society towards their well-being (p. 56). At their core, these objectives were firmly anchored in the rationale of welfare societies, exemplifying a comprehensive dedication to safeguarding society from individuals deemed 'abnormal' while concurrently striving for the advancement of human rights.

The concept of 'mental hygiene' mobilized a wide range of actors and encompassed a considerable diversity of professions, leading to a variety of approaches and definitions. The meaning and scope of mental hygiene varied depending on its proponents, the time period and the specific contexts in which it was discussed (Williams, 1932: 11). Notably, in the latter half of the 1930s, the international congresses showed a strong association with the eugenics movement (Rose, 1985: 126, 132; Thomson, 1995). When examining the organization of these congresses and the texts they generated, one striking aspect that cuts across different perspectives is the focus on the institutions that were perceived as 'protecting' society. For example, in preparation for the 1930 Washington congress, enquiries were sent to professionals, directors and practitioners involved with various types of institutions, including: psychiatric hospitals and colonies, facilities for the 'mentally defective', delinquency institutions and parole systems, clinics and dispensaries, mental hygiene societies at local and national levels, community education centres, legislation commissions, social service associations, and mental-hygiene institutions in primary and higher education (Williams, 1932: 27). The stated objectives of the congress organizers were to improve the efficiency of these institutions in treating and rehabilitating individuals while safeguarding society from the potential dangers posed by those interned. The organization of the congress itself reflected this perspective, with a vision of society centred on institutions. This vision was explicitly embraced, with the notion that '[t]he institution should be the centre from which community mental-hygiene influences emanate' (p. 58). The scope of the interventions by these institutions was broad, encompassing the 'care of incipient cases and the supervision of former patients' (p. 58).

The mental hygiene movement also targeted schools and families, especially parenthood and the dynamics within the family structure, as privileged areas for intervention (Donzelot, 1980; Foucault, 1997: 224–6; Thomson, 2006: esp. ch. 7). Institutions and contexts associated with child-rearing constituted a significant portion of what mental hygiene considered as the 'social'. Lastly, the prevention and protection framework of mental hygiene placed specific issues at the centre of its episteme, such as syphilis and alcoholism. The neurological and behavioural manifestations of these conditions were understood as part of the realm of mental illnesses. This expanded the hygienists' sphere of action to encompass the moral and religious values that governed sexual behaviours (Williams, 1932: xv–xviii). However, 'society' was primarily regarded as an object of concern for mental hygiene in relation to the impact of individuals' mental illnesses. This notion was explicitly articulated in passages assigning to mental hygiene the mission of analysing 'social problems growing out of nervous and mental disease, mental defect and emotional maladjustments of the individual to his personal and social environment' (p. 9).

The quantification of mental illnesses must be viewed within the context of the objectives and concepts prevalent in these congresses. Given the strong emphasis on an institutional understanding of the 'social', it is not surprising that there was minimal concern with quantifying the prevalence of mental illnesses within the community. Only one communication attempted to correlate statistically a set of so-called social conditions, such as economic status, marital status, geographical environment and professional situation, with different mental pathologies, specifically focusing on psychoses such as manic-melancholic psychosis, infectious delusions, paraphrenia and schizophrenic processes (Mira, 1937: 41). The author concluded that social conditions generally played a pathogenic role only indirectly, even in cases where their impact seemed more apparent, such as situational psychoses. The importance of psychopathic predisposition of individuals also had to be considered (p. 45). Among the social conditions examined, only economic conditions, defined as

the satisfaction of material needs, were deemed to have some degree of significance (p. 45). Thus, the author approached the 'social' primarily through the lens of specific pathogenic causality, with trauma, a psychogenetic factor, clearly outweighing the social factors.

However, the use of quantification was frequent in these congresses whenever the focus of discussion involved analysing the activities of institutions within the psychiatric field. A statistical committee, specifically designated to operate in the congress preparation, urged participants to promote the standardization of psychiatric classifications within institutions at national and international levels to facilitate comparisons (Williams, 1932: 50). Several presentations in 1937 responded to this call, including communications by: physician Maurice Desruelles (1937) on the unification of general statistics in psychiatric institutions; psychiatrist Hubert Bond (1937) proposing an international classification of mental disorders; and H Bersot (1937) discussing the unification of international psychiatric statistics.

As we will see in the final section of this article, the 1920s and 1930s saw the development of studies that sought to correlate social factors with the onset of mental illnesses. However, in contrast to this trend, the motivation behind standardizing classifications, quantifying mental illnesses and unifying statistics at mental hygiene international congresses seemed to stem more from a concern for the scientific integrity of medical management within institutions than from an epidemiological perspective.

The mental health movement and the quest for healthy societies

The history of quantification in the immediate post-WWII international mental health discourse is essentially a history marked by its absence. However, it is crucial to analyse the contours of this absence in order to illuminate the prevailing concept of 'social' among the mental health pioneers of this era.

Following WWII, the term 'mental health' replaced 'mental hygiene' in the nomenclature of these congresses, with its proponents agreeing on several crucial points regarding its definition. Mental health was understood not merely as the absence of disease but as a driving concept of an international political, expert and civic movement that aspired to create societies in which individuals could cultivate 'healthy personalities'. This, in turn, was considered a prerequisite for a 'healthy society' (Flugel, 1948: 83–9, esp. p. 87). The pursuit of mental health necessitated the close collaboration of various professionals, including psychiatrists, sociologists, social workers, educators, psychologists and politicians. Although psychiatrists were involved in the congresses, they were not the sole arbiters of the agenda. The mental health movement embraced humanistic and universalistic ideals, with the reduction of conflicts between nations and the promotion of world citizenship ranking high in its priorities (Wu, 2015). In the aftermath of WWII, its primary scientific and political objective revolved around understanding and mitigating levels of aggression in individual personalities and societies (Flugel, 1948: esp. p. 49).

Throughout the congresses held until the mid-1950s, the central concept used to address suffering and mental illness was the 'healthy personality', which was primarily examined through the lens of aggressiveness rather than from the perspective of suffering and happiness or well-being. The notion of 'personality' necessitated an integration of psychological developmental theories within sociologically oriented approaches. Biological factors underlying poor mental health were accorded relatively limited significance. To summarize and elucidate the mission statement of the 1948 London Conference (the International Preparatory Commission), Lawrence K Frank, a social educator, and Margaret Mead, an anthropologist, stated the following on behalf of a commission entrusted with preparing the conference:

> It is worth while noting that . . . the Statement asserts 'it is the goal of mental health to help men to live with their fellows in one world'. This is a striking illustration of the way in which the Commission lifted the conception of mental health out of its former restricted meaning, giving it, in the section on human development, the wider setting of the human being's many interpersonal relationships, then on the section on social life asserting the dependence of mental health upon the social and cultural setting in which human development takes place and the reciprocal interaction among personalities, so that, as quoted, healthy personalities require a healthy society and in turn a healthy society can arise and be maintained only by healthy personalities. The problem then was seen as how to interrupt these self-perpetuating circular systems which prevent the development of a healthy society. The Commission emphasised the possibilities for changing society and cultural traditions by utilising the possibilities for adult learning. (Flugel, 1948: 86–7)

The 1948 Congress held in London had a clear focus on the social determinants of poor mental health, with a particular emphasis on childhood. In their understanding of the term 'social', the organisers encompassed various domains, including the family, education, the law, the community, and work and industry (p. 84). Three years later, the subsequent Congress took place in Mexico City, demonstrating a shared commitment to expanding the movement's reach beyond Europe and North America. Interestingly, this congress also broadened the scope of the 'social environment' deemed relevant to the issues of mental illness and health. New topics were introduced, including race relations, migrations, different types of work (both rural and industrial), as well as culture and religion. Alongside discussions on peace and political stability, the reduction of poverty and economic well-being were widely recognised as fundamental conditions for fostering both 'healthy individuals' and 'healthy societies'.

The incommensurability of mental health

The presence and role of psychiatrists within the mental health movement were subjects of reflection and debate. Alfonso Millán, a Mexican psychiatrist, addressed this issue and analysed what he referred to as the 'paradox between the social expansion of psychiatry . . . and the reserve of psychiatrists themselves when it comes to accepting their social function in this world that is so tormented and full of problems of mental health' (Millán, 1952: 44). He noted the estrangement of psychiatrists from 'this great progressive movement of our specialty'. The main reason behind this estrangement was attributed to 'psychiatrists' limited perspective' on mental health issues, stemming from their lack of training in the social sciences and their narrow focus on clinical approaches during their training.

The 1954 Congress in Toronto formalised the concept of a 'multidiscipline', involving the human sciences, economy, psychiatry and psychology to address mental health. It also defended the importance of bringing together citizens and scientists (Line and King, 1955: 5). However, it qualified the ideals put forward in 1948 as 'grandiose' and 'utopian'. The congress's emphasis on epistemological topics suggested that the mental health movement was facing a blockade rooted in the utopian definition of mental health and the challenges of integrating different disciplines and types of knowledge, both lay and expert. The Congress President, HC Rumke from the Netherlands, delivered a speech on 'Solved and unsolved problems in mental health', in which he raised questions about the object of the mental health movement and its goals (p. 145). He distinguished the mental health movement from the mental hygiene movement, as well as from psychiatry, particularly the work being done in the psychiatric section of the World Health Organization (WHO). While both mental hygiene and the WHO's approach to psychiatry shared a positive vision of health and focused on the aetiology of illnesses, they remained fundamentally medical endeavours.

Rumke argued that the WHO was pursuing a form of 'medical mental hygiene' centred on the 'abnormal man', which he deemed limited in scope compared with the objectives of the mental health movement (p. 147).

Although Rumke acknowledged the grandiose nature of the 1948 definition of mental health, he supported the movement's efforts to improve the living conditions of the 'normal man' as a means of promoting 'healthier' personalities and societies. Yet his speech and those of other participants indicated a certain awareness that this conception of mental health constituted a political and epistemological utopia (p. 165). He observed that instead of progressing in a unified manner, knowledge in the field of mental health was becoming increasingly fragmented. This fragmentation was most pronounced in psychiatry, a specialty 'apparently in full flower', but also at greater risk than ever before (p. 148). Rumke noted that American psychiatry was becoming increasingly distinct from European psychiatry, with the former embracing psychodynamic approaches through the incorporation of psychoanalysis, while the latter remained predominantly clinical. This divergence resulted in the neglect of nosology, a loss of awareness regarding the relativity of diagnoses, and a disconnection from neurophysiological and biological perspectives.

GR Hargreaves, representing the WHO, also pondered the role of psychiatrists within the 'multidiscipline' team in the field of mental health, and said that they played a crucial role in the research team when it came to understanding the aetiology of mental health issues. However, he argued that their position should not be central when it came to decisions based on that knowledge (p. 175). Drawing a parallel with John Snow's discovery of the causes of cholera and the subsequent actions taken by public health authorities to prevent its spread, Hargreaves contended that it was the responsibility of public health authorities and citizens, particularly 'mothers and teachers', to act, based on aetiological knowledge. Throughout the Congress, quantitative data and arguments had a minimal presence, even when discussing topics such as preventive psychiatry or public mental health. The absence of quantification in the 1948 London Congress is even more significant when considering that previous congresses on mental hygiene had advocated for the development of quantification as a way to improve the scientific rigour of the field.

Against this backdrop, the next section of this article examines the landscape of psychiatry that unfolded in the aftermath of WWII, with its overarching aspiration of achieving a unified global psychiatry.

The fragmentation of the 'social'

The International Congresses of Psychiatry transport us to a distinct realm of the field. The inaugural Congress, held in Paris in 1950 and organised by prominent figures in organic psychiatry such as Henri Ey, with the collaboration of Pierre Marty and Jean Dublineau, primarily focused on the treatment of severe mental illnesses, including the controversial topic of lobotomy. However, despite the divergent areas of interest, some common themes emerged, such as psychoanalysis, childhood, and the social context of mental illnesses.

It is important to note that the 1950s witnessed an expansion of research into the biological causes of mental illness, leading to enthusiasm for physical treatments such as lobotomy and electroconvulsive therapy. Psychiatry also experienced a transformative period with the introduction of psychopharmaceuticals, which revolutionised the practice and revitalised biological approaches on mental illness. Additionally, the impact of psychoanalysis on psychiatric practices, particularly in countries at the forefront of *psy* knowledge production, such as the USA, France and Great Britain, cannot be overlooked. This influence was also evident on a transnational level. As Rose and Abi-Rached (2013: 35) have noted, scientific events during this time saw discussions

of psychoanalytic and biological interpretations of mental illness coexisting without a clear opposition until the 1960s.

The significance of these developments becomes apparent when examining the proceedings of the First International Congress of Psychiatry in 1950, which runs to six volumes. The Congress tackled a range of subjects including 'General Psychopathology', 'Brain Physio-Anatomy in relation to Lobotomies and Topectomies', 'Psychoanalysis', and 'Social Psychiatry' (Ey et al., 1952, Vols I–VI). Within this framework, the term 'Social Psychiatry' not only encompassed the examination of social factors but also extended its scope to the realms of genetics and eugenics (Vol. VI).

One notable presentation was given by Erik Strömgren, a Danish psychiatrist who later gained renown as an epidemiologist. He presented a comprehensive analysis of quantitative studies conducted in psychiatry over the previous 50 years, aligning his findings with the emerging agenda of world psychiatry, to which he subscribed. Strömgren's analysis encompassed 57 published studies, with the majority conducted in Scandinavian countries, Germany, Switzerland and the USA. He classified these studies into three categories:

1. Sampling methods: 24 studies conducted between 1885 and 1947, which used sampling techniques to gather data.
2. Census investigations: 24 studies conducted between 1926 and 1945, in which census data played a central role.
3. Hospital admission statistics combined with census data and, in some cases, hospital examinations: 9 studies conducted between 1931 and 1948, which incorporated hospital records alongside census data.

These studies exemplified the psychiatrist's inclination towards approaches on the causes of mental illness sensitive to social factors, suggesting that by the mid-twentieth century, different socio-ecological perspectives on mental illness were emerging in the USA and certain European countries. Strömgren advocated the utility of sampling methods and censuses in studying the prevalence of mental diseases (to 'ascertain all persons suffering from certain diseases or defects') (Strömgren, 1952: 183). However, he also emphasized the importance of these studies, to be conducted by biologists and medical geneticists, 'for the estimation of the eugenical dangers of the disease' (p. 184). He highlighted the significance of the 'biological point of view', which involved conducting follow-up studies on individuals born within a specific time frame and limited geographical area (the Klemperer method). By tracking these individuals throughout their lifetimes, 'conclusive risk-figures are obtained for kinds of diseases and abnormalities' (p. 184). Key to the validity of these studies was the quality of the sampling methods, particularly their ability to generate representative subgroups and to account for social factors.

Strömgren then introduced what he called a 'socio-medical viewpoint', defined as a type of investigation that does not intend to 'ascertain all persons suffering from certain diseases or defects but aims to determine and predict the number of individuals in need of assistance from society' (p. 184). From this perspective, the term 'social' referred to society's responses to mental illness rather than the social factors contributing to the diseases. As an example, he stated that '[f]rom a socio-medical viewpoint it is important to investigate the annual number of hospital admissions for mentally abnormal persons'. He added that '[e]specially interesting are the variations during shorter and longer periods, with diagnostic subgrouping, if possible'. These studies, he argued, held greater interest for governments and institutions than for psychiatrists.

According to Strömgren, the field of medical statistics had been limited due to: inconsistent diagnostic criteria; the lack of correlation between admissions and the number of affected

individuals; and variations in admissions based on social class, rural or urban residence, race and cultural level. Advancements in psychiatric statistics depended on accurately ascertaining the prevalence of mental disorders in the general population and measuring the treatment gap between that number and the number of hospital admissions. Advancements in the realm of 'socio-medical' – or, in this context, 'socio-psychiatric' – statistics hinged upon the establishment of uniform diagnostic criteria, the evolution of methodological frameworks capable of mitigating the influence of social factors, and the capacity to construct robust experimental samples conducive to sound statistical inferences, which is nowadays known as randomization within the field of epidemiology.[1]

Strömgren conducted a comprehensive analysis of numerous studies that explored the influence of social factors on mental illnesses. He encompassed factors such as economic status, migration, rural and urban environments, and the consequences of significant events like the Great Depression and wars. Surprisingly, he deemed many of these studies, particularly those derived from the mental hygiene field, as having limited value (Strömgren, 1952: 182). Strömgren's findings indicated that even major societal upheavals, such as wars or the economic depression of the 1930s, did not significantly impact the occurrence of mental illnesses. While advocating the comparability of medical statistics, he excluded 'uncivilised populations', wherein the understanding of mental phenomena was confined to 'isolated psychological phenomena' (p. 183).

In summary, Strömgren's perspective on the integration of the 'social' into psychiatry reveals a profound ambivalence. While he championed the notion of a 'social psychiatry', his conceptualisations of both the 'social' and causality implied a dismissive stance towards the significance of social factors in advancing a scientific understanding of mental illness.

Society and culture in schizophrenia

The Second International Congress of Psychiatry, held in Zurich in 1957, successfully responded to the call for a more quantitatively oriented psychiatry. This Congress played a crucial role in introducing psychiatric epidemiology into the vocabulary of the world forums of psychiatry. Focusing specifically on the topic of 'The present status of our knowledge about the group of schizophrenias', the Congress aimed to establish schizophrenia as an indisputable fact of mental illness that all psychiatrists could unite around, regardless of their scientific backgrounds or social contexts (Lovell, 2014: 14–15). Notably, a report on the Congress, by Robert J Campbell, MD, relied heavily on comparisons of prevalence, statistics and percentages. Campbell (1958: 318) praised the Congress for providing an unparalleled opportunity to compare viewpoints and approaches from various workers in the field. The report highlights the crucial role of quantification in facilitating comparisons across a broad range of cases. In the report's summary, Campbell underscored the significance of the Congress, acknowledging that within the field of psychiatry, 'variance of viewpoint from one country to another is the rule rather than the exception' (p. 333).

With participants from 59 countries, the Congress explored diverse topics related to schizophrenia (p. 318). Campbell's report reflects the Congress's thematic sections, including 'epidemiology', 'phenomenology and nosology', 'symptoms', 'course and prognosis' and 'treatment'. Numerous participants presented epidemiological studies on schizophrenia from various countries, defining its incidence in relation to factors such as family and cultural background (pp. 318–19). In the report, the epidemiology section set the foundation and tone for the subsequent thematic sections by establishing schizophrenia as an unequivocal aspect of psychiatry: 'it occurs in every segment of the population, without regard of race, or culture, or social class' (p. 319). To support this assertion, Campbell cited incidence rates of schizophrenia in Ghana, Thailand, Southern China and Nigeria (p. 319). Furthermore, he observed that '[n]ot only does schizophrenia occur in all

societies studied, but it appears, too, in all the forms generally recognised', noting the consistency of Bleuler's fundamental symptoms regardless of the geographic location (p. 319). Addressing a recurring topic in psychiatric literature since the nineteenth century, Campbell contrasted the content and form of delusions between 'western schizophrenics', whose delusions incorporate 'television and radar', and 'schizophrenics from primitive cultures' who express concerns related to the 'complains of being influenced by the evil eye, the totem pole or the medicine man' (p. 319).

A study on schizophrenia in Thailand, as reported in the Congress, indicated that its incidence was no higher there than elsewhere, and the type of patient affected was similar. The pathology typically manifested in late adolescence and young adulthood, predominantly affecting males, and showing a close association with 'asthenic body builds' (p. 320). However, despite comparable incidence rates in Thailand, the number of schizophrenia cases attributed to cultural factors was higher than in other countries (p. 319). This observation underscores the three key components of epidemiological studies: the country's population, the reported number of mental patients in hospitals, and the number of individuals diagnosed with schizophrenia.

Campbell's report also highlights an epidemiological study conducted in the USA by psychiatrist Franz Kallman, renowned for his genetic research in psychiatry and his sympathies for eugenic policies. Employing a similar methodology, Kallman analysed statistics of diagnosed schizophrenia cases within the country's population. The study yielded a 'general expectancy of schizophrenia' of 1%, consistent with the incidence found in most other countries (p. 320). Furthermore, Kallman examined the incidence of schizophrenia among the parents and twins of diagnosed patients, leading to several conclusions: (1) the majority of schizophrenic patients (90%) had non-schizophrenic parents; (2) a non-schizophrenic and adequate home environment could not prevent the development of schizophrenia in vulnerable offspring; and (3) one-egg twins had a six-fold higher likelihood of developing schizophrenia compared with two-egg twins, regardless of whether they were raised together or apart (p. 320).

The consistent incidence of schizophrenia across countries, and the findings from Kallman's study, demanded – or at least paved the way for – organic explanations of the illness. Subsequent sections of Campbell's report echoed various aetiologies of schizophrenia, which, despite some variations, centred on genetic factors and their effects on the brain and endocrine system. While psychogenetic factors were considered triggers in some cases, the organic aetiology emerged as the undisputed underlying cause of the disease. This marked a return to Bleuler's perspective, in contrast to the psychogenetic aetiologies attributed to Freud and his followers (Campbell, 1958: 321). Bleuler was cited as the prominent advocate of an organic aetiology of schizophrenia, where psychogenetic factors played a secondary role. Campbell noted that Bleuler's views on the relationships between somatogenic and psychogenic factors in schizophrenia were clarified in several papers presented at the Congress and were reflected in numerous discussions throughout the meeting (p. 321).

Some participants explicitly linked epidemiological studies, Kallman's presentation, and organic aetiologies. The significance of Kallman's research was acknowledged in both the epidemiological and aetiological sections of the report. In the aetiological section, Campbell highlighted that 'genetic studies have given many leads, and Kallman's statistics (U.S.A.) are particularly impressive'. Among Kallman's conclusions, Campbell cited that '[a]ll basic behavioural components are genetically controlled' and suggested that the basis of schizophrenia likely involved a gene-specific metabolic deficiency transmitted as a receptive unit-factor (p. 321). Another Congress participant, Bender from the USA, presented a paper on childhood schizophrenia in the section on 'phenomenology and nosology'. He concurred with Kallman's statistics and believed that no childhood schizophrenia could occur without the inherited genetic factor (p. 328).

At this juncture, it is worth analysing the meanings and ascribed roles of the 'social' in the accounts of schizophrenia presented at the Zurich Congress. As previously noted, the report on Thailand attributed to cultural factors a causal significance in the development of schizophrenia. The high number of cases of mental illness was explained by cultural and religious influences: 'the personality type favoured by culture is one of introversion and submission'; 'the religious training of the people, Buddhism, favours apathy, a lack of eagerness and a turning away from reality'; 'the unusual mother-child relationship exerts regressive effects on psychosocial development' (quoted by Campbell, 1958: 319). However, despite the impact of culture, the incidence of schizophrenia in the general population remained consistent with elsewhere. In the case of Thailand, the 'social' – through culture – acted as a modulating factor in shaping the form of mental illness. Nonetheless, the true causes of mental illnesses were organic.

Through the lens of epidemiology, coupled with genetic studies, schizophrenia emerged as a pathology with organic causes and discernible manifestations exhibited in specific mental and behavioural patterns or forms observed across different societies. Rumke referred to it as a 'disease of form', with the 'form' representing the fundamental symptoms described by Bleuler. In this context, the 'social' appeared as a modulating factor with little to no impact on the production of the illness. It is evident that this perspective deviated significantly from the conceptual world of the mental health congresses, with their emphasis on the close relationship between 'healthy or unhealthy societies' and 'healthy or unhealthy personalities', or the idea put forward by mental hygiene that social and moral behaviours played a significant role in the aetiology of mental illnesses.

In the sections on 'course and prognosis' and 'treatment', schizophrenia was also repeatedly addressed through statistics. In contrast to all other participants, Binswanger and Minkowski, who were both existential analysts, approached schizophrenia as a pathology that develops from a disordered relationship between an individual and their 'world'. The existentialists introduced the notion that meaning plays a crucial role in understanding the onset and phenomenology of schizophrenia: '[for the schizophrenic individual] The question is, how can one conduct a life impossible to conduct? The answer is: by substituting for the uninterrupted, objective, sequence of experience, a subjective sequence' (Campbell, 1958: 333). However, their account of schizophrenia also had a formalistic aspect. They described how the schizophrenic individual seeks meanings that are incompatible with their experiences, leading to masking, imitation, eccentricity and mannerisms. In sum, although the schizophrenic's 'world' was considered as a component relevant to understanding the onset and phenomenology of schizophrenia, the concept of 'world' was devoid of sociological and cultural texture or content.

Despite the apparent dilution of the concept of 'social', an intriguing development emerges: the growing autonomy of the notion of 'culture' within certain congress reports. The growing interest in culture marks a relatively novel phenomenon within psychiatric discourse. In the 1940s and early 1950s, culture was either overlooked or assimilated as a dimension of society. However, as the 1950s unfolded, it began to assert relative independence within discussions concerning psychiatry and mental health. This shift may have been influenced, in part, by the contributions of anthropologists such as Margaret Mead, who presided over the World Federation of Mental Health in 1956 and 1957. Notably, a select group of psychiatrists, with Eric Wittkower at the forefront, highlighted the impact of culture on mental illnesses, leading to the establishment of McGill's Unit in Social and Transcultural Psychiatry in the mid-1950s (Delille, 2018; Wu, 2021: 55).

As we will see next, the interest in exploring the role of culture as a significant knowledge category coincided with a growing sense of urgency for more consistent quantification methods, namely through the development of psychiatric epidemiology.

Versions of the 'social' in different forms of psychiatric epidemiology

In recent years, there has been a growing interest in the historical role of quantification in psychiatric epidemiology (Leplège, Bizouarn and Coste, 2011; Lovell and Susser, 2014; Wu, 2021: ch. 3). Authors such as Gerald N Grob (1985), Anne Lovell (2014), Allan V Horwitz and Grob (2011), and Steeves Demazeux (2013, 2014) have contributed valuable studies on the discipline's history. Lovell highlights the significant role played by global–local interactions and the translation efforts of non-governmental organization (NGO) experts in shaping the discipline's contemporary framework. Critical of the WHO's welfare definition of 'mental health', which was intertwined with the concept of a 'healthy society', Lovell deems it idealistic and ideological. In her view, this perspective hindered the development of a rigorous scientific approach focused on the prevalence and treatment of actual mental disorders (Lovell, 2014).

Historian Harry Wu has also made noteworthy contributions to this debate, specifically regarding the WHO's Expert Committee for Mental Health. Wu illustrates how the committee initially embraced an idealistic vision of contributing to a 'healthy' and war-free society. However, from the late 1950s, it transitioned towards a more technical and psychiatry-focused approach to mental illness. Within this shift, epidemiology played a vital role as a means of studying the aetiology of mental illnesses. The committee aimed to develop a large-scale international epidemiological study on mental disorders in 1957, although it ultimately fell short of this goal. Nevertheless, the WHO experts' studies on schizophrenia in the 1960s laid the foundation for modern psychiatric epidemiology, a development made possible by the abandonment of the 'idealistic notion of mental health' in the late 1950s (Lovell, 2014: 10; 14–15; Wu, 2021: 54).

Horwitz and Grob's study provides valuable insights that help to address the questions posed in this article by placing the emergence of psychiatric epidemiology within the wider context of quantification practices in psychiatry and mental health. They note that in the aftermath of World War I, there was a shift of interest from institutional statistics of mental illnesses to observing the prevalence of mental illnesses in populations, taking into account geographical and socio-environmental factors (Horwitz and Grob, 2011: 637–8). The authors argue that between the 1920s and 1940s, medical quantification underwent a significant transformation, laying the groundwork for what we now recognize as psychiatric epidemiology, with the pivotal moment occurring in the 1930s. During the Great Depression and its aftermath, medical quantification reflected both political and scientific concerns about the impact of factors such as poverty, race and migration on the incidence of mental illnesses. This marked a departure from earlier medical statistics, which focused on heredity or administrative aspects of psychiatric institutions (such as bed capacity, hospital infrastructure and staffing) (p. 638). In this period, psychiatric epidemiology, in contrast, emerged as a field primarily shaped by 'a group of statistically oriented social scientists concerned with problems relating to poverty, dependency and welfare', rather than being driven solely by doctors seeking hereditary causes of illness or producing data for hospital administration (p. 638). WWII military psychiatry made a significant contribution to the formation of the field by defending the notion that highly stressful environments could lead to a higher incidence of mental illnesses. This notion prompted the exploration of the relationship between 'personality' and 'environment' within specific populations and constituted the framework for post-war epidemiological studies in the USA. Notably, these advancements in American psychiatric epidemiology aligned with the international mental health culture that, as mentioned above, took shape in the aftermath of WWII.

Against this historical backdrop, Horwitz and Grob offer a compelling historical narrative of psychiatric epidemiology in the USA, which they describe as a 'checkered history'. They argue that an 'environmental way of thinking' regarding mental illness began to develop in the 1920s,

with notable studies involving social scientists examining the prevalence and causes of mental illnesses (p. 637).[2] During the mid-twentieth century, until the late 1960s, there was a focus on understanding mental illness through socio-economic variables, which informed federal policies addressing issues such as poor housing, poverty, and crime rates (pp. 638–41). However, during this period, psychiatric epidemiology fell short of its goal to establish a connection between socio-economic factors and rates of mental illness. The authors attribute this failure to insufficient attention given to epistemological and methodological issues, particularly the absence of a coherent system for classifying mental disorders. Consequently, after a decline in the 1970s, psychiatric epidemiology shifted to a categorical approach. This change in perspective became the underlying question for contemporary psychiatric epidemiology, implicitly or explicitly asking how mental disorders affect society. This shift in thinking aligns with the publication of the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III), as psychiatry adopted a classification system more amenable to quantification. With this development, psychiatric epidemiology fully embraced the biomedical paradigm at the expense of the social sciences. The arrow of causation observed from the 1920s to the late 1960s, which pointed from society to mental illness, was now reversed.

The above analysis of the concepts of the 'social' and 'society' in the making of psychiatry and mental health allows us to revisit Horwitz's and Grob's historical narrative on the development of modern psychiatric epidemiology. This analysis suggests that characterizing changes in psychiatric epidemiology as a mere reversal of the direction of causation between society and mental illness is overly simplistic. Instead, it reveals a more complex transformation in the concepts of the 'social' and 'society' themselves, as well as the growing interest in culture. Over the course of the discipline's development, these concepts, along with the very understanding of causality, have undergone a profound metamorphosis, shaping the discipline into its present form.

Conclusion: integrating the 'social' into psychiatry and mental health

The post-WWII era witnessed the development of the concept of 'mental health' as a prominent organizing principle. This concept evolved from the pre-war mental hygiene movement, but gradually detached itself from the latter's emphasis on prevention and eugenic undertones. Instead, mental health adopted a broader focus on overall well-being. While mental hygiene still adhered to nineteenth-century approaches to addressing the 'social question', two concepts then considered inseparable, at the forefront of its concerns. This reconfiguration of focus was accompanied by a distinct perspective on the 'social' and on methods of constructing knowledge about the social factors affecting mental illness and health.

The above analysis reveals that the causes of mental illness, be they biological or psychogenetic in nature, were not subjected to rigorous epistemological scrutiny. Therefore, these causal explanations remained relatively vague and susceptible to various interpretations or even coexistence without conflict. The concept of the 'social' in psychiatry and mental health was even more fluid and elusive than the biological and psychological dimensions. While it was frequently mentioned in discussions on mental health and illness, the concept of 'social' was often used as a catch-all term for the non-biological and non-psychological aspects of human life that are thought to have an impact on health and illness.

Throughout these developments, the objects of quantification became closely intertwined with the concept of the 'social'. During the 1920s and the 1930s, mental hygienists sought to quantify categories observed within specific institutional settings. The notion of the 'social' encompassed

both formal and informal institutions, such as hospitals, prisons, colonies, homes, schools and work environments, where the lives of specific groups of individuals unfolded. While mental hygiene aimed to establish its autonomy from psychiatry, it relied on psychiatry to provide the necessary categories for quantification. The scientific legitimacy of mental hygiene was ensured not through the development of a sociology of mental illness or epidemiological research, but rather through the international standardization of psychiatric classifications.

In the post-WWII mental health movement, the concept of the 'social environment' gained prominence. It implied that individuals were embedded within complex ecosystems known as societies, necessitating what Horwitz and Grob (2011) called the 'environmental mode of thinking'. Sociologists and anthropologists joined doctors and psychologists in this endeavour, which was soon labelled as 'utopian'. The 'social' was understood in multifaceted dimensions, with quantification playing a secondary role in knowledge production. In contrast, the concept of the 'social' within the emerging field of world psychiatry diverged from both the American psychiatric epidemiology of the time and the international mental health movement. Concretely, it underwent a decomposition into a series of social determinants that could be correlated with mental illness and, as mentioned earlier, subjected to methodical neutralization.

The analysis presented above offers valuable insights for critiquing certain aspects of prevailing trends in contemporary global mental health. According to Horwitz and Grob, the re-emergence of psychiatric epidemiology in the 1980s, now in a biomedical framework, has failed to adequately capture the distribution of mental disorders. They argue that epidemiologists interested in the 'social' should revisit the ethos and fundamental assumptions of mid-twentieth-century epidemiology. Specifically, this entails examining society and culture as significant causal factors in the production of mental disorders, while contextualizing prevalence data within structural and cultural considerations. However, in light of this analysis, an interest in the 'social' requires a more comprehensive reassessment of the very meaning and workings of 'social' and 'society' and, we might add, of 'culture' as well.

Moreover, in the present day, we are faced with new enquiries: What disciplines and forms of knowledge – whether academic or experiential and community-based – shape our understanding of the 'social' and the concepts and conditions through which society can be both an object and subject of knowledge? Furthermore, as mentions of 'primitive cultures' imply, we must heed Anne Lovell's observations on the Euro-American cultural bias ingrained in psychiatric epidemiology, which undermines the recognition of other scientific cultures, particularly those originating from the Global South (Lovell, 2014: 16). However, it is important to note that these observations, along with others of a similar nature, have yet to yield an epidemiology capable of delivering epistemic justice to non-Western societies – and, I would argue, even Western societies.

Lastly, I contend that while the mid-twentieth century definition of mental health may appear utopian, idealistic and 'ideological' (Lovell, 2014: 8–9), the scientific, ethical and political endeavours surrounding this concept in the post-WWII context warrant re-evaluation. It is true that in discussions within the International Congresses on Mental Health and in the WHO's deliberations analysed by Lovell, society often takes on the role of a 'therapeutic community' (p. 9), raising concerns in light of the critical literature on the medicalisation of life. The pervasive notions of a 'healthy society' and the interdependence of 'healthy' and 'unhealthy personalities', particularly when used to legitimise the moralistic and normalising hygienist interventions, reveal an uneasy amalgamation of technocratic health concepts and a naturalistic vision of society, where justice, culture and politics are recast in the language of health.

Nevertheless, for a brief period, a diverse group of professionals from various disciplines seriously acknowledged that, in order to comprehend suffering, mental illness and mental health, it was crucial to be concerned about social environments – including dimensions such as

race, migration, working conditions, culture and religion. Alongside peace and political stability, poverty reduction and economic well-being were widely recognised as fundamental prerequisites for healthy lives. As utopian as post-WWII mental health definitions may seem to us now, these ideas remain relevant and continue to inspire.

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Notes

1. As Hacking (1999: 206) explains: 'Randomization in the design of experiments is a technique for drawing statistical inferences. It has become part of the logic of induction, reminding us that induction is not just a matter of thinking but of doing.'
2. Among these studies, the authors cite *Mental Disorders in Urban Areas: An Ecological Study of Schizophrenia and Other Psychoses* by Faris and Dunham (1939) as a landmark. For this and other examples, see Horwitz and Grob, 2011: 637.

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