The Medicalization of the Human Condition

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As a psychiatrist who has been in practice since World War II, I have seen many profound changes in our profession. These include the ascendancy and then decline of psychoanalysis as the gold standard for treating patients, a far-reaching shift in the economic basis of practice, and an increasing emphasis on the "bio" aspect of the biopsychosocial paradigm that has been widely accepted as the theoretical model for our work (1).

However, the transformation I discuss in this article is the steady and eager efforts of many psychiatrists to remedicalize their profession, to extricate it from the conditions that prevailed in the early postwar period, when a medical identification was looked upon with an attitude close to disdain by the prevailing analytic community and when brain activities were relatively ignored as an influence on abnormal behavior. The guiding star of the remedicalization movement has been the successive editions of the *DSM*, which have been responsible for an atheoretical, symptom-based, and unpsychodynamic diagnostic scheme that has carried the day not only in this country but around the world.

I do not question that remedicalization was, in principle, necessary and that it has in many ways had a positive and invigorating effect on psychiatry and has led to more effective treatments. However, I do contend that the remedicalization pendulum has swung too far and that some American psychiatrists, in their eagerness to include all varieties and vagaries of human feelings and behavior in their professional domain, are running the risk of trying to medicalize not only psychiatry but the human condition itself. To medicalize the human condition is to apply a diagnostic label to various unpleasant or undesirable feelings or behaviors that are not distinctly abnormal but that fall within a gray area not readily distinguishable from the range of experiences that are often inescapable aspects of the fate of being human.

It needs to be acknowledged that there is an overlap between clear clinical syndromes and unwanted feelings and behaviors that are so common that to regard them as diseases or even disorders would make these terms meaningless. It is worth noting that "mental disorder," a term introduced to avoid using the word "disease," has not been satisfactorily defined by the framers of the *DSM*, who state in *DSM-IV* (2), "it must be admitted that no definition adequately specifies precise boundaries for the concept of mental disorder."

What conditions can be included in the gray area between normality and pathology? Examples abound. A prime one is the epidemic of social phobia in our country. Are there really 33 million Americans whose shyness and timidity are so extreme as to justify that diagnosis? A recent article in the *New York Times* (3) traces the path from what was formerly a personality trait, not always considered undesirable, through celebrity enlistment and, with a push from SmithKline Beecham, to medicalization of "what is, essentially, not a medical condition."

Depression is another important example. Severe, clear-cut depression, especially if combined with manic phases, is an unequivocal disorder that conforms satisfactorily to the medical model. However, less severe episodes of depressive affect cannot always be accurately distinguished from ordinary human unhappiness or "the blues," states of mind that do not justify a diagnostic label. In the words of the author of a recent book about the experience of depression (4), "if depression is an illness that affects as much as 25 percent of the people in the world, can it, in fact, be an illness?"

I believe that the uncertainty about St. John's wort as a treatment for depression illustrates my thesis. A recent carefully controlled study found negative results for St. John's wort as a treatment for major depression, and the investigators suggested that previous studies with more favorable results had significant design flaws (5). I further suggest that one component of the faulty design was that some of the subjects fell within the gray area I have been discussing and would have felt better within a reasonable period with or without medication.

Are all high-strung "nervous" people the victims of an affliction labeled generalized anxiety disorder? And can we reliably distinguish the rambunctiousness and distractibility of many boys from attention-deficit hyperactivity disorder? Among the personality disorders—a general category itself of somewhat doubtful validity—the gray area includes the following dichotomies: paranoid personality disorder versus a suspicious turn of mind, schizoid personality disorder versus a preference for solitude, avoidant personality disorder

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versus a mild to moderate sensitivity to rejection, and narcissistic personality disorder versus a tendency to be self-centered and to show off.

Finally, can we agree with the Surgeon General that one-fifth of the American people are in need of mental health treatments, without having to ask the same question I have quoted about depression? Does such a figure cast a shadow on the validity of the concept of mental illness itself and lend credence to those like Thomas Szasz (6) who claim that "mental illness" exists only as a social construct?

The framers of the *DSM* and many psychiatrists would support the claim that conscientious adherence to *DSM* criteria will protect from the dangers and confusions I have described. This claim has merit—the criteria serve to delineate and define most psychiatric disorders and to differentiate them from each other in a way that is useful for diagnosis and treatment.

However, I believe that the application of *DSM* criteria to the borderline areas I have been discussing is limited by two basic weaknesses. The first is that no subjective checklist of a patient's history and complaints can infallibly separate clinical syndromes that qualify as disorders from various kinds of human discomfort of lesser intensity. What is needed and what is still lacking is some kind of biological marker, such as tissue alterations or a serologic or imaging abnormality, that can distinguish, say, a clinical depression from a state of unhappiness. Such biological markers are available in other branches of medicine but not in psychiatry, except to a very limited degree. It is also true that most people who have depression, clinical or not, have other problems and concerns that affect their feelings and will influence the criteria by which they are diagnosed.

Second, the motivations and experience of the diagnosing psychiatrist must be taken into account in cases in which the clinical picture is equivocal. An important incentive for making a *DSM* diagnosis is to qualify the patient for insurance reimbursement, which is otherwise unavailable. Another incentive might be to justify prescribing a drug rather than taking a primarily psychotherapeutic approach when a psychiatrist is skilled in the former but not the latter modality. Other, less obvious but significant motivations may play a role.

To summarize my thesis, I believe that in pursuing the Holy Grail of remedicalization, psychiatry has corrected an error in one direction but has gone too far in the other. The result has been not only the excessive emphasis on medical-model diagnosis but also a related "furor psychopharmacologus" (7) that seeks a specific drug for every aberrant feeling or behavior as if we were in quest of a society tranquilized by "Soma" as in the dystopia described in Aldous Huxley's *Brave New World* (8).

Another consequence has been the downgrading of psychotherapy except when it is used in conjunction with drug treatment. Patients who seek psychotherapy often experience what can be called "problems of living," which are defined as conditions that produce psychopathological symptoms that are sufficient to negatively influence a person's well-being and relationships but not to justify a diagnosis of illness or disorder. Such patients are often best treated with psychotherapy alone and not with drugs. Under the tyranny of "medical necessity," an outmoded and no longer effective gatekeeper, these patients must either pay for treatment out of pocket or be smuggled into insurance coverage by gaming the system with an inaccurate diagnosis, subjecting the therapist to moral risk (9,10). This group of patients, sometimes rather patronizingly referred to as the "worried well," has constituted a component of my more than 50 years of practice and of the practices of colleagues, and we have helped many achieve beneficial results.

Rather than continue the charade I have described, the alternative course, as I see it, is for psychiatry to recognize and try to deal with the fact that ours is a profession that, while it has one foot firmly planted in medicine, is also deeply involved in other aspects of the human condition. To this extent it transcends the medical model. The integrity of the profession of psychiatry as well as that of other helping professions such as psychology and social work that also now operate uneasily under the constraints of a sometimes inappropriate illness model depends on the acceptance of both aspects of this identity. ♦

References

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