Editorial

Medicalizing Distress, Ignoring Public Health Strategies

Psychiatry, which has medicalized many forms of human distress, argues for individual treatments and interventions. It has blurred the disease-illness divide, subcategorized clinical presentations, lowered the thresholds for diagnosis and introduced many new psychiatric "disorders." Its phenomenological approach to diagnosis and classification employs symptom checklists and symptom counts sans context. The medicalization of distress is supported by the capitalistic project and the current political economy of health, fits in well with neoliberalism and allows the free market to expand its business interests. This essay contends that social and economic correlates of depression, anxiety and common mental disorders, despite robust evidence, are not emphasized. It argues that social and economic determinants of mental health demand public health and population-based strategies to prevent and manage common mental disorders in the community. Such approaches will impact a greater proportion of people than medical interventions.

Depression and anxiety, standard psychiatric diagnoses, are part of our vocabulary and popular culture. However, these terms are employed to highlight "idioms of distress," describe illness experience and to label diagnostic categories. Their widespread, flexible and interchangeable use has blurred the boundary between distress and disease. The disease halo has been inappropriately transferred to many forms of human suffering. The medicalization of distress has resulted in a focus on treating individuals. It has also resulted in ignoring the impact of social and economic stress on mental health resulting in very little emphasis on the need for and use of public health and population-based interventions.

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PSYCHIATRIC CONTEXT

Psychiatry in the 1970's was struggling with "unproven" etiologies for mental illness and with poor diagnostic agreement among psychiatrists. The discipline adopted an "atheoretical" approach to diagnosis using operational criteria,[1] that emphasized reliability and counted symptoms. It dismissed the relevance of context and environmental stress to diagnosis, as these require interpretation and reduce inter-rater reliability.[1,2] The creation and use of the suffix "disorder" for psychiatric categories sidestepped the disease-illness divide. The discipline also created a diagnostic label called "major depressive disorder," which attempted to identify people with more severe distress and "clinical depression".[1] It soon became the gold standard.

The diagnosis of depression, when viewed through the biomedical lens, tends to suggest the disease, supposes brain etiology and pathogenesis, documents signs and symptoms, offers differential diagnoses, recommends pharmacological therapies and prognosticates about the course and outcome. However, psychiatric diagnoses pose many challenges. The lack of laboratory tests for diagnosis has forced psychiatrists to rely on clinical features. The absence of pathognomonic symptoms has meant the use of clinical syndromes for labeling and symptom checklists for diagnosis. The criteria essentially count symptoms with little regard for context.[3] The recent increase in the number of psychiatric categories and the lowering of the clinical threshold has resulted in a wide net, which medicalizes a variety of normal human responses to environmental stress.

Epidemiological studies of depression also use diagnostic instruments, which do not evaluate stress and context and fail to identify short-term adjustment problems.[2] The elastic concept of depression and the rigid application of the diagnostic hierarchy and criteria has resulted in the marginalization of short-term stress-related adjustment disorders in clinical practice. Consequently, the hybrid category, major depressive disorder, identifies a heterogeneous group of people with melancholic depression (endogenous depression), those with chronic depression and with recent stressors

(neurotic depression/dysthymia) and normal people under severe stress (adjustment disorders).[2]

DISTINGUISHING DISEASE FROM DISTRESS

Separating normal human distress from depression is often difficult.[3] General practitioners, who often see milder forms of morbidity frequently associated with psychosocial adversity, hold psychological and social explanatory models for depression. Psychiatrists, with their biomedical frameworks, on the other hand, argue for disease models for such illness. They transfer the disease halo reserved for severe mental illness to all psychiatric diagnoses. While psychiatrists argue that the depression is easily recognized using simple screening instruments, general practitioners contend that these screens identify people in distress rather than those with disease.[3]

In the 1990's, specialist classifications of psychiatric disorders were simplified for use in general practice and many related categories employed in tertiary care were reduced to single diagnostic heads (e.g., anxiety, depression). However, these schemes (Diagnostic and Statistical Manual-IV for Primary Care[4] and International Classification of Diseases-10 for Primary Health Care[5]), although endorsed by psychiatry and academic general practice, were rarely employed in primary care.[6] The heterogeneity within labels, their frequent association with psychosocial stressors, high rates of spontaneous remission and of placebo response and the limited response to psychotropic drugs in milder conditions prevented their use in primary care[6] and argued against the sole use of medication as the solution.[7] Many critics argued against the medicalization of personal, social and economic distress.

PUBLIC HEALTH IMPLICATIONS

Nevertheless, many international investigations have since identified major depression as a significant contributor to the burden of disease.[8] Its high-life-time prevalence, associated disability, chronic course and recurrence were highlighted. Its frequent association with other common chronic medical conditions (e.g., diabetes mellitus, angina, asthma, arthritis, etc.) and the incremental worsening their outcomes have been documented.[9] Its contribution to suicide is widely recognized. Many national governments and international agencies acknowledge depression, with its significant impact on economies, as a major public health problem.

Many studies have also documented the link between poverty and depression, anxiety and common mental disorders. They have demonstrated a consistent relationship with low education[10] and insecure working conditions.[11] The experience of insecurity and hopelessness, rapid social change, risk of violence and physical illness are postulated as links between poverty and poor mental health.[10] Poor mental health worsens the economic situation, setting up a vicious cycle of poverty and common mental disorders.

Social determinants have a significant impact on the health of girls and women in general and on depression in particular with women are at a higher risk when compared with men.[12] Young women are overrepresented among those who commit suicide in India.[13] Gender injustice is a major issue for women in traditional patriarchal societies. Social exclusion and cultural conflicts can also cause mental ill health, distress and depression.

The structural determinants of daily life contribute to the social determinants of mental health and fuel inequities in health.[14] Viewing health in general as an individual or medical issue, reducing population health to a biomedical perspective and suggesting individual medical interventions reflect poor understanding.[15] The major barrier to scaling up effective interventions is inequality based on social, cultural and economic issues. Failure to recognize this relationship and the refusal to tackle these issues result in poorer health and mental health indices for the underprivileged and the marginalized, who constitute a large proportion of the population. Poverty and social exclusion have a multiplicative effect on the social determinants of health with those at higher risk for distress and mental health concerns also having a higher probability of being excluded from health care services.

Consequently, there is a need to move beyond urgency-driven medical solutions and incorporate public health perspectives, policies and approaches[14-16] in managing depression, anxiety and common mental disorders. The sole focus on medical solutions is an error of the public health movement in low and middle-income countries as it mistakes primary care for public health. Public health is often reduced to a biomedical perspective. Consequently, much of the efforts of the champions of public health end up in the provision of curative services, albeit at the small hospital, clinic or at the village level. Despite the failure of past mental health programs, they are repackaged[17] as solutions to mental distress, illness and disease (e.g., Mental Health Gap Action Program[18]). Public health requires the inputs from diverse disciplines (e.g., politics, finance, economics, law, engineering, social sciences, religion, etc.) and is much more than biomedical perspectives and solutions.

PUBLIC HEALTH STRATEGIES

The medical/psychiatric, psychological, social and economic causes of depression, anxiety and common mental disorders argue for a multi-factorial etiology for these states of emotional distress. Such a perspective calls for a multi-sectoral understanding of mental health and illness.[16] It argues for a multi-pronged approach to intervention. It contends that pure medical and psychiatric approaches to emotional distress would be restrictive and ineffectual for the vast majority of depression seen in the community. While severe and melancholic depression demands antidepressant medication, milder forms of distress respond to psychological support, social solutions and economic initiatives. Population interventions involving social and economic approaches would be mandatory for improving the mental health of a significant proportion of population.

Investments in education and provision of microcredit, in addition to reducing poverty, are recommended for their collateral benefits in reducing the risk of mental disorders.[10] Population-based strategies of meeting basic needs of clean water, sanitation, nutrition, immunization, housing, health and employment and initiatives for gender justice have been suggested as strategies to reduce distress and suicide.[19] Program to reduce social exclusion and discrimination, a reduced social class gradient and a more equal society will also help reduce emotional distress and depression.[16]

The social determinants of health apply to mental health as well. There needs to be a commitment to equity, effective governance systems, and context-specific program that address the wider social and environmental determinants.[14] Managing inequitable distribution of power, money and resources is cardinal to improving mental health of populations. Such population-based strategies will reduce a greater proportion of distress, now subsumed under a variety of mental disorder labels, than targeted medical interventions.

POLITICS AND ECONOMICS

The blurred disease-illness divide, the inter-changeable use of these concepts and the illusion of specific brain pathology are supported by academia, health, insurance and pharmaceutical industries. Despite evidence that social determinants produce significant mental morbidity, most intervention strategies favor *post-hoc* individual treatments to population-based public health approaches that are useful in reducing structural violence and in empowering large sections of society. Solutions that seem to make money trump those that promote health. The situation is similar to the one related to physical health where curative strategies which are profitable are preferred by the political and economic systems over approaches which are more equitable and will deliver better health. The technical approaches of evidence-based medicine are not necessarily value-neutral nor above specific interests.[20] Medicine is politics writ large and the health sector is a powerful player in national economies.

Psychiatric labels for distress have shifted the focus from the responsibility of the state for poverty and structural violence and transferred pathology and burden to individuals. The disparate environments under which anxiety, depression and common mental disorders now exist are brought together as many strands, de-contextualized and unified into disease labels.

Psychiatric disease labels and individual treatments offer distinctive niches to diverse stakeholders: Disease, reimbursement, profit, and deflection of responsibility.

The political economy of health, deeply rooted in capitalistic economic and social systems, undergirds these formulations. It reiterates the historical relationship between medicine and governments, with governmental administration serviced by experts responsible for managing social security, stability and economic growth.[21] It is an example of the broader role of medicine, of social control. Depression, anxiety, common mental disorder labels and the culture of medicine fit in well with the neoliberal agenda, allowing the free market to expand its business interests. It demonstrates the nested position of the discipline of medicine, within the agendas of governing, which determine perspectives, formation of knowledge, institutional control and policy.

Psychiatry, despite its current attempts at testable conjectures, is still within a paradigm, which seems inadequate for the complexity of the task. It is awaiting a paradigm shift,[22] which will provide new understanding. Nevertheless, modern psychiatry, based on operational diagnostic criteria and phenomenological classification, will persist with its failed strategy[23] of symptom counts sans context.

The discipline needs to acknowledge, that it helps people with emotional distress and with mental diseases; their differentiation is often difficult and that symptom counts do not distinguish them. It needs to accept that distress secondary to stress is heterogeneous; context, stressors, personality, coping, supports and meaning of the event impact outcomes. It needs to highlight the fact that much mental distress is also secondary to social determinants and not necessarily

due to diagnosable or treatable biological abnormalities. Distress, commonly seen in the community and in primary care, does not require psychiatric disease labels or psychiatric treatments. It mandates population-based interventions including a social security net to reduce social and economic hardship. The solutions should not only include supporting individuals in distress but also argue for public health strategies to reduce poverty, ensure justice and empower people.

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