

Unmet need or medicalising distress?

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The article by Samaranayake et al, in this issue of the *Journal*,¹ is a well-designed study. It managed to get a surprisingly high response rate (nearly 70%) for studies of this type by using paper versions of questionnaires (filled in prior to student lectures) rather than the usual computer-based surveys. There may be a lesson in that. The authors report high rates of sleep disorders, clinically significant anxiety and depression as well as harmful alcohol and drug use among the student population.

The question immediately arises about what these ‘disorders’ actually are and what do they mean. The authors seem to believe that their measures capture significant psychopathology and conclude that “accurate diagnosis using defined criteria will enable effective treatment for these conditions that impact greatly on the quality of life”. This implies that at least 40% and probably closer to 50% (if we add up the disorders even allowing for diagnostic overlap) of students are suffering from a significant psychiatric disorder.

Taken at face value this means that one in two students should be visiting a health professional in order to undergo a clinical intervention for a sleep disorder and/or a depressive disorder and/or an anxiety disorder and/or an alcohol and drug disorder. Obviously someone needs to warn student health services.

Could these results be seen as over-medicalisation of mental health issues? It seems reasonable to state that the University of Auckland students have quite high levels of distress including sleep disturbance, as well as anxiety and depressive symptoms. Interestingly a survey of Christchurch medical students 7 months after a major earthquake, using different instruments, reported lower rates of psychological distress. Only 6% reported significant sleep problems, 9% anxiety and 12% depression.²

Regardless, to convert what may be normal life experiences in many cases to mental disorders is difficult to justify. The authors own data supports this view. Despite the apparent high rates of psychopathology they go on to report that less than 2% of their sample are dissatisfied or extremely dissatisfied with life. Over 80% are, in fact, slightly to extremely satisfied. It is difficult to reconcile the apparent high prevalence of mental disorders with students’ general satisfaction with life.

The mental disorders that were screened for are created categories promoted in a diagnostic manual (the DSM 5)³ that has become a worldwide standard. There has been increasing concern that the diagnostic criteria for many of the disorders are too vague and encompassing and convert personal or social problems into medical ones.⁴

Particular conditions are promoted as widespread, serious, and treatable by specific interventions. Alternative approaches such as emphasising the self-limited or relatively benign natural history of a problem, or the importance of non-medicalised personal coping strategies are played down or ignored.⁵

This is not to say the DSM psychiatric diagnoses are purely social constructions but to acknowledge that accretion and practical necessity underlie most mental disorders rather than an independent set of abstract and operationalised criteria.⁶ Given our current state of knowledge, a more honest (if somewhat self-serving) definition of mental disorder might be that of Maddux et al.⁷ “Mental disorder is what clinicians treat and researchers research and educators teach and insurance companies pay for”.

We do need a guide to psychiatric disorders. While DSM 5 might be indispensable it is fallible and imperfect and this needs to be kept in mind when advocating screening and treatment for the disorders contained within it.

Criticisms of psychiatry for pathologising normality are not new. Nor is “disease mongering” confined to psychiatry.⁸ However, because distress is a fundamental symptom in psychiatry and the neuroscience underpinning its definitions is weak, psychiatric disorders are particularly vulnerable to expansion.

Some consider the widening of boundaries is cynically manipulated to expand markets for those who sell and deliver treatments, particularly pharmaceutical companies.⁵ While there is undoubtedly some truth in this view, there is also a deeply felt need to explain, or at least label, what might otherwise be seen as unexplainable human suffering or deviance. In addition, patient and advocacy groups often see such labels as a way of causing attention to neglected needs, gaining research funding and reducing stigma.⁶ Clinicians are concerned about people being denied access to health care, avoidable personal suffering and social exclusion so clamour for an extension in boundaries of the disorders they treat.⁹

What then is the harm in expanding the number of individuals suffering from mental illnesses? It might be argued that around half the students are suffering from at least some distress even if much of it is expectable and ‘normal’. I would argue that the risks outweigh the benefits. The obvious risks are unnecessary labelling (with potential consequences for such things as medical or income insurance), potential stigma, overtreatment, iatrogenic illness due to drug side-effects as well as resources diverted from treating more serious illness. Less obvious but equally important is that pathologising distress as illness may lead individuals to increasing self-identification as helpless and reliant on the services of health professionals.

Distress is seen as a signal that professional help is needed.⁴ Illness models also tend to attempt to relieve distress by focusing on individualised and private solutions rather than sociological or political explanations.⁵ If sleep, anxiety, depression and alcohol disorders are as widespread as this survey reports then rather than suggesting students attend GPs or student health services for individual treatment it might be better to focus on what stressors in university life lead to such high rates of mental disorder.

In conclusion, it appears that students at the University of Auckland often have sleep problems, depressive and anxiety symptoms, and drink too much at times. This is similar to international surveys of university students. Currently our society appears intolerant of what could be considered normal and expectable distress and labels these symptoms as disorders implying that they require professional help.

On the face of it, it seems unlikely that the majority of students have a mental disorder and a case could be made that most of these symptoms are transient and reactive and do not justify specific treatments.

Addressing general factors that may reduce stress among university students is more likely to be helpful than suggesting that around half the student body requires mental health interventions.

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