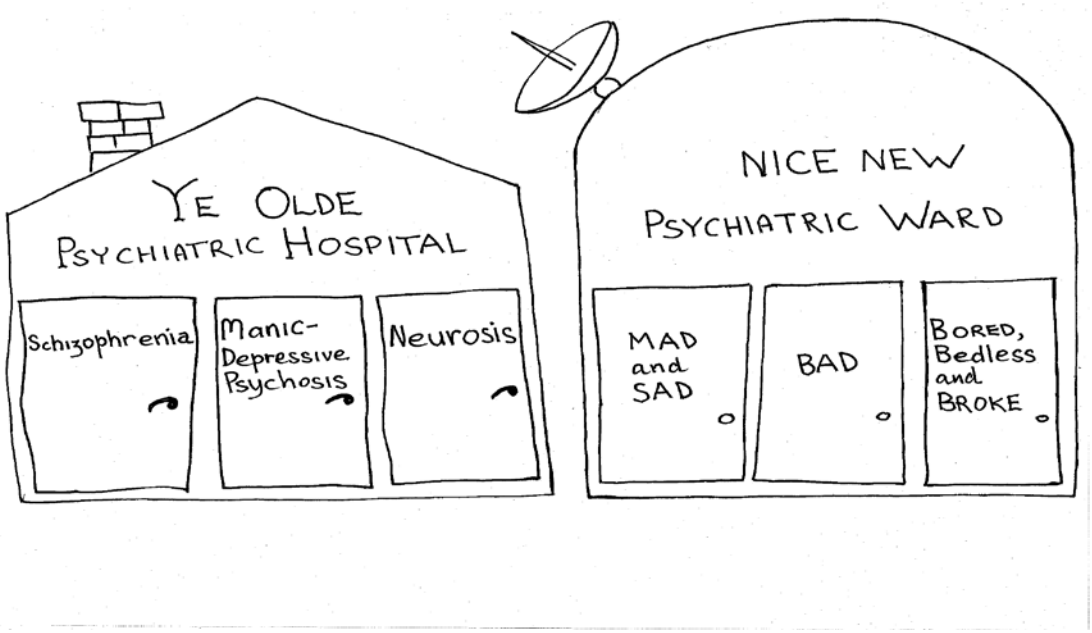
Chapter 32

MEDICALIZATION (PSYCHIATRICIZATION) OF DISTRESS



This cartoon compares old and new psychiatric facilities. The old psychiatric hospitals were not the cruel places they are portrayed by Hollywood (and those who weren't there); but that is another story. At the moment, many aspects of life are medicalized - as a result, people are admitted (at their request) to psychiatric wards, who have problems with living rather than psychiatric disorders.

Introduction

Medicalization, the reclassifying a non-medical problem as a medical problem, occurs in all branches of medicine (Conrad et al, 2010).

This chapter focuses is on medicalization in the field of psychiatry – and the term "psychiatricization" (Knezevic & Jovancevic, 2001) has been used in the title. However, as the term medicalization is more widely understood and will be used in this text. (The terms "pathologizing" and "psychologizing" have also been used to refer to this process.)

Distress is a central factor. There is no precise definition. For present purposes we observe that distress, like pain, is an unwanted state.

[Recently we have reunited the body and the mind (to make a person) and no longer need to draw 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). Thus, there is heaps of pain/distress about.

In the opinion of many, much of the distress with which psychiatry is now dealing, would be better dealt with by other institutions (which have more appropriate theoretical framework and resources). For example, psychiatry is now expected to assist (up to and including housing/hospitalisation) when individuals have social difficulties and are distressed following relationship breakdowns – which was formerly the province of the extended family (Jacob, 2006) and the clergy.

Many factors favour the "dumping" of individuals on Psychiatry - a branch of medicine which is poorly understood by other branches and the lay public. Psychiatry 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 and/or "difficult" individuals.

The problem of definitions

We have problems because of the lack of clear definitions.

In 1946, with the best intentions, the World Health Organization made a huge blunder. 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 it makes any distress whatsoever (be it obesity, or a loss at the races) the responsibility of the health professionals.

Psychiatry is relatively defenceless against the "dumping" of social problems on the doorstep, because of this lack of clear definition of its "territory".

Neither of the diagnostic systems (DSM-5, ICD-10) satisfactorily define mental disorder. DSM-5 begins, "A mental disorder is a syndrome characterized by a clinically significant disturbance in an individual's cognition, emotion regulation, or behaviour that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental function.…" To be fair, the definition continues and makes an attempt to exclude "an expectable or culturally approved response" and "conflicts between the individual and society", but problems persist. What is "a clinically significant disturbance"?

Psychiatrists are often forced to admit distressed people with social problem because if they refuse admission and a suicide occurs (a danger which attends all distress), the coroner and newspapers will be condemnatory.

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 2013. 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

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 many) was the book, The Manufacture of Madness, by Thomas Szasz (1970). Double (2002) more recently stated, "Mental health care may function as a panacea for many different personal and social problems".

It is claimed both birth (Shaw, 2012) and death (Goh, 2012) have been medicalized. It is claimed childbirth has been medicalized but recently it has been claimed that childbirth has been "de-medicalized" through the reduction in oxytocin use (Gaudernack et al, 2018). The DSM-5 has been strongly criticized for medicalization (Frances, 2013). In the lay press, the DSM-5 inspired practice of labelling misbehaviour in children as "oppositional defiant disorder" has been called into question (Ostrow, 2018). Recently, the case has been made that DSM-5 medicalizes possession – by classifying it as a form of "dissociative identity disorder" – thereby converting "distress into disease" (Padmanabhan, 2017).

Non-medical professionals may also become informed about and use medicalization. Recently, in Australia, three prominent cricketers were caught cheating and were criticized and penalized. This would appear to be appropriate – it is expected that detected cheats receive distress. However, a former Australian cricket captain stated that such an outcome needed to be take into "consideration" the "mental health of all players" (ABC News, 2018).

Initially, 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).

Dr Juan Garcia of New Zealand (personal communication) has pointed out that in literature (which is a fair proxy for the real world) medicalization may have nothing to do with doctors, and in fact, doctors may dispute the presence of any disorder. He points to two example in Macbeth by William Shakespeare (circa, 1607). The first is when Macbeth sees a ghost and his guests respond, "Gentlemen, rise, his highness is not well." Lady Macbeth explains this is a momentary "fit". The second occurs when Lady Macbeth walks and talks in her sleep. A physician is called who states "More needs she the divine than the physician". Macbeth ask for his wife to be "cured" and when this does not happen he is annoyed, "Throw physic to the dogs, I'll none of it".

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 have no real 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 disorder) however, there are psychological, sociological and biological differences, and the treatments which are effective for the standard disorder are ineffective in the management of wrongly "diagnosed" problems.

Medicalization harms the individual by denying the capacity of the individual as "a knower". It deprives the individual of a means of understanding and communicating his/her social experience (Illich, 2003).

Disorders of interest

Critics raise doubts about the validity of some 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
Shyness	Social anxiety disorder
Naughtiness	Conduct disorder, Childhood onset Conduct disorder, Adolescent onset
Delayed language	Expressive language disorder
Active	Hyperactivity disorder
Promiscuity	Sexual addiction (Schaeffer, 1997)
Sexually disinterested	Hypoactive sexual desire disorder
Unsatisfactory erections	Male erectile disorder
Unsuccessful gambling	Pathological gambling
Amorality	Antisocial personality disorder
Violence	Intermittent explosive disorder
Apprehension	Agoraphobia (specific places) Specific phobia (except places) Social phobia (social anxiety disorder)
Worried	Generalized Anxiety Disorder
Stress at work	Work stress (Wainwright & Calnan, 2002)
Stress	Acute stress disorder
Dependent	Dependent personality disorder

Narcissistic	Narcissistic personality disorder
Attention seeking	Histrionic personality disorder Factitious disorder
Avoidant	Avoidant personality disorder
Isolative	Schizoid personality disorder
Excessive coffee use	Caffeine intoxication Caffeine induced sleep disorder Caffeine induced anxiety disorder
Smoking	Nicotine dependence
Excessive alcohol use	Alcohol intoxication Alcohol abuse
Excessive cannabis use	Cannabis intoxication Cannabis abuse

Depression (Major depressive disorder)

See Chapter 8 for additional details.

Clinicians who work in psychiatric wards do not 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). Later episodes may occur spontaneously, without detected triggering events.

Depressed (sad, unhappy) mood is one, but only one, of the symptoms of Major depressive disorder (and related psychiatrically recognised conditions such as bipolar disorder), but depressed mood alone, is not sufficient to justify the diagnosis. Other symptoms include vegetative symptoms such as changes in sleep, ability to concentrate, energy and appetite (food, sexual intimacy). A psychiatric diagnosis can only be made safely 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 (or sad, unhappy or distressing). 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.

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 is 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”. The DSM-IV (the system in use at the time) did not have a “diagnosis” of “situational crisis”, but this was the term used in this particular hospital when patients were admitted because of complaints of distress in the absence of evidence of a psychiatric disorder, or threats by the individual that if they are not given a bed, they will self-injure. The diagnosis of “situational crisis” is a form of medicalization – in some instances because staff find it difficult to make a judgement, in other cases because the presenting individual resorts to black-mail. Other hospitals use other “diagnoses” in the same circumstances 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).

Medicalization of distress into Major depressive disorder has been facilitated by well-meaning attempts to solve social problems. Non-psychiatrists have been handed puny checklists and invited to make diagnoses. They have happily co-operated, with disastrous over diagnosis of mood 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 has been argued, however, that there is no such epidemic (Summerfield 2004, 2006a,b,c). Arguments against the epidemiological studies which underpin the "epidemic" story include that the symptom checklists which have been used do not take into account the circumstances and the meaning of those circumstances to the individuals being examined (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 of individuals to tolerate mild symptoms and encouraged the seeking of medical attention (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 (Ryang, 2017), it is not surprising that medicalization remains healthy. 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 of "depression".

[There have been some (isolated) voices against the medicalization of distress into Major depressive disorder. "Demoralization" is being described as "a normal response in certain circumstances" (Slavney, 1999). And, so-called "burnout" has been described as more closely related to demoralization than Major depressive disorder (Cannon, 2006).]

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-5 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, serious injury or sexual violence". 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

Distress following a traumatic event is to be expected and does not constitute a medical disorder. However, following severe and prolonged trauma, some individuals experience disabling and persistent psychological symptoms, which may as well be called PTSD.

Following a traumatic event, some "experts" assume that everyone will experience PTSD and even normal reactions are taken as evidence of 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). 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 31 for additional details.

Suicide is not a DSM-5 diagnosis (unlike Major depressive disorder and PTSD), but "Suicide behaviour disorder" has been listed under 'Conditions for Further Study'. Suicide is, in fact, a legal finding made by a non-medical official. Nevertheless, Coroners, newspapers, surviving family members, and invested researchers strongly medicalize this behaviour.

Suicide is medicalized in the following circumstances: 1) when suicide is believed to be synonymous with medical disorder, 2) when suicide is believed to be the result of a medical disorder when no medical disorder exists, and 3) when the management of all suicidal behaviour (including that not associated with severe mental disorder) is considered to be the role and responsibility of health professionals (Pridmore, 2011).

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 (1897) provided a sociological explanation of suicide which has remained influential for over a century.

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

The belief that suicide is proof of mental illness is supported by "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 may give a different perspective. These are produced by journalists whose professional survival depends discovering and publishing all the available facts. In 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 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.

People complete suicide because they are distressed: some 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; Pridmore 2010). To claim that all these people suddenly develop a mental disorder is extreme and unhelpful medicalization.

People who complete suicide 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. When distress is the result of mental disorder, medical services may be appropriate. However, when there is no mental disorder, assistance and support is usually better supplied well away from pressured, stigmatizing, expensive psychiatric services.

Conclusion

The community (citizens, police, courts, and welfare agencies) and some doctors medicalize distressing circumstances such as interpersonal conflict, unemployment and homelessness, and designate them as problems for psychiatry/mental health to solve. This would not be a great problem if the solutions were straightforward and psychiatry/mental health had the knowledge and 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, in the end, it could deliver. 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. Hopefully, psychiatry is not poised to repeat history, and make claims of potency which are totally unrealistic.

In part, medicalization is a response to psychosocial changes in society and 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 difficulties 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.

Psychiatry probably has something it can do for those medicalized conditions which have arisen through the modernization of society (Double, 2002). However, it is important to rely on science and avoid fads.

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. And, 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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