EDITORIAL

From "madness" to "mental health problems": reflections on the evolving target of psychiatry

MARIO MAJ

Department of Psychiatry, University of Naples SUN, Naples, Italy

There was a time when the target of the psychiatric profession was very clear and widely accepted. It was "madness", that is, a few patterns of behaviour and experience which were obviously beyond the range of normality.

In the perception of part of the public opinion, of several colleagues of other medical disciplines, and paradoxically of some fervent critics of old asylums, this traditional target of psychiatry has remained unchanged: psychiatry deals with people who are "mad".

But the actual target of the psychiatric profession has changed dramatically in the past decades. It has become a range of mental disorders (or of "mental health problems", according to some official documents of international organizations), including several conditions which are obviously on a continuum with normality. Fixing a boundary between what is normal and what is pathological has consequently become problematic. This boundary is often determined on pragmatic grounds, or on the basis of "clinical utility" (i.e., prediction of clinical outcome and response to treatment), although this pragmatism may involve some tautology (in fact, requiring that a diagnostic threshold be predictive of response to treatment seems to imply that a condition becomes a mental disorder when there is an effective treatment available for it).

In this new scenario, psychiatry has become the focus of opposite pressures.

On the one hand, the profession is being accused to unduly pathologize ordinary life difficulties in order to expand its influence (e.g., 1,2). This criticism becomes harsher when the above-mentioned evolution of the target of psychiatry from "madness" to "mental health problems" is, in good or bad faith, ignored: pathologizing ordinary life difficulties becomes "making us crazy" (3). Of course, the argument is presented with greater emphasis when the perceived unduly "pathologization" occurs in children or adolescents, or when it is considered to be a consequence of an alliance between psychiatry and the pharmaceutical industry.

On the other hand, the psychiatric profession is being pressured to go beyond the diagnosis and management of mental disorders, acting towards the promotion of mental health in the general population (e.g., 4,5). Within this frame, especially in those countries in which community mental health services are most developed and psychiatrists are leading those services, there is a call for dealing with "mental health problems" which are not proper mental disorders, such as the serious psychological distress occurring as a consequence of a natural disaster or of the ongoing economic crisis. Furthermore, psychiatrists are being pressured to diagnose and manage proper mental disorders as early as possible, which means dealing with a variety of conditions that may be "precursors" or "prodromes" of those disorders, but more frequently are not, with the unavoidable risk to, again, pathologize situations that are within the range of normality.

The two Special Articles which appear in this issue of the journal (6,7) are both relevant to the above debate.

Indeed, the ongoing economic crisis is having a significant impact on the mental health of the population in many countries, especially where scarce social protection is available for people who become unemployed, indebted or poor due to the crisis. Mental health services are often called to intervene, in a situation of uncertainty and confusion about roles and competences.

A couple of recent episodes from my country, Italy, are emblematic in this respect. Last spring, a group of widows of entrepreneurs who had committed suicide, allegedly as a consequence of economic ruin, marched in an Italian town under the slogan "Our husbands were not crazy". "It was despair, not mental illness, which brought my husband to do that", one of them said (8). In the same period, in another Italian town, the widow of an entrepreneur who had committed suicide blamed the professionals of a mental health service because they had not hospitalized him compulsorily. They had found him worried about his economic problems, but they had thought he did not have a mental pathology. "He was depressed. They should have hospitalized him", the widow said (9).

So, psychiatry is being blamed on the one hand for unduly pathologizing and stigmatizing understandable psychological distress, and on the other for not pathologizing that same distress and not managing it as if it were proper mental disorder.

Equally emblematic is the ongoing discussion on "attenuated psychosis syndrome" and "juvenile bipolar disorder" (the former proposed for inclusion in the DSM-5; the latter never included in the DSM, despite considerable lobbying). On the one hand, the need is emphasized to diagnose and manage schizophrenia and bipolar disorder as early as possible, even before the typical clinical picture becomes manifest, in order to improve the outcome of those disorders; on the other, concern is expressed about the risks involved in false-positive diagnoses, especially in terms of societal stigma and self-stigmatization and of misuse of medications (e.g., 10,11).

This uncertainty and confusion is likely to persist for several years. In this situation, what the psychiatric profession mostly seems to need is a refinement of its diagnostic (especially differential diagnostic) skills. The detailed description of proper mental disorders provided by current diagnostic systems may not be sufficient, especially for psychiatrists working in a community setting. First, we may also need a description of ordinary responses to major stressors (such as bereavement, economic ruin, exposure to disaster or war, disruption of family by divorce or separation) as well as to life-cycle transitions (e.g., adolescent emotional turmoil). The current attempt, within the development of DSM-5, to describe "normal" grief as opposed to bereavement-associated depression, in order to guide differential diagnosis, is a first step in this direction. Second, we may need a characterization of the more serious responses to the above stressors which can come to the attention of mental health services although not fulfilling the criteria for any mental disorder. The serious and potentially life-threatening psychological distress related to economic ruin, in which shame and despair are the most prominent features and the diagnostic criteria for depression are often not fulfilled, is a good example. The current delineation of "adjustment disorders" in both the ICD-10 and DSM-IV is too generic and ambiguous to be useful for differential diagnostic purposes and as a guide for management.

Of course, other mental health professionals (and perhaps other professionals outside the health field) will have to collaborate with psychiatrists or even take the lead in those characterizations. This may hopefully contribute to the construction of a transdisciplinary, clinically relevant, body of knowledge in the mental health field, whose existence is at present questionable.

The characterization of the above "mental health problems" could guide the development of adequate interventions and community resources. On the one hand, in fact, there is the risk of an inappropriate extension of interventions used for proper mental disorders to the new emerging conditions (e.g., use of antidepressant medications for the understandable psychological distress related to economic ruin); on the other, there is the risk to reduce the intervention to the provision of practical advice (which in some contexts is likely to be entrusted to untrained volunteers) while differential diagnosis and professional management are also needed.

Proving that effective interventions are available for these emerging mental health problems will not, however, be sufficient. We will also need to convince the public opinion that there is an acceptable balance between the benefits provided by those interventions and the risks (in terms of societal stigma and self-stigmatization) of any mental health referral (12). This calls for a real integration of mental health care in the community (including active partnership with primary care workers, social services and relevant stakeholders) in parallel to the development of effective interventions. One or the other of these two elements is often emphasized, while in reality both of them are essential.

Finally, it cannot be ignored that, just as a consequence of the ongoing economic crisis, the human and financial resources of mental health services are being significantly cut down in many countries. These services may be unable to implement further activities at a time when they have difficulties to carry out their traditional ones. This argument was indeed put forward initially in some countries recently struck by natural disasters, such as Sri Lanka and Indonesia. But mental health professionals in those countries have been able to turn the emergency into an opportunity to convince administrators of the importance of mental health care for the society, so that the final outcome has been a growth as well as a better integration of mental health services. One could argue that the current economic crisis may represent in several countries an analogous opportunity to show how essential mental health care is for communities, and how flexible mental health services can be in addressing the emerging needs of those communities, if appropriately supported.

References

1. Horwitz AV, Wakefield JC. The loss of sadness. How psychiatry transformed normal sorrow into depressive disorder. Oxford: Oxford University Press, 2007.
2. Stein R. Revision to the bible of psychiatry, DSM, could introduce new mental disorders. Washington Post, February 10, 2010.
3. Kutchins H, Kirk SA. Making us crazy. DSM: the psychiatric bible and the creation of mental disorders. New York: Free Press, 1997.
4. World Health Organization. The world health report 2001. Mental health: new understanding, new hope. Geneva: World Health Organization, 2001.
5. World Health Organization Regional Office for Europe. Mental health: facing the challenges, building solutions. Report from the WHO European Ministerial Conference, 2005. Copenhagen: World Health Organization Regional Office for Europe, 2005.
6. Wahlbeck K, McDaid D. Actions to alleviate the mental health impact of the economic crisis. World Psychiatry 2012;11:139-45.
7. Carlson GA. Differential diagnosis of bipolar disorder in children and adolescents. World Psychiatry 2012;11:146-52.
8. Alberti F. Le vedove della crisi in corteo: i nostri mariti non erano pazzi. Corriere della Sera, May 5, 2012.
9. Di Costanzo A. Imprenditore suicida, la moglie accusa. La Repubblica, April 26, 2012.
10. Corcoran CM, First MB, Cornblatt B. The psychosis risk syndrome and its proposed inclusion in the DSM-V: a risk-benefit analysis. Schizophr Res 2010;120:16-22.
11. Parens E, Johnston J, Carlson GA. Pediatric mental health care dysfunction disorder? N Engl J Med 2010;362:1853-5.
12. Bolton D. What is mental disorder? An essay in philosophy, science and values. Oxford: Oxford University Press, 2008.