LETTER TO THE EDITOR

Management of the psychosocial effects of economic crises

The actions to alleviate the mental health impact of the economic crisis proposed by Wahlbeck and McDaid in the October 2012 issue of *World Psychiatry* (1) are indeed thoughtful and realistic. It is important, however, to draw attention to the fact that some of these proposed actions do not have a universal application potential.

For example, while it is true that alcohol-related deaths are linked to economic crises in certain countries, in others, notably Greece, the crisis has had an opposite effect, i.e. reduction in alcohol consumption as well as drunk driving (2). In these cases, alcohol pricing and restrictions in alcohol availability would serve no purpose – they might even produce increased demand for alcoholic drinks for reasons similar to those observed between 1920 and 1933 during the prohibition of alcohol in the USA.

Depression is one of the main consequences of economic crises. It should be taken into account, however, that clinical depression is different from normal sadness. Sadness is a normal adaptive response to adverse circumstances. It is the opposite, i.e. the lack of a response (apathy) that under adverse circumstances could be considered to be abnormal, and sometimes even a sign of underlying psychopathology (schizophrenia, personality problems or hysterical negation of reality) (3).

Although the differentiation between depression and normal sadness is sometimes difficult (4), it is important to keep it in mind. During periods of crisis (like the one presently occurring in Southern Europe) the mass media are very quick in claiming that society as a whole has become depressed ("a depressed society", "a depressed nation" and the like). Obviously what is happening is an adaptive and fully understandable phenomenon, not requiring treatment but measures to combat the causes that produce it. Not so much on a behavioral medicine basis but rather on a political and economic basis.

While overdiagnosing depression is an issue, underdiagnosing it is an equally important issue. The polymorphic and atypical clinical expression of depression is a major source of diagnostic difficulty. Depression can hide behind a great number of conditions, ranging from alcoholism, substance misuse and burn-out to accident proneness, sexual dysfunction and a great variety of somatizations, and even antithetical symptoms ("smiling depression") (3).

It appears that a great proportion of suicides occurring during periods of economic crisis are committed by people who suffer from either atypical or typical depression. In view of this, it is important to carefully screen for depression. This is important anyway, but during periods of economic crisis it becomes an absolute necessity.

Policies aimed at strengthening social capital need to focus on culture-specific social resilience factors. For instance, in Southern European countries, family (and the local community) has traditionally fulfilled a substantial role in social welfare. Supporting local communities and the family institution in these countries at times of crisis is therefore a priority.

Vulnerable persons in the community and psychiatric patients are among the persons most likely to suffer during periods of economic recession. Paradoxically, it is the services for these very groups (that are at risk and hence in greater need of protection) that are curtailed during economic crises. This obviously calls for evidence-based advocacy interventions. It is important to speak to decision-makers not so much on humanistic grounds but rather in a language they understand, i.e., in terms of cost-effectiveness (5,6). Further research on cost-effectiveness is of course necessary to reinforce the existing data.

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