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Case Report

The Psychiatrization of Negative Emotions

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Abstract

Introduction: It is of the utmost importance to distinguish psychiatric illness from negative emotions to avoid psychiatrization of normal emotional responses. **Case description:** An 82-year-old man without a history of psychiatric disease was seen in the emergency room after a suicide attempt by hanging. He was committed and medicated with 25 mg of sertraline. Fifteen days later, the patient was evaluated in a psychiatric consultation. No psychopathology was present, and he had been cheerful and functioning well since he exited the inpatient unit. Sertraline was weaned off, and he was released from the consultation. **Comment:** The case report addresses psychiatrization driven by top-down factors, such as the diagnostic vagueness of classification systems or the heterogeneity of psychiatric assessments. Thus, diagnosing in mental health must involve much more than following a checklist and merely considering the patient's words and responses to questioning.

Keywords: psychiatrization; older adults; negative emotions

Introduction

Psychiatric disorders are undoubtedly a burden to patients, families and society. [1] As such, it is of the utmost importance to diagnose psychiatric illness accurately and distinguish it from negative emotions. This is important as sadness or anxiety, mainly in the context of life events, are not necessarily symptoms of a mental health problem. In fact, usually, these emotions are transient and do not demand any therapeutic intervention, even when part of mild depression.[2] Furthermore, if supportive interventions are recommended, non-pharmacological approaches can be effective.[3,4]

Herein, we present a case report as a basis to reflect on how misperceptions about negative emotions and mental health issues may be contributing to an overdiagnosis of psychiatric disorders.

Case Description

Psychiatric emergency department

Mr A, an 82-year-old married man without a history of psychiatric disease, was admitted to the emergency room after a suicide attempt by hanging. An argument had occurred during a family dinner. To alleviate the situation, he got out of the house and drove his van to the nearby farmland. Initially, his intention was only to escape the strained family environment. Still, after reflecting for a few minutes, he felt he "was not doing anything in this life anymore" and decided to hang himself. He tied a rope to the wooden ceiling, used a farming basket to climb up and jumped. He was found almost unconscious, but still remembers hearing his wife's voice yelling for help to get him down. He confessed he had been feeling sad and distressed for some time, as none of his children wanted to continue the family business.

The son, who was present in the emergency room, mentioned that he had spoken with Mr A the day before and that Mr A seemed well. He also added that his siblings were involved in the restaurant business but left to pursue other interests, which made Mr A sad.

Mr A's mental status examination was described as follows: "General appearance dishevelled. Facial expression of anguish and tears. Cordial and affable attitude, but downcast posture. Quick and tenacious attention span. Spontaneous, coherent, and organized speech of simple elaboration. Depressed mood, with syntonic affect. Denies suicidal or self-harming ideation at the moment. No psychotic symptoms are observed. Insight preserved. Given the seriousness of the suicidal act and the family conflict as the reason for the depressive state, hospitalization was proposed for "clinical stabilization, risk containment, and family intervention, which the patient accepted". He was committed and medicated with 25 mg of sertraline per day.

Inpatient unit medical record (the day after)

«Mr A explains that two days before, he was having dinner with his family when they got into an argument. The daughter who lived with him and his wife told him she would leave the house. He felt wronged, since he had always been very supportive of her. Furthermore, he had been feeling overwhelmed at work and sad that none of his children wanted to take over the business. He went for a walk to clear his head, and the idea that was no longer worth living occurred to him". He then tried to hang himself with the intention of ending his life, without having ever planned it before.

Today, he feels "1000%" remorseful and is reluctant to face family and friends to explain what happened. He is worried about his wife, saying: "She is an angel...she has many health problems and needs my help a lot". He already spoke with his children, who are willing to help him.

At mental status examination (09:26 a.m.): "Cordial, affable, and cooperative. Syntonic contact. Attention easily captured and maintained. Depressed mood, with mobile, reactive affects congruent with the mood. Sometimes tearful. Spontaneous, perceptible, logical, and coherent speech, without alterations in rate, volume, or prosody. No evidence of alterations in sensory perception or in the content, form, or possession of thought. Regular sleep and appetite. No self-harming ideas. Projects into the future. Insight preserved."

The granddaughter corroborates Mr A's story and explains that his children have not spoken to each other for about 8 years. However, after Mr A's suicide attempt, both the patient's children and grandchildren agreed to support him and his wife, as well as to help run the restaurant. She requests that the patient be discharged so that he can attend his grandson's first communion the next day.

At reassessment (10:39 a.m.), Mr A, who has already spoken with his granddaughter, feels more relieved, hopeful about the future, and motivated. The mood is also visibly improved. He requests discharge so he can attend his grandson's first communion and support his wife. He is confident that things will go well at home and at the restaurant with the help of his family and, once again, states that he is very sorry for the suicide attempt.

He is discharged with the indication of escalating sertraline from 25 to 50 mg once daily. A follow-up consultation is scheduled in two weeks.»

Follow-up consultation

Mr A presented at the follow-up consultation with his daughter and had been taking sertraline 50 mg per day for the last eleven days. He showed no psychopathology and had been cheerful and functioning well since he exited the inpatient unit. As no symptoms or signs of a psychiatric disorder were detected, the indication was to wean off sertraline, and he was discharged from the consultation.

Mr A's electronic health record was recently consulted. This is an integrated official Portuguese health software that, with the person's authorization, provides doctors with access to an individual's clinical records, including prescriptions. To date, more than four months after the psychiatry consultation, Mr A has never been medicated with psychopharmacological drugs again, nor is there any evidence that he needed any psychological or psychiatric support.

Comment

Psychiatrization has been defined as a "complex process of interaction between individuals, society, and psychiatry, through which psychiatric institutions, knowledge, and practices affect an increasing number of people, shape more and more areas of life, and further establish psychiatry's importance in society as a whole". [5] One of the main concerns related to psychiatrization has been

its contribution to lowering the threshold of what is considered abnormal, leading to an overdiagnosis of mental health disorders, prescription of unnecessary pharmacological treatments and inflation of epidemiological data. [6] It has been pointed out that a significant change in the diagnosis of Depression occurred with the criteria adopted in DSM-3. [7] The symptom-based classification of the disorder and the overall disregard for context have led to a significant increase in the diagnosis of Depression, a disease previously considered rare by clinicians. More recently, DSM-5 went further and withdrew the bereavement exclusion from the diagnostic criteria, eliminating the only reference to contextual sadness and broadening the concept of illness. [7] Furthermore, uncomplicated Depression appears to include non-pathological normal-range human reactions, which may be contributing to an increased number of misdiagnoses. [8,9] Mislabeling an understandable emotional response as a disease is ethically pernicious, as it puts individuals in a vulnerable position of facing decisions regarding an illness they do not have, contributing to the entrenching of the patient status and harming personal dignity and personal expectations. In addition, it exposes healthy people to unnecessary risks, such as medication or stigma and undermines the principle of equitable justice by potentially diverting clinical and financial resources from those who genuinely need them. Moreover, both the heterogeneity of psychiatric assessments and clinical presentations [10,11] and the clinical improvement commonly observed with an unclear placebo effect [12,13] add to the difficulty of distinguishing mental disease from normative emotional responses.

In our case report, the patient was assessed by three medical professionals from the Psychiatry Department across three settings: the emergency department, the acute hospitalization unit, and outpatient care. In the first assessment, the patient was perceived as suffering from a depressive disorder, which led to the proposal of hospitalization and the initiation of an antidepressant. The next day, the case began to be interpreted differently as a more likely emotional reaction to a specific context. As such, after a systemic approach involving the family, and given the absence of significant psychopathology, the patient was discharged home and referred to outpatient care. Nevertheless, the augmentation of sertraline to 50 mg per day was still prescribed. When the patient was seen in outpatient care two weeks later, he had been taking 50 mg of sertraline for the last eleven days, and no psychopathology was detected. The asymptomatic state cannot be attributed to medication, as the patient had already shown improvement the day after admission at the inpatient care unit, and both he and his daughter stated that he had been cheerful and functioning well since his discharge. In addition, no sufficient time had yet passed for the antidepressant to take a therapeutic effect. [14] Finally, the current absence of evidence that he needed any further psychological or psychiatric support, strengthens the clinical decision of disregarding a psychiatric illness, the stoppage of antidepressant treatment and the discharge from psychiatric consultation.

The case report clearly illustrates a scenario of psychiatrization driven by top-down factors, such as the diagnostic vagueness of classification systems, the heterogeneity of psychiatric assessments, and the professionals' tendency to reduce clinical and legal risks, avoid conflicts, and acknowledge suffering. [6] It is, of course, both understandable and acceptable that a clinician facing a serious suicide attempt, where several risk factors are present (e.g. older adult, male gender, stressful context, lethal suicide method used), takes the necessary measures to protect the person's life. However, one must bear in mind that this does not necessarily include either making a diagnosis of mental illness or choosing a pharmacological approach, as suicide can happen in non-mentally ill people. [15] The elimination of the potential stressors and/or the development of adequate coping mechanisms, if necessary, through some psychological support, can sometimes be sufficient to resolve the situation, avoiding a diagnosis of a psychiatric illness, unnecessary drug prescriptions and stigma. In this regard, it is also of the utmost importance to have evidence-based psychotherapies widely available, which are recommended as a first-line treatment for clinically mild diagnosed depression and do not have the potential risks associated with medication. [16]

Our case report raises the following questions: Are mental health professionals also being influenced by the pathologization of minor disturbances of well-being, as part of the psychiatrization

of society? [6] If so, together with the minimization of the importance of context in mental assessment by international classifications [7,8], may it be leading to an overdiagnosis of psychiatric illness, inflating epidemiological data?

Portugal has a high consumption of psychotropic medication, particularly anxiolytics, as compared with other countries, which has been directly related to the significant prevalence of psychiatric disorders. [17] The reasons are, of course, most certainly diverse. However, simultaneously, psychiatrization may be contributing to overdiagnosing mental illnesses like Depression, and inefficiencies of the mental health system and an insufficiency of non-medical professionals, such as psychologists, may be favouring a drug-oriented approach. Indeed, data suggest that the ratio of psychologists (10,32/100.000 inhabitants) is below the recommended level of 20/100.000 inhabitants. [18] In contrast, the ratio of 15 psychiatrists per 100.000 inhabitants [19] exceeds the 10 psychiatrists per 100.000 inhabitants proposed by international organizations. [20]

It is essential to remember that science is not dogmatic and is characterized by a culture of permanent questioning. Also, the range of normal emotions and behaviour can be represented by a Gaussian curve, meaning that those who deviate from the centre can still fall within the range of the non-pathological. Thereby, especially in such a complex area as mental health, where biological markers are scarce, psychiatrists must keep a keen critical sense, both regarding international classifications and the several stakeholders involved in mental health, and adapt their practices to the context and culture in which they work. Finally, the legacy and teachings of authors such as Jaspers must be treasured and encouraged, particularly the importance of context and empathy [21] as fundamental tools for accurate patient assessment. Diagnosing in psychiatry involves much more than following a checklist and merely considering the patient's words and responses to questioning.

Conflicts of Interest: The authors have no conflicts of interest to disclose.

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