American Handbook of Psychiatry

Social Disintegration and Mental Disorder

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Table of Contents

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It is widely recognized that when circumstances force isolation on an individual, he is apt to show psychophysiological disturbances and symptoms of psychiatric disorder, such as depression, anxiety, and delusions. The sources of isolation generally lie in some disruption of the communications the individual has with other people. Most influential, as a rule, are matters that affect ties with family members because of their strong emotional character, but ties with friends, neighbors, coworkers, bosses and employees are also significant, owing to the bearing they have on such matters as self-esteem and identity. If the disruptions are sudden, they may be regarded as crises; it they are continuing, they may be considered in terms of chronic stress.

Those circumstances that force isolation on individuals are usually imbedded in society and culture. It is this fact that provides the frame of reference for the present chapter, in which I consider social and cultural influences in relation to mental health and mental illness.

The total field is large and parallels those that focus on genetics and on organic factors.

A Concept of Psychiatric Disorders

The term “psychiatric disorder” is here employed to designate everything commonly found between the covers of a general textbook in psychiatry. It is thus a category such as surgical disorder or medical disorder. I do this as a means of outlining the territory of reference and to avoid the more restrictive connotations of such terms as “mental illness,” which might imply psychosis, or “emotional disturbance,” which might exclude the cognitive.

The mass of information in a psychiatric text has a number of components: descriptions of behavior, including verbal statements about subjective states; theoretical explanations of these behaviors; descriptions of entities in which behavior and explanations are combined so as to constitute diseases, or illnesses, reaction types, or so on; a nosological system for naming and ordering the entities; and recommendations for treatment according to entities.

The possibility of valid generalization about textbooks stops somewhere close to here. Beyond this point one encounters differences and controversy among clinicians regarding phenomena, theory, and the most suitable ways of organizing the subject matter. There are, for example, the psychoanalysts, the organicists and the eclectics, and there are of course many divisions and crossovers among these. From outside psychiatry and psychology comes theory about sick roles, social determinism, and challenges to a lot of things

vaguely labeled “the medical model.”

A situation of this sort makes scientific investigation difficult, but not impossible. One course is to adopt certain limited definitions, to hold them tentatively but use them systematically, and to see if they provide a basis for improved definitions and sharper issues for research. This procedure can be described as employing operational definitions in order to advance through successive approximations.

With this in mind, suppose we select that part of the field covered by psychiatric texts concerned with describing behaviors (including both physiological phenomena and expressions about subjective states). This restricted area is still of considerable size in that it contains all the behaviors of major interest to psychiatry, but it does exclude etiological implications and the conceptualization of entities. A tentative ordering can be achieved by accepting, for the time being, such traditional groupings as anxiety, depression, and schizophrenia. We may conceptualize these as patterns, commonly referred to as symptom patterns. Inasmuch, however, as the word “symptom” has connotations of some underlying entity (for example, a disease), it is probably better to say “behaviors of psychiatric interest” (BPI).

The utility of this procedure is that it permits counting the frequency of BPIs in populations and enables one to do so independently of etiological

assumptions or interpretations. This is a step toward setting up indicators of psychiatric disorder that can be treated epidemiologically. But more is needed. In addition to discovering something about types and frequencies of BPIs, it is also desirable to learn something about severity.

The notion of severity, as employed clinically, has as a rule two dimensions. One is degree of manifest disability or impairment; the other is the implied seriousness of the condition. This usually involves some expectation with regard to eventual outcome. For example, an anxiety symptom pattern and a schizophrenic symptom pattern could be equally impairing, but the schizophrenic pattern would be considered more serious.

Let us again take the phenomenal rather than the speculative meaning and, rejecting the concept of seriousness, limit ourselves to the disability or impairing aspect, and utilize criteria that bear on interference with work, family, and community roles. Impairment by reason of a BPI can thus be estimated along dimensions from none to severe. There is an advantage here in having a measure of independence between BPI and impairment. In population studies, for example, BPIs can be tabulated and analyzed with or without reference to degree of impairment.

The operational conception of psychiatric disorder presented thus far may be summarized as an array of behavior patterns each of which can vary

along a dimension of impairment. Several questions immediately arise, of which two are: Why select this particular conception? What relationship does it have to clinically identifiable psychiatric disorders?

The selection arises from the kinds of questions we wish to ask of nature. Any research on the relationships of societal and cultural factors to psychiatric disorders has to be concerned with the untreated just as much as with the treated, and with the well just as much as with the people who have disorders. This means sampling surveys of total populations, and this in turn puts boundaries on the kind and amount of data that can be obtained from all subjects in a standard manner. Under these circumstances, data on behavior patterns of psychiatric interest are much more feasible than are data pertinent for psychiatric diagnosis (or what Oppenheimer calls "interpretations").

A second major reason (pertinent to the sociocultural questions we desire to ask) is the need to avoid building causal relationships into the ways the phenomena are defined. It is true, of course, that most of the etiological concepts in dynamic psychiatry are not directly social, but they are indirectly. Mother-child relationships, for example, are differentially affected by cultural variations and by differences in socioeconomic class levels. Further, the repertoire of symbols and their significance may vary markedly under the influence of such factors.

A third point is the fact that clinicians appear to agree among themselves much better regarding BPIs and ratings of impairment than they do on diagnostic formulations.

What is the relationship of BPI to clinically identifiable psychiatric disorders? The last word has not been said on this, but several studies indicate that if an individual has been found by survey methods to have marked BPIs and a significant degree of impairment, a psychiatrist conducting an independent assessment is highly likely to find that the individual is manifesting some kind of clinically identifiable type of disorder. Conversely, it is very rare for the person low in BPIs and who is not impaired to be adjudged as suffering from a psychiatric disorder. There are exceptions in both directions, but it appears safe to say that there is strong association between BPI rating systems and any of several different diagnostic orientations.

This is perhaps enough to indicate the concepts (BPI) with which societal and cultural factors will be approached. There remain still, of course, numerous questions, but they would require more space than is available here.

One, however, may be touched upon in conclusion: What definition of pathology is being employed? I am using a functional definition. Borrowing

from Virchow, I would like to suggest that pathology is not only a matter of lesion but of danger to the organism. BPIs are considered pathological when:

1. They constitute a behavior pattern that in some degree places in jeopardy the survival of the individual. Subjective suffering and social disability are both aspects of this.

2. The malfunctioning is self-perpetuating, that is, it tends to persist despite efforts of the individual and/or others to exert control.

A Concept of Sociocultural Disintegration

Up to this point we have been discussing psychiatric disorders and, by implication, personality. The focus, in short, has been on the individual level of integration, not on biochemistry, cells, organs, or such psychological faculties as cognition and affect but on the functioning of a total system made up of these components.

In this section I should like to direct attention away from individuals to societal systems. This constitutes a major jump, something like moving from cells to a whole person. The meaning of "societal system" may be illustrated by a village or a town. Such a community is a system in that it has patterns of interpersonal behavior that are essential to the survival and welfare of the whole. These patterns enable the group to obtain what is needed for

subsistence, protection against weather and disease, control of hostility and other forms of disruption, the creation of new members and their education, disposal of the dead, networks of communication, storage of information, ways for arriving at decisions and taking united action, and much else. Such collective, patterned activities have been called the "functional prerequisites of a society."

A societal system is an integer distinct from the individual level by virtue of having properties that are more than the sum of the components. The components contribute, of course, but the net result is behavior of the whole, consisting in patterns that could not be produced by multiplying individual behaviors. It is rather the product of many, various, and reciprocal behaviors on the part of individuals.

I am putting emphasis on this matter of a "jump" because all of us who have been engrossed in the study of personality have considerable difficulty in thinking of human groups in other than additive terms. Although societal phenomena are dependent on the organic and psychological characteristics of individuals, they can be studied in their own right, and such of course is the business of the social psychologist, the sociologist, and the anthropologist.

To further develop the point, let us note that societal systems (communities) continue to exist while the individuals who compose them

enter and leave. The analogy to cells in some parts of the body suggests itself. To a certain degree societal systems are independent of the individuals who compose them, for they can outlast many generations and even survive when large numbers of the constituent individuals are killed, as in an epidemic or war. Conversely, a societal system may flounder, fail in fulfilling its functional prerequisites, and eventually disappear without there being a commensurate mortality among the individuals who compose it. As ghost towns demonstrate, these people may survive through moving away and being absorbed in other systems.

Let us take a moment now to expand the notion of societal system beyond the example selected at the start, a town. What has been said about towns can also be said about larger clusters of people, such as cities. It can be said too of countries and tribes that are composed of many cities and towns. In such cases, the cities and towns are subsystems within the larger whole.

It is also evident that subsystems of another kind exist within the above types of groupings, namely, institutions such as government, industry, and schools. These also exhibit behavior patterns that are more than the sum of individual components, and they generally have a life that extends beyond that of these components.

If a societal system has functional prerequisites, it is evident that it can

function well or badly. Historians and statesmen have long had a somewhat organismic view of human groups even though they may not have developed it fully. In Western civilization, writing about functional and malfunctional societal systems appears to have begun in the Greek city states, in the setting of their fierce competition with each other, and their successes and failures. Plato's theories and his attempt to apply them to Syracuse are well known. Gibbon's *Decline and Fall of the Roman Empire* was an effort to look back and comprehend the widespread, catastrophic malfunction of Mediterranean societal systems that ushered in the Dark Ages.[2]

The notion of societal systems and the notion of good and bad functioning at the societal level are basic to understanding the concept of sociocultural disintegration. It was in relation to this background that my own studies of human groups in disarray led to the ideas summarized in the remainder of this section.

As a beginning, let us imagine two contrasting human groups. One, at an ideal pole of sociocultural integration, we shall call the "model." This is a perfectly functioning community in which subsistence, protection, communications, and all the other functional prerequisites of a society are operating smoothly. In contrast to this, at the opposite pole of utter sociocultural disintegration, is the "collection." Here there is no system, but instead a collection of human beings whose procuring of food, shelter,

defense against attacks, and so on are purely individual matters. A passive inert mass of human beings can be supposed, but it is easier to visualize the conflict of individual interest leading to Hobbes's war of all against all.

It is unlikely that either the collection or the model has ever existed in pure form, but postulating them helps to make two points. (1) A town or other similar type of societal system must be somewhere between these two extremes. Thus, though it may be far from perfect, it may still, in practical terms, be functioning pretty well; or it can be toward the disintegrated pole and gravely impaired with regard to its functional prerequisites and so have little margin separating it from extinction. Such a condition is manifest in such matters as failures of communication, lack of leadership and followership, broken homes, fragmentation and confusion of shared values, and increased intragroup hostility and violence. Degree and type of integration or disintegration thus constitute a frame of reference in terms of which communities can be compared with each other, or the same community with itself as different points in time.[3] (2) Both integration and disintegration are always going on in any given community at the same time, like anabolism and catabolism. The total process may be looked upon as a dynamic equilibrium that now swings toward greater integration and now toward less. I would suggest, however, that communities moving overall toward the pole of disintegration pass ultimately a threshold from beyond which the ordinary integrative processes are powerless to recall them. There is descent then into

a state of chronic malfunction, or possibly extinction of the community.

This frame of reference highlights three questions: What causes communities to reach a state of irreversible disintegration? Can measures of prevention be developed? Once such disintegration has occurred, can it be cured?

At the present moment in history, the importance of these matters hardly needs underlining. It is manifest that sociocultural disintegration is an exceedingly widespread phenomenon. The rise of crime; economic maldistributions; the inadequate coping of administrative bodies; strikes by police, sanitary engineers, transportation workers, hospital staffs, and others; and the melting away of shared values and recognized codes of ethics and conduct are all specific examples of impairment with regard to functional prerequisites such as subsistence, division of labor, communication, protection of various kinds, control of hostility, united action in problem-solving, and so on.

The questions of cause, prevention, and remedy are much in discussion. There is a certain amount of scientific information available for use, but this is overlaid by much else stemming from folklore, political and economic interests, and the blindness of aroused passions. While a behavioral science approach might be of service in solving the problems, the irony is that the

scientific approach itself requires a base in a well-integrated societal system. So far as knowledge of cause goes, there appears to be evidence that poverty, migrations, population increase, and rapid social and cultural changes constitute factors that both initiate and then become an expression of sociocultural disintegration, making up many interwoven vicious circles.

Our problem in this chapter is the relationship between sociocultural disintegration and psychiatric disorders. We shall, therefore, deal with the causal factors in sociocultural disintegration only insofar as psychiatric disorders constitute one of them.

A Theory of the Relationships of Psychiatric Disorders and Sociocultural Disintegration

Sociocultural disintegration, as we have seen, involves societal malfunction. This is part of the definition. Our theory states that this societal malfunction increases the prevalence of psychiatric disorders in the population of the affected societal system. Discussion of the techniques for measuring integration and disintegration are beyond the scope of this chapter. Suffice it to say that they exist at a first approximation level and that refinement of instruments is a major area for investigation. This process occurs in multiple ways, some of which may be described as follows.

1. Through an increase in the frequency of organic diseases. This occurs

because the functioning of medical institutions (for example, hospitals, outpatient care, and public health services) shares in the disintegration and also because economic difficulties and failures in the coordination and administrative aspects of the societal system result in an increase of unsanitary conditions and a reduction of food resources leading to widespread malnutrition. In short, the more a community is disintegrated, the less it is able to protect itself against organic disease.

As illnesses based on infection grow, and as accidents and malnutrition increase, there is a proportional increase in those psychiatric disorders in which the organic component plays a major role. These may include brain damage from syphilitic and viral diseases, damage to the central nervous system by lack of B-complex and other vitamins, and brain damage from poorly conducted parturition and from prenatal illnesses, such as rubella.

This is probably enough for illustration. The central idea is that even though some of the diseases of civilization, such as those based on a too rich diet, might be improved by disintegration, the net effect would be major increase in morbidity with a consequent increase in all psychiatric disorders in which organic factors play a key part in the etiological complex. In practical terms we would expect to see this in war-shattered populations and those torn up by uncontrolled migrations, such as the septic fringe and deteriorated core of many cities. We would expect it in populations whose societal systems

had been disintegrated because of economic disasters and in communities where the process of social and cultural change had become accelerated to the point that the consequent failures in function were so marked and so widespread as to push these systems beyond the threshold of spontaneous recovery.

Furthermore, as the general level of morbidity rose, one could expect that this too would become progressively more and more of a factor in the disintegration process, adding a new malfunctional cycle to the numbers already in progress. That is to say, the more people ill, the fewer to manage the roles in the societal system. The ill thus constitute a diminution in the system's resources for recovery and an increment toward disintegration. BPIs from intellectual deficiencies, emotional labilities, and other manifestations of brain damage would constitute a significant part of this morbidity.

2. Through failure of the child-nurturing and child-rearing patterns of the societal system. Due to economic breakdowns, the dissolution of codes of conduct, and the evaporation of shared sentiments, the growing child must experience many influences detrimental to the growth of a well-functioning personality. There would be a greater frequency of maternal deprivation, inadequate or absent father figures, and such incongruities and discontinuities in peer relationships as render the interpersonal medium in which personality formation occurs both noxious and distorting.[4]

Altogether, then, where social disintegration has lasted long enough to see generations grow up through its noxious influence, there would appear more and more individuals with impairing BPIs of the type associated with neurosis, psychosis, and personality disorders. As with the mainly organically based psychiatric disorders, these would add in turn to the forces making for sociocultural disintegration. Such would be particularly true of the personality disorders, with their asocial, dyssocial, and antisocial manifestations.

3. Through stress applied during youth, middle life, and old age. The notion here is that BPIs are in part manifestations of psychological strain derived from experiencing the world as a sea of frustrations, terrors, and disappointments. Very little works out according to hopes, and almost nothing has meaning. Such conditions are due to the lack of shared values, lack of standards and codes of behavior, and lack of opportunity for satisfaction of such basic needs as freedom from fear, access to love and respect, a sense of belonging to a worthwhile group, and opportunity for the expression of spontaneity.

The above theory of stress and strain requires some elucidation: Personalities are seen as dynamic systems, and certain conditions of the societal environment constitute stress to which the systems react. When the stress is prolonged and severe, the reactions have a tendency to become

chronic, malfunctional, and to persist after the stress has been removed. In other words, manifest psychiatric disorders emerge.

In accepting societal stress as part of the etiological complex involved in the production of psychiatric disorders, it is not necessary to scrap psychodynamic theories. It may well be that many people have neurotic personalities as a result of experiences in early life. Social stress theory would assume that some of these could be so severe as to be evident in even the most benign environment. It would also assume that most people are able, under favorable conditions, to control or adapt their neurotic tendencies so that no very impairing BPIs result. Under stress from societal disintegration, however, the functional adaptations give way, and impairing BPIs emerge. The more severe and prolonged the disintegration, the greater the stress and the larger the proportion of people in the population who would manifest disorder. Finally, it can be assumed that when stress is sufficiently prolonged and severe, even persons without a neurotic predisposition will suffer damage to the personality and begin to show malfunctional, hard to reverse patterns of behavior characteristic of psychiatric disorders.

As indicated under points one and two, here also the psychiatric product of sociocultural disintegration becomes a contributor and adds to the network of interlinked deteriorating cycles, which, like chain mail, resist efforts to penetrate and modify. Anxiety, hostility, and delusional behaviors

increase, short-term remedies such as drugs and the excitement of violence are sought, whereas long-range and cognitive efforts decline.

Illustrative Findings and Interpretations

In the Stirling County study, covering ninety-seven communities, a number of settlements were identified as exemplifying disintegration, and others, integration, utilizing sociological and cultural criteria. Neither group was at the extreme of the continuum, nor was it static; what the labels indicate is that within the range offered by the county, some communities lay more toward disintegration and others more toward integration. To this may now be added what became an evident fact: Differences between these two categories of settlements were considerable, with most of the ninety-seven communities occupying a place between the settlements at the extremes.

When the prevalence of BPIs and their degree of impairment were assessed by means of samples, it was found that by and large the disintegrated groups had a much higher prevalence rate of impairing BPIs than did the well-integrated groups.

This statement sums up the findings in a very by and large fashion. The observations that underlie it are numerous and various, and the statistical treatment is intricate. It is necessary to incorporate qualifications and to consider alternatives at numerous points in the course of building logical

inferences.

A few selected major points may be noted as follows.

1. The settlements in question were small, ranging in size from 100 to 450. Generalization from these to other societal systems of different size and composition is not as yet justified on the basis of any well-controlled body of data. The theoretical frame of reference, however, does postulate a strong relationship between societal disintegration and high prevalence of psychiatric disorders and would expect it to be demonstrable in many different kinds of communities and without regard to size. From this point of view, the Stirling County study results constitute specific instances of general process relationships, dissected out by the research and made visible. Parallel studies conducted in Nigeria have given similar findings.

2. The study dealt exclusively with adults. Hence it remains for future investigation to probe the theoretical expectations regarding the noxious effect of growing up in a disintegrated societal system. The expectation, however, remains highly plausible because the characteristics of child-parent and child-peer relationships in such situations fulfill criteria of noxiousness from the viewpoint of virtually any psychological theory of development from psychoanalysis to operant conditioning.

3. The sample of respondents used in Stirling County to estimate the

prevalence of BPIs were the same individuals who contributed a major part (though not all) of the data pertaining to estimates of community integration and disintegration. This raises the possibility of one variable being contaminated by another. People suffering from anxiety and depression, for example, may see their communities in more negative terms than do others. Conversely, lack of social control may appear at the individual level as personality disorder of the sociopathic type.

The above is a serious problem, and it is highly desirable to develop techniques that employ different samples for the two main sets of variables and that base estimates of integration-disintegration on observed behaviors, excluding respondent opinions.

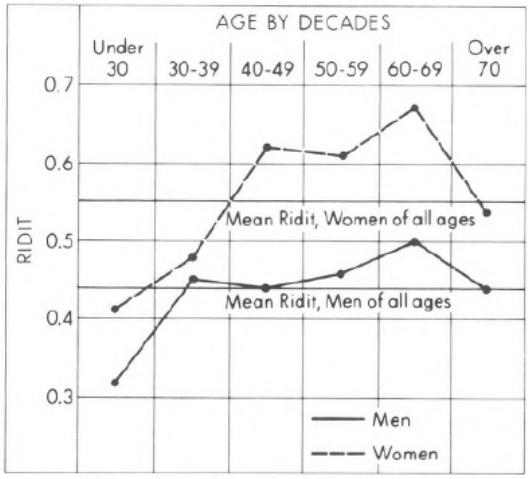
On the other hand, despite the need for such progressive refinement, the issue does not really call in question the correlation of high frequency of disorder with marked sociocultural disintegration. There are plenty of BPIs and indicators of disintegration that are not open to any reasonable suspicion of contamination. Psychophysiological manifestations and behaviors characteristic of anxiety are not individual expressions of such societal variables as lack of leaders, deficient communications, or broken families. It is more plausible to suppose they are either cause or consequence.

4. The correlations demonstrated in the Stirling study do not prove that

the societal factors are the cause of the psychological. It could be either way, or both together interacting, the joint result of some third influence. Our theoretical frame of reference suggests the high probability that in the present state of the world, there are many physical and sociocultural forces at work creating disintegrated societal systems, and that chronologically the beginning of the interacting, malfunctional cycle (or spiral) is most commonly a tear in the social fabric. If our theoretical orientation bears resemblance to what is going on in nature, then a prime issue for the welfare of mankind is to find where effective intervention can be applied. It appears virtually certain that the individual treatment level alone will not suffice. Discovering ways to prevent or reverse sociocultural disintegration is thus a central issue in the mental health field.

Figure 28-1 depicts the distribution of impairing BPIs according to age and sex. The statistic used here is the "ridit" rather than percentage, and this is done in order to be congruent with previous publications. For the purposes of this chapter it is probably sufficient to note that 0.50 is the mean for the entire Stirling County sample. Ridits above this are indicative of more psychiatric disorder than the mean, and ridits below indicate less. The ridits are based on ratings which in turn are based on BPIs.

FIGURE 28–1. **Variation in ABCD Ridit with Age and Sex.**



(Reprinted from D. C. Leighton et al., *The Character of Danger: Psychiatric Symptoms in Selected Communities*, Vol. III [New York: Basic Books, 1963], p. 255. Reprinted with permission.)

Table 28-1 shows the ridits according to disintegrated areas, well-integrated areas, and the county. The figures suggest not only the predicted relationship between psychiatric disorder and sociocultural disintegrative process but also a marked difference between men and women in this relationship. Attention may be drawn to the following:

1. Overall, women have a higher prevalence rate than men. This difference increases with age.

2. Both sexes have the highest rates in the middle years, and both have some dropping off of frequency with age.

3. In disintegrated areas, there is little difference between men and women; what difference there is appears to be toward greater frequency in men.

4. In well-integrated areas, the marked sex difference persists, but it may be in either direction. Thus in one integrated community the men have a higher rate than the women, albeit both are lower than the mean. In another integrated community, the women have a very much higher rating than the men: The women are ten ridits above the mean ("more ill"), while the men are ten units below. This suggests that what may be a benign environment for one sex may be noxious to the other. Disintegration, however, is apparently bad for both.

*Table 28-1. Mean ABCD Ridits for the Disintegrated Areas, Fairhaven and Lavallee, and the County by Sex**

		WELL INTEGRATED		
	DISINTEGRATED AREAS	*Fairhaven*	*Lavallee*	WHOLE COUNTY
Men	0.68	0.43	0.47	O.44
Women	0.65	0.60	0.40	0.55

**Modified from D. C. Leighton et al., The Character of Danger: Psychiatric Symptoms in Selected Communities, Vol. III (New York: Basic Books, 1963), p. 330.*

Further work conducted since 1952 suggests that differences of this sort may be associated with role stress. In other words, in sociocultural systems undergoing marked change, certain societal roles come under more

stress than others, and sometimes the most stressful roles are those determined by sex, in some cases male, in other cases female. There is also some evidence to suggest that similar differences apply to roles determined by age, so that in one population certain younger roles may be more stressful, whereas in others the pressures are felt in roles characteristic of older persons. All these points are invitations for further research in areas that are of maximum significance at the present time.

Some Implications

The BPI approach opens possibilities for reexamination and new understanding regarding the nature of psychiatric disorders. This is by means of opportunities for reliability and numerical treatment.

For example, BPIs can be derived from representative samples of community populations and analyzed through multivariant methods. By these techniques it should be possible to find out which BPIs hang together in such a manner as to indicate dimensions. What is presently considered psychoneurotic anxiety, for example, may be resolved into several distinctive patterns. Further, since BPI surveys gather data from individuals along the entire range from those with none to those with highly impairing BPIs, it is possible for patterns to emerge that constitute syndromes not previously recognized by psychiatry. This could be the case if the syndromes are mild or

if they are of such a nature as to lead the individuals so affected to avoid medical consultation.

A revised and refined descriptive psychiatry based on BPIs would facilitate the investigation of etiologies on both a wide and more intensive basis. Because of its nature, this procedure does not in itself foreclose on explanations, but rather opens questions for inquiry. It anticipates that a given BPI may be a final common path for more than one cause or for several causes in combination. The way is, therefore, prepared for systematic study and, where consistent relationships can be found between etiological factors and particular pattern characteristics, a diagnosis in the full sense of the word may become possible.

Conversely, there is the possibility of uncovering the range and variation of BPIs that may be associated with a given noxious factor.

The above comments refer to all kinds of possible causes, not just to those that are social and cultural. Further, within the sociocultural field, the comments have wider applicability than the elucidation of the relationship of mental health and mental illness to integration and disintegration. Disintegration can account for only a part (albeit an important part) of the disorder variance in populations. For example, there is much evidence to indicate that integrated communities can develop mass delusions and shared

passions that are self-perpetuating and highly dangerous for survival. History is full of examples, many of which focus on religious and political ideologies. Without depending on such dramatic extremes as the crusades, witch hunts, or the dancing manias of the Middle Ages, it should still be possible to examine the process of social cohesiveness and its relationship to BPIs. The use of drugs and alcohol, antisocial behavior such as violence, and the spread of apprehension, despair, and suicide are contemporary examples in which both disintegration and integration play a part, with the latter taking the form of closely bound groups, somewhat detached from the larger society. They apparently arise, at least in part, as a re-integrative reaction to disintegration, but they can often serve to augment rather than stem the general trend toward disintegration.

Conceptualizing psychiatric disorders in terms of BPIs provides a way to avoid becoming polemically stuck on such issues as the appropriateness of the medical model and whether, after all, mental illness is a myth, the product of role definitions. The real, underlying problems are rather those concerned with how the BPIs affect individuals and the community in which they live. Are the patterns disturbing to the person? Are they disturbing to others? Are they easily reversed, or do they require special methods? If so, what methods: drugs, psychotherapy, group therapy, development of coping abilities, or alteration of the societal environment? If several of these together, what is the best combination?

A further point about BPI surveys derives from the fact that they bring to the fore persons who are at the zero end of the range, that is, persons in the population who do not have BPIs and who by this definition are healthy. These constitute a type of individual little examined in psychiatry. Their comparative study with persons who are impaired owing to BPIs sets the stage for describing patterns of health and elucidating their etiologies, utilizing procedures parallel to those employed with regard to BPIs. This means an empirical approach, something very different from much previous work on positive mental health, in which the starting point was frequently a theoretical or ideal construct for defining a mentally healthy personality.

The assessment of sociocultural systems in terms of the integration-disintegration frame of reference leads to theory that has some explanatory power. It provides, for example, an answer to the question as to why so many studies have found a high frequency of psychiatric disorders in the lower socioeconomic class levels: The stress of life in these classes is essentially that of living in a socioculturally disintegrated environment. In the Stirling County study there are some incomplete data that suggest that when low socioeconomic status is not accompanied by sociocultural disintegration, the prevalence of BPIs is no greater than in the white-collar levels. A study in Sweden of a rural area has suggested that when the lowest socioeconomic class is well integrated it may have a low prevalence of disorders.

The potential for explanation is not limited to matters of class difference. It can also be called upon to explain why rapid cultural change sometimes does and sometimes does not involve a high frequency of BPIs. The same applies to populations undergoing migration. In other words, one can say that low socioeconomic class, rapid cultural change, and migration have in common that they constitute a state of risk with respect to sociocultural disintegration. If the disintegration occurs, there is a rise in the frequency of impairing BPIs. If adaptation of the societal system occurs without disintegration, no rise in BPIs will take place. What is needed now is further work to define the limits of this explanatory power and to delineate the processes involved more specifically.

The usefulness of disintegration theory, however, depends in part on the further development and refinement of method so that the data will be at the same level of objectivity, reliability, and susceptibility to numerical treatment as the BPIs.

On the basis of such methodological advances, it should be possible to begin the investigation and definition of disintegration thresholds, that is, the point beyond which reversal of trend toward organizational breakdown becomes impossible without intervention from the outside. Related to this are a host of problems regarding the nature of the threshold. Chief among these, from a mental health point of view, is the impact on the societal system of

increasing the frequency of impairing BPIs. Is the threshold in a large measure determined by a saturation point of BPIs in a population such that coping behavior is overwhelmed and a downward spiral established?

The causes of integration and their relationship to mental health and mental illness are a field of investigation comparable with that of studying the causes of disintegration, and largely open to the same kinds of method. Its importance attaches to the possibility of discovering how benign cycles may come into existence, that is, the counterpart of the vicious cycles and downward spirals. How do mutually reinforcing trends toward integration and low BPIs appear? Further, is the beneficial dimension of integration (so far as mental health is concerned) a curvilinear one? Is there an optimal point of integration beyond which the BPIs begin to rise again because the societal system is too rigid to accommodate human needs? As patterns of mental health become clearer, will it be possible to identify levels and types of integration that are stultifying with regard to these modes of adaptation? Do societal systems have a built-in tendency to oscillate about some optimal point of integration, due perhaps to over-integration leading through increased BPIs toward disintegration?

Turning now to the practical implications for service, the central issue is: How much of what has been said in previous pages can be accepted as a legitimate basis for action? From this point of view, I would like to suggest

that the following assumptions are tenable.

1. There is considerably more psychiatric disorder in populations generally than is being reached by any existing system of delivering services. Much of this is low level in the sense that hospitalization is not indicated, but it represents a considerable amount of suffering and great hampering of interpersonal relations among millions and millions of people.

2. Certain kinds of societal conditions are strongly associated with high frequencies of disorder in populations. Many of these conditions are open to modification.

If one is willing to accept these two assumptions, it follows that the weight of evidence and the force of logic call for revision of service patterns and the development of action programs aimed at modifying noxious sociocultural factors. The theory of sociocultural disintegration can be of help in establishing priorities and in giving some idea of the processes with which change efforts will have to cope.

Arguments against attempts to improve the sociocultural environment (such as some clinicians have made) can no longer be justified by saying, "There is no proof that preventive measures work." To insist on such proof prior to action is to demand more than is demanded for psychotherapeutic effort. Instead of "Prove it before we do it," the emphasis can be placed on

"Let us do it, but with controls so we can learn from the doing and evaluate the results."

If we consider first the matter of dealing with individuals who are burdened with impairing BPIs, it seems likely that there will continue to be a place for some long-term one-to-one psychotherapy with and without the aid of drugs. Aside from this, however, is the pressing need for psychiatry to set up the present trend toward redefining its roles and functions so that many of these can be conducted by paraprofessionals and by professionals who have shorter periods of training. The same applies to the other mental health professions, namely psychology, social work, nursing, and occupational therapy. In particular, one may note the importance of having these five professional groups continue to work together to redefine their respective roles in order to achieve a more efficient distribution of tasks. These activities would span treatment, the reduction of disability, counseling, and crisis intervention.

When we turn to the problem of change in noxious sociocultural factors, it appears very likely that there is need for the development of a new kind of professional whose competence might be in at least three fields: mental health, societal systems, and applied behavioral sciences. If we take the mental health center as an example, this professional could hold a position with some such title as "Director of Community Relations." The aim would be

for him and his staff to work with the other human services in the community and in the planning phase of new developments with a view to environmental enrichment and the reduction of noxious influences. His methods would be catalytic and facilitative, with two main objectives: (1) to interject mental health considerations where needed in the present services and planned enterprises of the community, and (2) to stimulate the development of planned change where this is not occurring but is needed from a mental health point of view. As part of these objectives he would be concerned with helping to bring the other members of the mental health center in contact with those parts of the community in which they are needed and where they would have opportunity of being influential. He could augment their knowledge of the community, aid in identifying high-risk groups, and assist in the development and adjustments of the center's own plans and policies.

There are many other implications of a practical nature, but since the notion of this new kind of mental health professional, the community catalyst, is the most outstanding, it is perhaps the appropriate place to stop.

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Notes

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2 Our present-day understanding of societal functioning takes much of its origin from the sociologist Emile Durkheim and the anthropologists Bronislaw Malinowski and A. R. Radcliffe-Brown. To this should also be added the influence of general systems theory as illustrated in the writings of Ludwig von Bertalanffy and Kenneth Boulding.

3 Discussion of the techniques for measuring integration and disintegration are beyond the scope of this chapter. Suffice it to say that they exist at a first approximation level and that refinement of instruments is a major area for investigation.

4 Beiser analyzes this process in relation to Erikson's eight ages of man.