Psychiatry and the Myth of “Medicalization”

April 18, 2013 | Depression [1], Addiction [2], Cultural Psychiatry [3], Major Depressive Disorder [4], Somatoform Disorder [5]
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The ethical aim of psychiatry is the relief of suffering and incapacity.

Whatever happened to common sense? You know what I mean—these psychiatrists medicalize every ordinary feeling and behavior, every normal stress and strain of living. Why, the way they want to call ordinary shyness “Social Anxiety Disorder,” or ordinary grief “Major Depressive Disorder”—it’s ridiculous! These so-called diagnoses are just false positives—not cases of disease or disorder. These self-appointed experts keep invading the territory of normal human experience like conquistadors! Then they prescribe all kinds of harmful medications for nonexistent diseases. And now, they are expanding their diagnostic system, to the point where nobody is normal anymore!

Are any of these claims even controversial these days? Even for some readers of *Psychiatric Times,* I suspect not. After all, we have heard this line of argument from respected academics; many patients, or consumers; some of psychiatry’s own luminaries; and many sincere and conscientious clinicians. Recently, one particularly renowned critic pointed to the “diagnostic imperialism” of DSM.[1] Indeed, before the final text of DSM-5 has even appeared, several books criticizing the manual have been published or are soon to be published.

But does this narrative of psychiatry’s medicalization of normality really represent common sense—or is it mostly common nonsense? In my view, the medicalization narrative contains some kernels of truth, and many defenders of the term proceed from honorable and well-intentioned motives; for example, the wish to reduce unnecessary use of psychotropic medication—and who could be opposed to *that*? But on the whole, I believe the medicalization narrative is philosophically naive and clinically unhelpful. On close examination, the term “medicalization” proves to be largely a rhetorical device, aimed at ginning up popular opposition to psychiatric diagnosis. It not only stigmatizes the field of psychiatry and those who practice in it, but it also undermines our ability to provide the best care to our patients, by spuriously normalizing their suffering and incapacity.[2]

I am not claiming that careless diagnosis and over-diagnosis never occur in psychiatry. Alas, as in all of medicine, sometimes they do—particularly when insufficient time is allowed for the initial evaluation of the patient, and when no validated scales or screening instruments are used.[3] (*Under*-diagnosis also occurs, as in the failure to recognize MDD in some settings—but that’s another story.[4]) Neither am I voicing a full-throated defense of the DSM-5 manual. Indeed, while I respect the

good-faith efforts of the framers of DSM-5, I have serious concerns regarding some of their decisions, such as lowering the threshold for the diagnosis of somatoform disorders (now called Somatic Symptom Disorders).[1]

What I do want to claim is that when a psychiatric diagnosis is accurately and carefully made, according to generally accepted (eg, DSM or ICD) criteria, it should not be normalized or declared non-disordered because its manifestation is understandable or explained by the psychosocial context in which it occurs—or because it is deemed proportionate to some hypothetical evolved mechanism.[5]

The normality fallacy

For the proposition "psychiatry is medicalizing normality" to be true, we would need (a) adequate definitions of the terms "medicalizing" and "normality" and (b) convincing evidence that psychiatry is actually doing what the proposition asserts. Yet both required elements of truth turn out to be complex and problematic. For one thing, psychiatry's critics almost never bother to define the terms "medicalizing" and "normality." (Does medicalization refer to application of the medical model, or to the use of medication? And what is the medical model, exactly? Is normality a purely statistical term? Is it used in relation to a particular cultural subgroup, to the human species as a whole, or to the particular patient's usual state of affairs?)

Moreover, those who argue that psychiatry medicalizes normality while simultaneously asserting that there is no clear demarcation between normality and abnormality effectively refute their own argument.[6] For if there are no absolute, categorical boundaries separating normal from abnormal, then the claim "psychiatry is medicalizing normality" cannot logically be sustained: *the argument is devoured by its own premise.* That is: if normality has no precise boundary in the realm of disease—including psychiatric disease—then *there can be no verifiable medicalization of normality*. Neither can there be a veridical demonstration of psychiatry's alleged diagnostic imperialism or its supposed creation of diagnostic false positives. Such claims are no more verifiable than a landowner's complaint that someone has impermissibly planted a tree on his property, when there are no clearly established property lines. But let's be clear: this doesn't mean that we can't make reasoned, empirically grounded judgments as to *what conditions merit medical evaluation or treatment*.

Psychiatry's ethical aim is the relief of suffering and incapacity

So long as the patient is experiencing a substantial or enduring state of suffering and incapacity, *the* patient has disease (dis-ease).[5] To assert this is not to medicalize normality, but to affirm what physicians have recognized as an ethical imperative, for millennia: the need to relieve the misery of the patient. Indeed, as Prof H. C. Erik Midelfort, Professor of History at the University of Virginia and author of *A History of Madness in Sixteenth-Century Germany,* comments:

. . . for ancient and early modern physicians, there was no clear, bright line between disease and health. They did not, generally, decide that someone was suffering an understandable and proportionate sadness and was not therefore "ill." They generally decided that if one were suffering, for whatever reason and whether proportionate or disproportionate, they would do what they could to help . . . [and their remedies] did not depend upon a strict decision that so-and-so was fundamentally "ill" while someone else was merely sad for good, sufficient, and proportionate reasons. (E. Midelfort, personal communications, October 2008 and March 2012.)

Indeed, as historian and *Psychiatric Times* blogger Prof Greg Eghigian[7] has commented:

Midelfort get[s] at something important that many commentators on the history of psychiatry often either ignore or consider unimportant: the fact that the overwhelming majority of patients treated by psychiatrists, "mad-doctors," mental healers, etc, over the centuries have presented symptoms clearly crossing the "threshold of chronicity or severity." And indeed, this is one of the reasons why I have problems with the way in which self-identifying critics of psychiatry invoke the term "medicalization"—they more often than not neglect the extraordinary and painful nature of the maladies . . . [patients] were/are facing.[7]

Prof Eghigian leads us toward a critical insight: the obsessive debate about what is or is not normal is largely a distraction from 2 practical issues facing all physicians:

• What is the threshold for considering a condition a disease or disorder?
• How can we best help the patient?

As a practical matter, internists do not consider an upset stomach as crossing the threshold of disease, nor do psychiatrists of any wisdom consider a mildly fidgety, bored, and inattentive child to have a disease or disorder called "ADHD." But in both instances, these threshold decisions are based primarily on the absence of pronounced or enduring suffering and incapacity—not on an obsessive fixation on what is normal. (If common upset stomach suddenly became vanishingly rare, it still would not qualify as disease.)

Physicians, fundamentally, are not philosophers or evolutionary biologists. We do not, as a matter of daily routine, entertain metaphysical and semantic questions, such as "What is truly normal for the human species?" Rather, physicians have a general concept of what constitutes health, and a general concept of enduring and significant departures from health. We find ourselves faced with a waiting room full of distressed and often incapacitated human beings who, in ordinary circumstances, are voluntarily seeking our help. We do our best to respond to them not as specimens of abnormality, but as suffering individuals—and as fellow human beings.

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