STUDIES OF SOCIAL ATTITUDES AND VALUES IN RELATION TO PSYCHIATRIC EPIDEMIOLOGY

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FOR MANY years the annual rate of first admissions to psychiatric hospitals in England and Wales has shown a steady rise (Registrar General 1964). Changes in the legal and administrative arrangements for the care and treatment of mental disorders are probably accountable for the greater part of this rising influx. The Mental Treatment Act 1930 established voluntary admission and enabled local authorities to set up out-patient clinics. The development of the National Health Service brought a substantial enlargement of the specialist establishment in psychiatry. More recently the Mental Health Act 1959 has abolished the special status of psychiatric hospitals and has removed all formality from the admission procedure for all except a minority of patients.

These changes in social policy towards the mentally ill may arise in part out of rather widespread changes in attitudes towards mental illness among the general population. Implementation of the policies must, in turn, serve to generate modifications in social attitudes.

The passage of patients into and out of the specialist mental health services and the factors which play upon and determine this movement represent one stage of a cycle which begins with the earliest recognition by the individual patient (or by his relatives) that something is wrong. The process continues when the abnormality is reckoned by the patient, or by his family, to have medical significance, and when a decision is made to seek advice, usually from the general practitioner. A further stage is encountered in the appraisal of the case by the G.P. and in his diagnosis and treatment, and in his decision whether to handle the case himself or to refer the patient for a psychiatric opinion.

Part of the work of the M.R.C. Social Psychiatry Research Unit (S. Wales detachment) has been to examine certain aspects of the elaborate social process whereby psychiatric

cases are defined in the community, recognised by community members and by medical and social agencies, and dealt with by one means or other. Studies of this kind are very relevant to the epidemiology of mental disorder since, by the nature of such illness, the detection and enumeration of cases is intimately linked with prevailing social "yardsticks" pertaining to the acceptable bounds of "normal" behaviour and experience and also to the categorisation of deviant behaviour as falling within the doctors' province.

Attitudes to the Psychiatric In-patient

A feature of post-war British psychiatry has been the mobilisation and rehabilitation of many long-stay patients in mental hospitals. The increasing number of cases with residual symptoms living either with their families, or at institutions in closer proximity to the local population than traditional mental hospitals, demands much tolerance and sympathy from relatives, friends, neighbours and members of the general public. The Mental Health Act 1959 emphasised the desirability of developing a comprehensive scheme of care and treatment in the community. The success of this policy will depend, in part, on the attitudes which prevail towards mental disorder in the community.

An enquiry was carried out in S. Wales to examine the attitudes of relatives to a family member in a mental hospital and especially those attitudes which may influence family behaviour if and when the time comes for the patient to leave hospital (Rawnsley, Loudon and Miles, 1962). The survey was based upon all patients, 230 in number, who were in mental hospitals at the time of the enquiry and those whose home addresses on admission lay in one of three defined areas in S.E. Wales—a mining valley, a rural area, and a small town.

Patients were assessed by the hospital staff in terms of their social capabilities and potentialities. Attitudes of relatives were studied principally by home interviews conducted with a sample of relatives from each family and by the examination of records of contacts—visits, letters, parcels—between relatives and patients.

Twenty per cent of the patients, many of them with very long hospital stay, were found to lack any contact with their families for the past year or more. It was a little surprising, therefore, to discover relatives of these patients—usually close relatives—living locally. Furthermore, offers of accommodation in the event of discharge were forthcoming in a quarter of the cases where contact had been lost for so long.

6.1% of the patient sample had been continuously in hospital for a year or more, were fit to live at home (according to the hospital staff) and had a home waiting for them (according to the family). Although on the face of it these patients would appear to be promising candidates for rehabilitation, certain reservations must be entered. There is evidence that contact with close relatives at home may have a deleterious effect upon schizophrenics (Brown, Carstairs and Topping, 1958). Disquieting reports have also been published of the disrupting effects on the family of the returning patient with residual disability (Wing, Monck, Brown and Carstairs, 1964).

These studies, carried out in an area where the community aftercare services were inadequate, indicate very plainly the need for intensive supervision of the partially remitted schizophrenic after leaving hospital.

In the S. Wales investigation, analysis of frequency of visits by relatives and of their willingness to accommodate patients in the event of discharge by age of patient and by duration of stay in hospital indicates that, although interest expressed through visiting is sustained in the elderly group of patients, this is not matched by willingness to house them. Judging by the response of relatives, it is clear that a policy which seeks to discharge long-stay elderly patients of either sex must look for accommodation outside the family. The provision of special hostels for the elderly long-stay patient with mild symptoms is an obvious solution. Social work with families would be best reserved for the younger group whatever their length of stay in hospital.

Married schizophrenics of less than two-years' stay command a higher level of active interest (as judged by visiting frequency) and

better prospects of accommodation on discharge than do single schizophrenics. This finding illuminates earlier statistical enquiries into the differential probability of discharge for single and married patients. Thus Norris (1956) showed that amongst schizophrenic admissions in 1947-49 to some London hospitals, single patients had the greatest chance of retention for two years and that the married had least, with the widowed and divorced occupying an intermediate position. Brooke (1959) showed that 19% of single schizophrenic first admissions in England and Wales in 1954-56 were still alive and in hospital two years later, while 12% of the patients who had been married at some time were likewise retained. Wing, Denham and Monro (1959) found that single schizophrenic patients in two cohorts of admission to Long Grove Hospital had a worse prognosis for discharge within two years than married patients.

Comparison of the attitudes of relatives to patients from the three geographical areas in S. Wales indicates that despite equivalence of "active interest" revealed through visiting, patients from the town have a substantially lower proportion of relatives willing to house them on discharge than have patients from the rural area. Patients from the mining valleys are intermediate in this respect.

One important factor not systematically examined in this study is the attitude of the patients themselves to their future and, in particular, to the prospect of leaving hospital. Although many patients would undoubtedly prefer an early discharge, others are too apprehensive or too settled to want it. Folkard (1960) found that the expectations of a group of selected chronic patients regarding prospects of discharge and level of performance after discharge, were more optimistic than those expressed by their relatives. Wing, Bennett and Denham (1964) have shown that the desire of some chronic male schizophrenics to leave hospital can be substantially sharpened by exposing them to an Industrial Rehabilitation Course at a Ministry of Labour Unit.

The General Practitioner

Patients with psychiatric illness form a substantial fraction of the G.P.'s case load. In a survey carried out by the General Register Office in collaboration with the College of General Practitioners (Logan and Cushion, 1958) 171 volunteer G.P.s kept an account of their contacts with patients, including a record of the nature of the illness, for one year.

During the year, 5% of all patients on the practice lists consulted their doctors for an ailment regarded as psychiatric. This is an average value for a large number of practices. Other studies by individual G.P.s reveal a large variation in the estimates of psychiatric morbidity in different practices which can be accounted for, in part, by the way the frequency of cases has been calculated and expressed (Kessel and Shepherd, 1962). Several other factors probably contribute to this variation and the influence of any single factor is difficult to assess. The practice populations may differ in their distribution by sex, age, occupation, social and geographical mobility and other characteristics known to be related to the occurrence of psychiatric disorder. The range of psychiatric disorders included in the count is subject to wide variation, depending on the aim of the enquiry and the views of the observer, and is difficult to control because of differences in the usage of diagnostic terms.

In addition, doctors probably differ in the extent to which they perceive a particular condition as psychiatric, especially if the patient presents initially with what appear to be "physical" symptoms, such as pains in the abdomen, back or head. The influence of certain characteristics of the G.P. upon recognition of psychiatric cases has been elegantly demonstrated in the report by Mowbray, Blair, Jubb, and Clarke (1961) of a pilot study by the West of Scotland Faculty of the College of General Practitioners and the Department of Psychological Medicine, University of Glasgow. Fifteen G.P.s in seven groups or practices sampled their practices at the point of termination of each transaction with a patient (including obvious terminations and also, where less obvious, points at which there was no undertaking to see the patient within a period of one month). Diagnoses were categorised as 1. physical illness (62%); 2. psychological factors in physical illness (21%); 3. psychosomatic illness (5%); 4. psychiatric cases (3%); 5. personal problems (2%); 6. other category (7%). A significant negative correlation ($r = -0.7$) was found between number of years since medical qualification and the proportion of patients placed in combined categories 2 and 3. The corresponding correlation between years since qualification and proportion in category 4. was also negative, but not significant ($r = -0.27$). The level of interest in psychiatry of the 15 doctors was rated on a 5-point scale by an official of the College who knew all the participants. A

positive association was found between level of interest and the proportion of patients placed in each of the categories 2, 3 and 4 separately.

Having recognised or suspected the existence of a psychiatric disorder, what factors weigh with the G.P. in his decision to refer a patient for psychiatric opinion and treatment? In a study by Kessel (1960), neurotic patients referred to hospital by a group of G.P.s did not differ in the form of their illnesses from many of those not so referred. It was difficult to decide what factors had led to their referral. In the enquiry reported by Mowbray and others (1961) a series of G.P.s' letters referring patients to a psychiatric clinic were analysed. The findings suggested that few practitioners referred patients on the basis of a positive diagnostic appraisal, tending rather to stress abnormalities of conduct, the existence of social problems or inappropriate responses to medical attention as reasons for referral. It was concluded that variation in type and number of referrals could be due to a wide variety of attitudes to psychiatry on the part of practitioners.

An interesting opportunity occurred in S. Wales to make a close comparison of the factors influencing referral of patients to psychiatric services from six general practices, including eight practitioners, situated in the same mining valley (Rawnsley and Loudon, 1962, a and b). Information about cases referred during the period 1951-59 was gathered from hospital and clinic records. This included clinical data, name of G.P. and a statement as to whether the patient was referred directly by the G.P. to a psychiatrist or came by way of another specialty, e.g., the general medical clinic. Data about the practice populations was gathered principally from a private census taken throughout a defined area in the mining valley by Professor A. L. Cochrane of the Medical Research Council Epidemiological Research Unit. One of the items on the census schedule requested the name of the G.P. The populations of the six practices were found to be closely similar in their distributions by sex, age, occupation, number in household, place of birth and education.

Despite this homogeneity, the rate of referral of patients directly to psychiatric services shows a substantial variation among the practices, so that, for females, the highest rate (36.8)* is almost twice the total average (19.4) and more than three times the lowest (10.8). One reason for this diversity of rates could be the

*Average annual rate of direct referrals per 10,000 population at risk.

selective recruitment of psychiatric cases to those G.P.s regarded by the population as being especially competent or sympathetic in handling such problems. This hypothesis is not supported by evidence available from the material. It may be supposed that doctors differ in the criterion of clinical severity which they apply in deciding to refer a patient, or in the relative proportions of diagnostic categories referred. The findings, however, show no significant difference between the six practices in either of these factors, nor in the distribution of referrals by age, civil state or occupation.

A clue to the factors which may influence referral came from interviews conducted with the G.P.s themselves. The commonest reported factor was the failure to respond to treatment provided by the G.P. However, a medley of "non-clinical" factors was also mentioned, each of which appeared to weigh in varying degree with individual doctors. Examples are, 1. pressure from relatives for something else to be done; 2. request by patient to see a specialist; 3. serious impairment of patient's working capacity; 4. lack of emotional support for patient from members of the family; 5. G.P.'s opinion that the patient may find it more acceptable to be told he has nervous trouble by a specialist, rather than by his own doctor.

It was not possible to make a quantitative estimate of the influence of each of these factors separately upon referral practice. Their diversity, however, even among the eight G.P.s studied was noteworthy. The varying weight accorded to these non-clinical factors by different G.P.s could perhaps account, in part, for the variation in direct referral rates.

The variation in rates of referral to psychiatric services shown in the above study has implications for epidemiological research in psychiatry based on specialist-treated cases. Since the G.P. is the principal agent by whom patients are passed to the mental health services, he must exercise a powerful influence on mental hospital and clinic morbidity statistics. The habits of G.P.s in referring cases may well be determined, in part, by the nature of the training in psychiatry received at the medical school. The psychiatric morbidity statistics for a large population might be influenced by the teaching policy in psychiatry in the medical school which produces a substantial proportion of the doctors for the area.

Attitudes Values and Symptom Patterns

The findings suggest that some doctors take

their cue for referral from the relatives' attitude or from that of the patient. To this extent, therefore, referral will depend in part upon the attitudes prevailing in the populations to illness, to doctors in general, and to psychiatrists in particular. There may well be variations in such attitudes which are related to sex, age, social class, area of residence and other factors.

The study of the relationship between the prevalence of mental disorder measured by direct survey of a population and the complex web of social attitudes, values and standards which also prevail in the same population raises difficult issues both theoretical, methodological and technical.

Detection of the common psychiatric ailments—neuroses and personality disorders, for example—depends upon reports of behavioural anomalies or of changes in inner experience which will, in turn, be governed by the standards of "normal" behaviour and experience of patients themselves, or subscribed to by their relatives or by other members of their social world. Quite apart from the awareness of the existence of abnormality, attitudes of diffidence arising from the possibility of stigmatisation may lead to concealment of such disorder even during special enquiry. Beliefs concerning depression or morbid anxiety may cause a denial of such phenomena. Potent in this regard may be the notion that these manifestations are not of medical importance but rather indicate moral defect or a weak character. The neurotic may be held personally responsible for his symptoms which are seen, in the last analysis, to be susceptible of voluntary control in a way which does not apply to manifestly "organic" symptoms.

An opportunity to study the influence of the social climate upon the pattern of psychiatric symptomatology arose when the entire population of the South Atlantic island of Tristan da Cunha was evacuated to England in 1961 following a volcanic eruption (Rawnsley and Loudon, 1964).

Although there has usually been fairly regular contact between Tristan and the rest of the world, the community may be regarded as closed in that, for half-a-century before the volcano erupted, there had been virtually no permanent migration in or out of the island. The nature and circumstances of life on Tristan—close proximity of residence in a corner of an inhospitable island mountain; universal inter-relatedness through blood or marriage;

an economic life requiring much co-operation in certain processes—had led to a remarkable homogeneity in social values and attitudes and a low tolerance for departures from generally accepted standards.

In 1937 the population was subject to an epidemic of major hysteria which was extremely well documented by the doctors of a Norwegian expedition which arrived shortly after the epidemic began (Christophersen, 1946). Twenty-one islanders were affected, 11% of the population. It was possible to identify these cases by name from the details provided in the Norwegian report and 19 of them came to England as evacuees, almost 25 years later.

The hysteria took a variety of forms—faints, convulsions, “sleeping spells”, “fighting spells” and “choking spells”. The epidemic gradually subsided over a period of several months and although sporadic cases have occurred since, the condition has never recurred on the same scale. It is difficult, in retrospect, to say what factors may have precipitated this outbreak. Strained relationships between families; sexual rivalries and jealousies; the isolated monotonous life, are among the causes mentioned both by the Norwegian investigators and by members of the community. In the early stages, at least, this series of dramatic exhibitions attracted a great deal of attention and evoked much interest in the population.

In a socio-medical survey conducted in 1962 by a social anthropologist (J. B. Loudon) and a psychiatrist (K. Rawnsley), the investigators were impressed early in the course of the enquiry by the high frequency of headaches (59% of adult population) and by the remarkably stereotyped manner in which these were described. They were bifrontal in distribution, the position often being indicated by a characteristic gesture. They were common both on Tristan and in England and sufferers were accustomed to have them every week or two. Sometimes they were disabling, causing the patient to cease work for a while, but usually they were said not to interfere with life activities. They were not associated with eye symptoms or vomiting and were relieved by aspirin. The commonest provoking factors were exposure to strong winds or bright sunshine; menses; and worry.

An association was found between the occurrence of headache, especially of worry-provoked headache, and a history (from the Norwegian report) of previous hysterical attacks. Thus,

of the 19 individuals known to have had hysteria 25 years previously, 16 now stated they were subject to headaches associated with worry. Only three members of a control group of 19, matched for sex and age, had headaches of this kind.

Sixty per cent of the islanders who reported headaches denied the influence of anxiety or worry in provoking attacks. In considering the physiogenic as well as the psychogenic basis of the Tristan headaches one is reminded of the experimental work by Holmes, Goodell, Wolf and Wolff (1950) on responses of the nasal mucosa to a variety of stimuli in normal subjects. Swelling of the turbinates, hyperaemia, increased secretion, obstruction, lowered pain threshold, and sometimes the development of a rather characteristic headache occurred in response to the following: pain elsewhere in the body; cold; bright lights; menses; allergens and certain emotional states, notably anxiety, resentment, anger, guilt, humiliation, frustration. To recapitulate: the precipitating causes of headache reported by the islanders were worry; bright sunshine; strong winds; and menses.

Two hypotheses may be advanced but cannot be resolved on the evidence provided by this survey:—

1. A high proportion of the population is liable to nasal congestion with consequent headache in response to a number of provoking agents. Those of neurotic disposition may find that their undue load of anxiety or other morbid affect is especially potent in producing the response.

2. There is a nucleus of people, perhaps quite a small one, with headache due to nasal congestion. In addition, however, there are islanders who, without a physiogenic mechanism of this kind, have adopted the headache response to anxiety as a convenient, socially acceptable, commonplace symbolic reaction. The homogeneous nature of Tristan society, together with the high degree of social interaction, may have powerfully influenced the establishment and spread of this symptom. If one accepts the Norwegian figures for prevalence of headache in 1937, it must be concluded that this malady has become much more extensive in recent years. Headache may now have become, in part, an endemic neurotic symptom modelled on a physiogenic disorder, but spreading through the community in a less dramatic though more enduring fashion than the convulsive hysteria of 1937.

The association between certain social attitudes and the prevalence of symptoms has been studied in the much more complex, much less homogeneous society of a rural area in S. Wales. The work of a social anthropologist in this population (Loudon 1961, 1964), together with the private sociological census made in collaboration with Professor Cochrane's Unit laid the basis for a division into population sections which differed socially in many respects.

A comparative survey has recently been made of the prevalence of a large number of symptoms in random samples drawn from each of the social sections of the rural population. Special techniques were devised for application in home interviews for the assessment of symptoms and of associated attitudes. The attitudes measured were (a) level of sympathy manifested towards certain symptoms; (b) extent to which the same symptoms are regarded as proper objects of medical care.

Symptoms were assessed using techniques designed to minimise the observer's active participation with the consequent distortion due to prejudice and bias in the observer. For comparative purposes, main reliance was placed on two "objective" procedures—a modification of the Cornell Medical Index Health Questionnaire which, in its original form comprises some 200 questions (to be answered 'Yes' or 'No') about physical and psychological symptoms; and specially designed scales for a limited number of symptoms (Ingham, 1965). The scales had an advantage over conventional questionnaire forms in providing a method of grading the severity of the symptom. They also, by their design and method of presentation, served to reduce the influence of certain spurious response "sets", e.g., a tendency to answer "Yes" to questions whatever the content, which might otherwise yield spurious variations between social categories.

Other measures of morbidity were also employed, including re-interview of a subsample by a psychiatrist who was ignorant of the performance on the first interview; special observation by G.P.s for a period of three months; records of attendance at psychiatric hospitals or clinics in recent years.

The results of this investigation have yet to be published, and no attempt will be made to present them in this paper. The survey is mentioned principally in order to draw attention to the outline strategy and design of a particular research project aimed at uncovering asso-

ciations between the complex web of social values and attitudes (viewed as elements in the social structure and organisation of a population) and the pattern of psychiatric symptomatology.

It was predicted that there would be positive associations between the social attitudes (of sympathy, and of readiness to seek a doctor's advice) in a section of the population towards particular symptoms and the prevalence of these symptoms in the population section. The social anthropologist, deploying his skills initially at the "micro" level of observation of social relations, behaviour and values, was able to proceed at the "macro" level to the construction of an ad hoc social classification of the entire rural population yielding divisions peculiarly relevant to the purpose of the enquiry. The psychologists devised techniques for the quantitative estimate of both attitudes and symptoms with built-in safeguards to offset the prejudices of the interviewers and to reduce the influence of response "sets". The psychiatrist, using more conventional clinical skills, was able to provide data for comparison with the psychological measures.

Sir Aubrey Lewis (1961) has bemoaned the dependence on symptom counts in psychiatric surveys rather than on diagnoses. He regards such a state of affairs as "humiliating because it throws us back to the infancy of medicine; it aligns us with the school of Cnidus, so sharply rebuked by the rival Coans twenty odd centuries ago for differentiating a host of types of disease solely according to the subjective symptoms complained of, without regard to what examination might reveal or a common cause underlie." Nevertheless he concludes, "It must be sadly admitted that we cannot escape it in our present state."

Progress in the epidemiology of mental disorders hinges in the first place upon the sharpening of methods for the reliable and valid estimation of psychiatric morbidity. Attempts to design such methods quickly evoke fundamental questions concerning the nature and definition of psychiatric disorder. The answers involve, *inter alia*, consideration of social values and attitudes pertaining to human behaviour. In addition to influencing the recognition and disposal of the psychiatric case by the G.P. and affecting the fate of the patient in hospital, social attitudes may make a powerful contribution to determining the occurrence and content of psychopathology.

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