Chapter 32

MEDICALIZATION/PSYCHIATRICIZATION OF DISTRESS

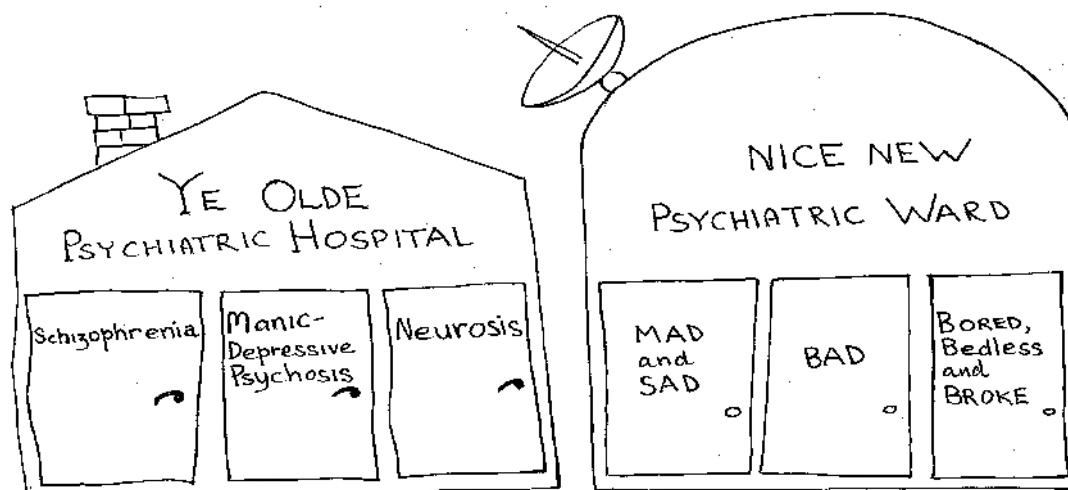

Illustration. This cartoon says much about the (frustration of the) author, with the suggestion that the old psychiatric hospitals performed a useful clinical function. More relevant to the chapter at hand, however, is the suggestion that currently, medicalization of all aspects of life has resulted in people being admitted to psychiatric wards who do not have psychiatric disorders. It is argued that the doors in the middle and the right of the new unit should lead by an underground passage to separate facilities.

Introduction

The Shorter Oxford English Dictionary provides at least 4 definitions of distress, extending from, "the act of straining" to "anguish or affliction affecting the body, spirit, or community". In short, there is no precise definition. For our present purposes perhaps all we can say is that distress is an unwanted state, like pain.

[Recently we have reunited the body and the mind (to make a person) and no longer make the mistake of attempting to draw a distinction between physical and mental pain.]

The Buddha listed painful situations/events: "birth is painful; old age is painful; sickness is painful; death is painful; sorrow, lamentation, dejection, and despair are painful. Contact with unpleasant things is painful; not getting what one wishes is painful" (The Sermon at Benares).

Using The Buddha's opinion, psychiatry deals with distress; patients, their families and friends, all mental health workers experience distress as a consequence of psychiatric disorders.

Psychiatry is now dealing with distress which, in the current author's opinion, is not the responsibility of psychiatry. For example, psychiatry is now expected to assist (up to and including hospitalisation) when individuals have social difficulties and are distressed following relationship breakdowns. Western society is now expecting the profession of psychiatry to deal with forms of distress for which it lacks a theoretical framework and demonstrated practical capacity.

Many factors favour this "dumping" of individuals on Psychiatry. This branch of medicine is poorly understood by other branches and the lay public, and has traditionally managed some of society's most "difficult" individuals. But this does not mean psychiatry has an automatic, primary role in the management of situational crises.

The problem of definitions

We have severe problems due to the lack of clear definitions in this field.

In 1946, with the best intentions, the World Health Organization made matters much worse. The first line of the Constitution of the WHO gives the definition of heath as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". Space does not permit a full analysis of this definition, but the words "complete physical, mental and social well-being" signal the need for economic, social, political and judicial influences which are way beyond those of health professionals.

Psychiatry is relatively defenceless against the "dumping" of social problems on the doorstep, again because of the lack of clear definition of its "territory". Neither of the diagnostic systems (DSM-IV, ICD-10) satisfactorily define mental disorder. DSM-IV states, "…no definition adequately specifies precise boundaries for the concept of 'mental disorder'" (page xxx), and later, "…each of the mental disorders is conceptualized as a clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability…" (page xxxi). Again, distress becomes the responsibility of clinician, in this case, those specializing in psychiatry. There are no guidelines to help with separating pathological states from painful non-pathological states.

In her book, The Broken Brain, Nancy Andreasen (1984) observed that the question, "What is mental illness?" is difficult/impossible to answer, but that when the question is reframed as, "What are the common mental illnesses?" there is "astonishing agreement". This may have been so in 1984, but it is not so in 2007. Most would agree that schizophrenia, bipolar disorder and obsessive-compulsive disorder are all mental disorders/illnesses; but what of "sexual addiction", "antisocial/sociopathic personality disorder", "burn out" and excessive shyness?

Medicalization/psychiatricization of daily life

This chapter deals with medicalization as it applies to psychiatry, thus the term "psychiatricization" (Knezevic and Jovancevic, 2001) has been used in the title. The term medicalization has wider usage in the scientific literature, and will therefore be used in the text. (The terms "pathologizing" and "psychologizing" have also been used in referring to this process.)

Medicalization is the defining of non-medical problems in medical terms, usually as an illness or disorder, and usually with the implication that a medical intervention or treatment is appropriate (Zola, 1972). Medicalization leads to "normal" human behaviour and experience being "re-badged" as medical conditions (van Praag, 2000). An early claim of medicalization (too sweeping, in the opinion of the current author) was the book, The Manufacture of Madness, by Thomas Szasz (1970). "Mental health care may function as a panacea for many different personal and social problems" (Double, 2002).

Initially, (in spite of the fact that the WHO definition of health was the root cause) the medical profession was held solely responsible for the phenomenon of medicalization, and the term "medical imperialism" was coined. For example, on the rebadging "deviance" as a series of medical disorders, sociologist Ian Robertson (1987) writes, "They have become so only because physicians – and particularly psychiatrists – have successfully claimed authority over them". While this has been and continues to be part of the explanation, the complete answer includes broader community factors (Scott, 1990). The current "engines driving medicalization" have been identified as biotechnology (especially the pharmaceutical industry and genetics), consumers, and managed care (Conrad, 2005).

The majority of psychiatrists working in public general hospitals lament the emergence of medicalization/psychiatricization, which has allowed the community (citizens, police, courts, and welfare agencies) to force clinical psychiatrists to accept responsibility for situations/problems over which they exert no significant influence.

A good case can be made for the validity of psychiatric disorders such as schizophrenia, major depressive disorder, bipolar disorder and obsessive compulsive disorder. And, using "evidence based" protocols, the psychiatrist is capable of providing the best possible management for people suffering these disorders.

The new, medicalization-generated disorders may look, on casual inspection, like the traditional disorders (the crying person may appear to be suffering a depressive disorder0. However, there are psychological, sociological and biological differences, and the treatments which are effective for the traditional disorder are ineffective in the management of inappropriately "diagnosed" and referred problems.

Disorders of interest

Critics raise doubts about the validity of recently described “disorders”, many spawned by the medicalization of the difficulties of everyday life (distress). The following table lists some behaviours and potentially matching diagnoses. The intention is not to discredit these diagnostic categories, but to illustrate the potential for normal behaviour to be cast as a mental disorder.

Behaviour	Diagnosis	DSM-IV Code
Shyness	Social anxiety disorder	300.23
Naughtiness	Conduct disorder, Childhood onset Conduct disorder, Adolescent onset	312.81 312.82
Delayed language	Expressive language disorder	315.31
Active	Hyperactivity disorder	314.01
Promiscuity	Sexual addiction (Schaeffer, 1997)	NYI
Sexually disinterested	Hypoactive sexual desire disorder	302.71
Unsatisfactory erections	Male erectile disorder	302.72
Unsuccessful gambling	Pathological gambling	312.31
Amorality	Antisocial personality disorder	301.70
Violence	Intermittent explosive disorder	312.34
Apprehension	Agoraphobia (specific places) Specific phobia (except places) Social phobia (social anxiety disorder)	300.22 300.29 300.23
Worried	Generalized Anxiety Disorder	300.20
Stress at work	Work stress (Wainwright & Calnan, 2002)	NYI
Stress	Acute stress disorder	308.30
Dependent	Dependent personality disorder	301.6
Narcissistic	Narcissistic personality disorder	301.81
Attention seeking	Histrionic personality disorder Factitious disorder	301.50 300.16
Avoidant	Avoidant personality disorder	301.82
Isolative	Schizoid personality disorder	301.20
Excessive coffee use	Caffeine intoxication Caffeine induced sleep disorder Caffeine induced anxiety disorder	305.90 292.89 292.89
Smoking	Nicotine dependence	305.10
Excessive alcohol use	Alcohol intoxication Alcohol abuse	305.00 303.00
Excessive cannabis use	Cannabis intoxication Cannabis abuse	292.89 305.20

NYI = Not Yet Included in DSM, but under consideration, and referred to in professional and lay publications.

Medicalization takes particular forms of distress and calls them particular psychiatric disorder. The disorders most frequently misdiagnosed psychiatric disorders are 1) Major depressive disorder, and 2) PTSD. Suicide is not a psychiatric diagnosis but a Coroner’s court finding, but is medicalized by many commentators, and thus forms a 3rd topic of interest.

Depression (Major depressive disorder)

See Chapter 8 for additional details.

Few (if any) clinicians who work in psychiatric wards doubt the existence of Major depressive disorder. This is a serious and usually recurring disorder. Episodes last months, but may be shortened by treatment. Early episodes may be triggered by undesired events (loss). When multiple episodes are experienced, it may be impossible to identify a triggering event of the later episodes.

Depressed (sad, unhappy) mood is one, but only one, of the symptoms of this disorder. Other symptoms include vegetative symptoms such as changes in sleep patterns and appetite (food, sexual intimacy). Depressed mood alone is not sufficient to justify the diagnosis. Major depressive disorder (and related psychiatrically recognised conditions such as bipolar disorder) can only be diagnosed when a recognized constellation of symptoms has been present for a sufficient length of time.

Medicalization and Major depressive disorder

As The Buddha pointed out, many life experiences are painful, and cause sadness, unhappiness or distress (these words so similar as to be interchangeable). The mistaken belief is now held by many (citizens, police, courts, and welfare agencies), that sadness/distress automatically indicates a psychiatric disorder, the need for psychiatric treatment, and the need for psychiatric services to "take responsibility" for the individual (See illustration).

AGE	ADMIT	UR	DIAGNOSIS	
30	15-Feb	224691	Mania	
20	1-Mar	281297	Situational Crisis	1
35	26-Feb	279575	Schizophrenia	
39	27-Feb	233388	Schizophrenia	
30	1-Mar	327579	Situational Crisis	2
19	28-Feb	414102	Situational Crisis	3
49	27-Feb	655614	Mania	
18	20-Feb	235999	Schizophrenia	
56	1-Feb	209051	Schizophrenia	
40	25-Feb	348912	Drug Psychosis	
30	21-Feb	226554	MDD Poly sub	
33	5-Mar	353365	MDD	
21	30-Jan	371426	Mania	
28	20-Feb	379737	Schizoaffective d/o	
24	3-Mar	282492	Situational crisis	4
23	7-Mar	229448	MDD	
28	30-Jan	4132466	Psychosis/Assessment	
22	29-Jan	293976	Delusional disorder	
55	16-Jan	328654	Schizophrenia	
57	8-Dec	276507	Schizophrenia	
63	2-Mar	278413	MDD	
36	2-Mar	424423	Situational crisis	5

33	25-Feb	763422	Drug Psychosis	
Empty				
24	27-Feb	388827	Situational crisis	6
36	19-Feb	295341	Schizoaffective d/o	
48	15-Jan	231785	Psychosis	
24	20-Jan	403020	Schizophrenia Poly subs	
26	1-Mar	293476	Situational crisis	7
64	22-Dec	206247	MDD	
Empty				
48	1-Mar	437533	Paranoid psychosis	
50	25-Feb	349547	Schizophrenia	
46	4-Mar	266742	Situational Crisis	8
28	26-Feb	239792	Post natal depression	
67	24-Jan	34988	Dementia	

Illustration. This list shows the "bed status" from a 36 bed psychiatric ward of an Australian teaching hospital one day in early March, 2007. 34 beds were occupied. Eight people had been admitted with the "diagnosis" of "situational crisis". This is not a DSM-IV diagnosis, but is the term used in this hospital when patients are admitted due to complaints of distress or threats that if they are not given a bed they will self injure. Medicalization was involved in the presentation and admission of the majority of these patients. It is possible that one or more other patients listed here could also have a medicalization generated disorder. In other hospitals other terms are used to designate such problems including, Depression NOS (not otherwise specified; meaning not meeting criteria of Major depressive disorder, or other depressive disorders) and Personality disorder NOS (not otherwise specified).

There have been some steps out of the quagmire; grief has been designated a normal process and excluded from DSM-IV, and demoralization is being recognized as "a normal response in certain circumstances" (Slavney, 1999). So-called "burnout" (Cannon, 2006) appears to approximate more closely to demoralization than Major depressive disorder.

Medicalization of events/states into Major depressive disorder has been facilitated by well meaning attempts to increase public awareness of Major depressive disorder. Non-psychiatrists have been handed puny checklists and invited to participate in the diagnostic process. They have co-operated, with (not surprisingly) disastrous over diagnosis of psychiatric disorders.

The World Health Organization (1996) claims there is a world wide epidemic of depression (Ustun et al, 2004), and experts claim Major depressive disorder is frequently missed by general practitioners. A recent cross sectional study in Australia found depression and dysthymia (a mild form of depression) in 5.8% of the adult population (McLennan et al, 1997).

It can be argued, however, that there is no such epidemic of depression (Summerfield 2004, 2006a,b,c). The epidemiological studies which underpin the epidemic claims have arrived at inflated figures , it is said, through the use of symptom checklists (quantitative instruments) which do not take into account the circumstances and the meaning of those circumstances to the individual (Jacob, 2006; Summerfield 2006a).

Differentiating distress from Major depressive disorder can be difficult (Pilgrim & Bentall, 1999) and, distress is part of normal reaction to stress, a common feature of people facing the demands of life (Jacob, 2006).

Progressive medicalization of distress has lowered the threshold for tolerance of mild symptoms and for seeking medical attention for them (Barsky and Borus, 1995). The social supports available to the individual have been reducing over the last century, and the mental health team in now providing the psychological and social support which was previously provided by the family and local community (Jacob, 2006). Antidepressants have become the panacea for loneliness, relationship difficulties, interpersonal conflicts, inability to cope with day to day stress.

Given, 1) distress is ubiquitous, 2) differentiating distress from Major depressive disorder is a task requiring expertise, 3) traditional emotional supports are now less available, and 4) drug companies and at least some psychiatrists have promoted the medicalization of distress, it is not surprising that this process continues. Nor is it surprising that the community (citizens, police, courts, and welfare agencies) is now binging/sending droves of distressed individuals to hospitals with lay-generated (inaccurate) diagnoses.

From this unsatisfactory predicament, there are two possible ways to go. First, psychiatry/medicine could (in co-operation with appropriate experts) develop the anthropological, psychological and sociological skills and resources to become a surrogate family/community for needy individuals (i.e., purposeful expansion of medicalization). Second, medicalization could be wound back and psychiatry/medicine could refuse to manage non-pathological states for which it has nothing unique to offer. As part of the second option, society would need to focus on the underlying causes of human misery: lack of education, unemployment, poverty, substance abuse, and other unmet needs, and at the same time encourage individual responsibility and effort.

Posttraumatic stress disorder (PTSD)

See Chapter 11 for additional details.

Psychological reactions to war were described during the first half of the 20th century. (Jones et al, 2007). PTSD was first described in the USA following the Vietnam War (1965-73). It is the only condition in the DSM-IV for which an aetiological (causative event) must be identifiable. The individual must have been exposed to a traumatic event in which there was “actual or threatened death or serious injury, or a threat to the physical integrity of self or others”. Other diagnostic criteria include the re-experiencing the event, avoidance of reminders of the trauma, decreased ability for emotional warmth toward others and persistent increased arousal (or nervousness).

Initially, the diagnosis of PTSD was largely limited to the consequences of war experience. However, recent epidemiological studies reveal general population prevalences from 3.3% (Australia; McLennan et al, 1997) to 11% (Mexico; Norris et al, 2003), with the majority of the diagnoses related to civil events (motor vehicle and other accidents, rape and assault).

Medicalization and PTSD

Immediately following traumatic events, most (95%) exposed survivors experience some mental distress (Norris et al, 2003). Therefore, in the early stages, some psychological distress is "normal". ICD-10 has described "a mixed and usually changing picture" including "daze, depression, anxiety, anger, despair, over-activity, and withdrawal may be seen, but no one type of symptom predominates for long".

Some scholars who take a broad sociological/cultural view doubt the validity of the diagnosis of PTSD, or at least the claimed high prevalence of this disorder (Summerfield, 1999, 2001; Bracken, 2002; Pupavac, 2001, 2004). As with Major depressive disorder, caution has been expressed against the uncritical use of diagnostic checklists which can inflate prevalence (Summerfield, 1999).

A recent study of 245 adults exposed to war found 99% of these survivors suffered PTSD (De Jong et al, 2000). A possible conclusion from such findings is that PTSD is a normal response, and treatment is therefore not indicated. A more likely explanation is that normal responses have been medicalized and incorrectly labelled as PTSD.

There is no terminological equivalent for PTSD in many language groups (Pilgrim & Bentall, 1999), which indicates that this is not a universal disorder and that cultural factors are important. Modern Western society emphasises the vulnerability of the individual and the prudence of risk avoidance (Pupavac, 2001), which creates the expectation that trauma will result in pathology. Summerfield (2001) observes that Western society has become "an individualistic, rights conscious culture", and that PTSD "is the diagnosis of an age of disenchantment". Pupavac (2004) observes that current Western society lack a clear moral or ideological framework, that individuals are thereby less robust, and that social policy involves the "psychologizing of social issues".

Suicide

See Chapter 32 for additional details.

Suicide is not a DSM-IV diagnosis (unlike Major depressive disorder and PTSD), but a legal finding made by a Coroner's court. Nevertheless, Coroners, newspapers and surviving family members, and invested researchers strongly medicalize this behaviour.

Suicide has occurred throughout history, and involved ordinary and elevated individuals: Anthony and Cleopatra, Hannibal, Nero, Virginia Woolf, Sigmund Freud, Earnest Hemingway, van Gough, and Sylvia Plath is a small sample of the better known. Judas suicided because he was remorseful about betraying Jesus, Hitler suicided because he lost the Second World War. Sometimes a reason can be clearly identified, and sometimes not. Hunter S Thompson (famous US journalist and author) suicided in 2006; he left notes indicating that he did not like being old, was weary of life, and wanted his friends to have a pleasant wake.

Emile Durkheim (translated, 1951) provided a sociological explanation of suicide which has remained influential for over a century.

Suicide is more common among people with mental disorders. Although the figures have often been exaggerated (Blair-West & Mellsop, 2001), Coroners, newspapers and other guardians have indulged in the fantasy that if a person has suicided there must have been mental illness, some mental health professional must be to blame, and those individuals must be held publicly accountable.

The belief that suicide is proof of mental illness receives some support from “psychological autopsies”: groups of interested experts sift through all the information available regarding the events of the individual’s life immediately prior to suicide for any evidence of mental disorder. Not surprisingly, they find it. In his influential monograph on the psychological autopsies of 134 people, Eli Robins (1981) found 94% had suffered diagnosed or undiagnosed mental disorder, and only 2% were free of mental and physical disorder.

Newspaper reports of suicide give a different perspective. These are produced by journalists whose professional survival depends discovering and publishing all the available facts. In a 61 newspaper reports of suicide, 20% of those who suicided were known to have a mental disorder, 70% were suffering stress but no known mental disorder, and in15% the suicide was unexplained (Pridmore et al, 2006a). Proponents of the everyone-who-suicides-is-mentally-ill school will argue that newspaper reporters are not clinicians and would not recognize mental illness. On the other hand, the clinicians who conduct “psychological autopsies” are aware that the person who has died has suicided; the only way to make psychological autopsies scientifically respectable would be to conduct blind studies with equal numbers of people who had suicided and people who had died by other means.

It is clear that people suicide because they are distressed or to choose to make a political statement. There are also ample accounts of people suiciding rather than face public humiliation or imprisonment (Pridmore et al, 2006b). To claim that all these people are mentally disordered is extreme and unhelpful medicalization.

These people are distressed. Patfield (2000) believes that suicidal behaviour is related to a sense of helplessness and alienation rather than a direct consequence of depressed mood. Butterworth et al, (2006) has confirmed an association between demoralization and suicidal behaviour. Distressed people can and should receive assistance, but this is usually better supplied well away from pressured, stigmatizing, expensive psychiatric services.

Conclusion

The community (citizens, police, courts, and welfare agencies) and a few doctors medicalize distressing circumstances such as interpersonal conflict, unemployment and homelessness, and designate them as problems for psychiatry to solve. This would not be a great problem if the solutions were straightforward and psychiatry had the tools to do the job.

But, psychiatrists do not have the solutions to these predominantly social problems. There are others (nurses, social workers, welfare officers, psychologists) who are less expensive and just as, if not more, effective in giving emotional support.

It is conceded that, at times, psychiatry has been overconfident and anticipated greater success than could be achieved. One example was that during the early years of psychoanalysis, exponents expected to be able to "cure" all manner or problems, including, criminality. This was hubris. At the moment there is a handful of mental health professionals (Cloninger, 2006; Murfett & Charman, 2006) writing about how to achieve "wellbeing". While wellbeing (undefined by the cited authors) sounds like a worthwhile goal, it would appear an unduly ambitious goal for psychiatrists who are trained for, and would be well advised to limit their attention to, the alleviation of psychiatric disorders.

It is stated (Cloninger, 2006), "Psychiatry has failed to improve the average levels of happiness and well-being in the general population, despite vast expenditures on psychotropic drugs and psychotherapy manuals." This comes as no surprise, surely psychiatry set out to help disordered individuals, not save mankind. Perhaps psychiatry may be poised to repeat history, and make claims of potency which are totally unrealistic.

Following the era of psychoanalysis and reliance on various forms of psychotherapy, came a wave of interest (which is persists to the present time) in the biological aspects of psychiatry. With this biological focus, psychiatry has relatively neglected the psychosocial aspects of mental disorders.

In large part, medicalization is a response to psychosocial changes in society, the loss of traditional ways of understanding the world and sources of support. Summerfield (2004) observes a loss of religion as means of explanation of the vicissitudes life, a cultural preoccupation of emotional trauma, a promotion of personal rights and a language of entitlement. For him, this is "an age of disenchantment" (Summerfield, 2001). Pupavac (2001, 2004) drew attention to the social policy focus on "risk management" which she believes erodes confidence and resilience.

Thus, at a time when psychiatry is moving toward a more biological stance, changes in society call for greater attention to psychosocial factors.

In this chapter the claim has been made that psychiatry is the diagnosis, treatment and research of the disorders which are listed in the DSM-IV, and that issues not listed in that document are not the responsibility of psychiatry. (There has also been the suggestion that some of the diagnoses which have recently crept into DSM-IV via the process of medicalization can be ignored.)

The alternative approach would be to "accept", research and attempt treatment of these new, medicalized conditions which have arisen through the modernization of society (Double, 2002). In this case we would need to hone the psychotherapy skills and pay greater attention to the psychosocial factors which many psychiatrists have neglected over the last decades.

Psychiatry is currently unable to provide effective service to many who are brought to our door with the medicalization of distress. Such problems were formerly managed differently. New approaches are needed. The current situation causes distress among mental health professionals.

An exercise for the very keen student

What are the similarities and differences between medicalization (psychiatricization) and somatization?

There is no authoritative answer to the question. Can the following be improved?

	Mechanism	Interpreter	Attitude of society	Example
Medicalization (psychiatricization)	Psychological distress is interpreted as a psychiatric disorder	The society	Encouraged, or at least condoned	Unhappiness secondary to relationship breakdown presented as Major depressive disorder
Somatization	Psychological distress is interpreted as a physical disorder	The individual	Discouraged, at worst, considered a form of cheating	Unhappiness secondary to relationship breakdown, presented as chronic back pain

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