To treat or not to treat:
the 'medicalisation' of unhappiness?

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ABSTRACT

In recent years antidepressant use has risen significantly. As doctors are, for whatever reason, the gatekeepers of such drugs, we examined the attitudes of psychiatrists regarding the tension between preserving patient autonomy -- in this case, a patient's choice to be prescribed antidepressants regardless of the presence or absence of clinical symptoms -- and the role doctors may be playing in medicalising sadness/unhappiness. Questionnaires were sent to 40 Dunedin-based psychiatrists addressing three main issues: Do psychiatrists think depression is different to sadness? Do psychiatrists think society is medicalising sadness? Who should be responsible for the choice to prescribe -- the patient or the doctor? Our results show that there is a qualitative difference between a patient with clinical depression and a patient who is sad/unhappy, with identifiable characteristics distinguishing the two, and that there is a limit to a patient's autonomy when it comes to requesting antidepressants. And though respondents believed the medicalisation of sadness/unhappiness should be a concern for doctors, their justification for denying a patient's request for antidepressants lay not so much in any concerns over the possibility of medicalisation but in their professional obligation to treat only those with a diagnosable medical condition.

INTRODUCTION

In the past two decades antidepressant use has risen significantly and there continues to be debate as to why this increase has occurred. Are doctors now better educated and thus better at diagnosing clinical depression[1], or is it the work of the multi-billion dollar pharmaceutical industry?[1,2] Is it that the state of the world in which we now live - the demands, the expectations - is much more conducive to a general melancholy leading to an increased prevalence of clinical depression within the developed world?[1,3] Or, as explored in this research project, is the increased use of antidepressants part of a social trend in which painful emotions like sadness and unhappiness have become medicalised, as the boundary between the physiology of normal distress merges increasingly with the physiology of pathological distress?[1,4]

Doctors have long been the gatekeepers of drugs and other treatments[5], so if people are increasingly turning to antidepressants for whatever reason, we must examine the roles and responsibilities of the doctors. "Considerable debate prevails about whether unpleasant changes in emotional state associated with [stressful life events] should be defined as mental illness and be treated with drugs... but clearly drugs are not appropriate for the relief of the stress and 'blues' of everyday life... [However] the psychiatrist's judgment to withhold medication may be met with the patient's demand for the right to prompt drug relief."[6] Much of mental health remains a mystery and the boundaries between the normal and the pathological remain unclear, thus when it comes to what doctors should do the debate continues.

AIM

To examine the attitudes and beliefs of psychiatrists regarding the tension that may exist between preserving patient autonomy in the present day – in this case, a patient's decision to be prescribed antidepressants regardless of the presence or absence of clinical symptoms – and the role doctors may be playing in shaping our society into one in which painful emotions like sadness and unhappiness no longer exist.

METHOD

A questionnaire was developed containing 29 statements to which respondents specified their level of agreement on a five-point Likert Scale, one being strongly agree and five strongly disagree. These statements were divided into five sections: Depression vs. Sadness/Unhappiness; Prescribing of Antidepressants; Patient Demand, Need and Autonomy; Sadness/Unhappiness and Social Trends; and Doctors' Roles. At the end of each section additional room was given for any further comments. Ethical approval was then obtained from the University of Otago Ethics Committee.

A list of 40 Dunedin-based consultant psychiatrists was provided along with contact information found through public records. The questionnaire was mailed to each of these psychiatrists and an email reminder sent two weeks later to those who had not yet responded. No further demographic information was obtained through the questionnaire, although the respondent's gender and place of work was already known. Each questionnaire had a random number assigned which corresponded with the name of the respondent for administrative purposes. This information was destroyed before the data analysis began to preserve anonymity. Each statement was analysed individually and the percentages for each level of agreement for a statement were calculated. Any additional written comments were transcribed and analysed to help explain questionnaire

replies. Some correlation analyses were also performed to ascertain the strength of correlation, if any, that existed between various statements.

RESULTS

Twenty-five psychiatrists responded (response rate of 62.5%) of which 14 had written additional comments. We found that a significant majority of respondents believed there is a qualitative difference between a patient with clinical depression and a patient who is sad/unhappy (average Likert Scale score of 1.23). In addition, most disagreed with the statement that there are no identifiable characteristics distinguishing depression from sadness, with an average Likert Scale score of 3.96. One respondent stated that "there is a significant phenomenological difference between sadness and depression which relates to a sense of brokenness - despair - that NOTHING will allow an improvement, that life will now be without pleasure; this is akin to the Jasperian comment on un-understandability of psychosis," while another respondent commented that "sadness is limited to an area of a person's well-being; depression is global."

A significant majority of the respondents believed that to 'treat' sadness/unhappiness is not justified merely by the desire or will of the patient. As one respondent stated, "A doctor must take responsibility for prescribing the best and most appropriate medication. They should not prescribe merely on patient request." (Original emphasis) Most respondents disagreed with the following statements: when prescribing antidepressants it is not the doctor's responsibility to discern between patients with clinical depression and patients who do not have clinical depression (average Likert Scale score of 4.53); a patient should be given antidepressants upon request when they are not clinically depressed (average Likert Scale score of 4.57); and a patient's demand/desire for antidepressants should be met even when it is against the doctor's professional judgment (average Likert Scale score of 4.74). A statistically significant correlation was found between those who believed there is a qualitative difference between patients with clinical depression and patients who are sad/unhappy with those who believed that meeting a patient's demands/desires for antidepressants is not justified by the patient's fundamental right for self-determination (Correlation Coefficient = 0.619; P-value = 0.001).

When it came to questions regarding medicalisation/social trends, respondents were relatively more ambiguous in their beliefs. There was a wide-ranging response to the statement that the rise in antidepressant use is due to an increased prevalence of depression with an average Likert Scale score of 3.54, as well as to the statement that the rise in antidepressant use is due to the medicalisation of sadness/unhappiness with most respondents agreeing or neither agreeing nor disagreeing (average Likert Scale score of 2.74). One respondent stated that "psychiatrists seem to generally fall into two categories (from observation), either biologically-oriented or psychodynamically-oriented; there are few who have a good grounding in both. I believe this is influential in the medicalisation of sadness/unhappiness," while another commented that "most of this [medicalisation] may be driven from wider societal pressure and not originate within medicine (or maybe not), but medicine runs the risk of reinforcing medicalisation because it flatters our egos to be able to 'save' people."

The majority of respondents disagreed with the statement that doctors do not play a significant role in the wider social changes that occur over time (average Likert Scale score of 3.87), in addition to the statement that it is not the doctor's responsibility to consider the implications of their decisions, if any, to wider social changes that may be occurring (average Likert Scale score of 3.87). Most also disagreed with the statement that doctors do not have a professional obligation to be concerned with the possibility of the medicalisation of sadness/unhappiness with an average Likert Scale score of 3.96.

DISCUSSION

The results of this study have shown that there is a limit to a patient's autonomy when it comes to requesting antidepressants. Most psychiatrists who responded believe that there is indeed a difference between patients suffering from clinical depression and those who are feeling sad or unhappy. Therefore, like a healthy patient unjustifiably requesting antibiotics, they believe it is the doctor's responsibility to discern between patients with a medical, and therefore treatable, condition and those who do not, antidepressants being appropriate only for the former. Although it may not always be straightforward to diagnose, especially patients with mental health problems involving significant amounts of psychological and emotional distress without a diagnosable mental disorder[7], doctors must use their professional judgement to do what they believe is best for the patient. This could mean prescribing or withholding a drug against a patient's wishes.

Considerable debate exists in medical literature regarding the idea of the medicalisation of sadness/unhappiness. With the advances we are daily making in medicine, science and technology, the Huxlyean fear of the inevitable atrophy of human desires for independence and enlightenment in exchange for a pseudo-utopia echoes in the minds of many. A new world order in which, by the power of science and technology, the experience of pain and suffering no longer exist and the widespread distribution of the perfect drug called 'soma' is used by the totalitarian government to create and preserve this seemingly perfect society. And though the idea of a brave new world is worrisome for all sides of the debate, two very different perspectives exist regarding sadness/unhappiness and the current use of antidepressant: the moral and the medical.[3]

The moral perspective is rooted in the concept of depressive realism in which depression is considered a manifestation of truths necessary for any true philosopher, genius, and artist, bestowing upon the sufferer insight about their identity and about life.[3] Melancholia, sadness, and unhappiness are believed to be an essential part of what makes us human.[8] Therefore, by medicalising those experiences and 'treating' them with an 'artificial' psychopharmacological happiness we are losing bits of who we truly are.[9]

In contrast, the medical perspective sees depression as a purely medical problem, easily treatable and contained through prescription of antidepressants.[3] Those holding this perspective argue that it is not so much the character change itself that worries those holding the moral perspective (for who could blame a person for being happier?), but suspicion and mistrust of the 'artificial' method of change[10,11], as well as a cultural preference for the melancholic genius over the sanguine optimist.[10] However, they argue there is no prima facie obligation to suffer merely because it will bring about a better character, and although we do need to be careful to prevent the genesis of a Huxlyean state, we must, more importantly, avoid stigmatising those who seek help for their mental pain.[11] "It may be true that antidepressants are currently over-prescribed and that some who use the drugs do so for improper reasons. However, these facts must not deter physicians and patients from legitimate use of antidepressants, in cases where there is real suffering."[11]

The psychiatrists in our study generally seemed to hold more of a medical perspective of depression, though not enough information was obtained to infer support for any of the specific arguments made in the literature. What we do know is that our respondents do indeed believe the medicalisation of sadness/unhappiness should be a concern for doctors, however their justification for denying a patient's request for antidepressants was less to do with concern over medicalisation and more to do with non-maleficence and their professional obligation to treat only those with a diagnosable medical condition.

Thus the ethical issue highlighted by our research was the concept of professional integrity verses the doubtful and/or problematic demands of society[12], though this may have been somewhat inherent in the nature and setup of our study. The doctor, although a professional, is a social creature prone to bias, influenced by not only their socio-cultural context and personal and social biographies, but also their professional training, the scientific understanding of their discipline, and the economic and organisational constraints of practice settings.[13] Although most psychiatrists in our study currently believe that the mere desire of the patient is not justification enough to 'treat' unhappiness, as Chodoff points out, "the psychiatrist is particularly vulnerable to pressure from government and

cultural sources and instances that will inevitably arise when these come into conflict with professional convictions... On such occasions, a difficult ethical issue is whether genuine responsibility to society is discharged better by adhering to professional standards or by obeying the dictates of law and custom."[12]

It must be noted that there was one respondent who disagreed significantly with the majority on the larger issues of concern. This psychiatrist stated, "It is unfortunate that doctors are in the role of social controllers of [the] use of drugs. This is a fundamental denial of human rights by the paternalistic society in which we live. Doctors should be teachers, educators, advisors - not the present agents of control by the state." For this respondent it seemed that the limits to a patient's autonomy, as defined by the doctor, were more or less unjustified, although s/he still agreed that a patient's demand/desire for antidepressants should not be met when it is against the doctor's professional judgement. Therefore, although this respondent believed that the "doctor's role needs to be changed from controller to educator," the importance of professional integrity was nonetheless underscored.

CONCLUSION

Our research has suggested that the respondent psychiatrists may have been more hesitant to express strong opinions on social trends and the idea of medicalisation, however they were undeniably clear on what their role as doctors, and subsequently as the gatekeepers of prescription drugs, entailed. As one respondent commented, "The doctor also has autonomy and should not prescribe when that might be harmful for no benefit... A person may be free to take anything legal (ie. St. John's Wort) but a doctor is not bound to prescribe anything." In other words, yes there is a limit to a patient's autonomy when to deny their request is in the patient's best interest because "the psychiatrist... has a central role to play in ensuring that while the therapeutic potential of psychotropic drugs is fulfilled, the ethical factors are kept under close and careful scrutiny."[7]

LIMITATIONS

The main limitation of this study was our relatively small sample size and the possible inapplicability of our findings to other societies and cultures. Our findings may not apply to other New Zealand psychiatrists, as there may be various local cultural influences affecting the beliefs and attitudes of the psychiatrists in another region. Our findings may also not apply to other non-New Zealand psychiatrists (for example, psychiatrists in the United States) because the beliefs and attitudes of psychiatrists are, as explored above, affected by the context in which they live, train and work. Another limitation is the possible inapplicability of our findings to doctors of other specialities. For example, the beliefs and actions of psychiatrists examined in this study may differ significantly from those of other doctors like general practitioners who may experience more time constraints and other boundaries, as well as being more likely to have patients struggling to deal with the 'normal' stress and blues of everyday life as opposed to very serious and extreme clinical depression. It is also important to note that the scale used in the questionnaire was developed for the purposes of this study, so has not been rigorously validated. Therefore due to these limitations our results suggest certain hypotheses rather than presenting tested and validated conclusions.

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