# 'Mental Health and Suicide'
## *Papers and articles challenging the current approach*



## Excerpts from articles below:

The medicalisation of suicide is not without consequence: it distorts our understanding of suicide, leads to the dissemination of false information about suicide, and contributes further to the stigma surrounding suicide and mental illness.

*https://www.omicsonline.com/open-access/the_medicalisation_of_suicide_e104.php?aid=32427*

Suicide is medicalised when it is considered a medical diagnosis per se, when it is considered to be secondary to a mental disorder when no mental disorder is present, and when no mental disorder is present but the management of suicidal behaviour associated with distress is believed to be the sole responsibility of mental health professionals

*https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3328934/*

The medical/psychiatric, psychological, social and economic causes of depression argue for a multi-factorial aetiology for the condition. Such a perspective calls for a multi-sectoral understanding of depression and mental health. It argues for a multi-pronged approach to intervention. Within such a framework, pure medical and psychiatric approaches to depression would be restrictive and ineffectual for the vast majority of depression seen in the community

*https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3516018/*

Presentations associated with psychosocial adversity, like most clinical phenomena,[16] often lie on a continuum with distress at one end and disease at the other. However, the absence of gold standards for diagnosis of psychiatric disorders, the lack of pathognomonic symptoms and the use of individuals' perception of unpleasant feelings and phenomena, which form part of the normal range of emotions, makes it difficult to separate distress from depression, anxiety and common mental disorders.[17]

*https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3696230/*

Depression and anxiety, standard psychiatric diagnoses, are part of our vocabulary and popular culture. However, these terms are employed to highlight "idioms of distress," describe illness experience and to label diagnostic categories. Their widespread, flexible and interchangeable use has blurred the boundary between distress and disease. The disease halo has been inappropriately transferred to many forms of human suffering. The medicalisation of distress has resulted in a focus on treating individuals. It has also resulted in ignoring the impact of social and economic stress on mental health resulting in very little emphasis on the need for and use of public health and population-based interventions

*https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4201784/*

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## LINKS ONLY

*https://theconversation.com/what-causes-depression-what-we-know-dont-know-and-suspect-81483*

**What causes depression? What we know, don't know and suspect**

*http://www.telegraph.co.uk/news/2017/05/21/doctors-reliant-depressionquestionnaire-designed-bypfizer-campaigners/?WT.mc_id=tmg_share_em*

**Doctors 'too reliant' on depression questionnaire designed by Pfizer, campaigners warn**

*https://www.mja.com.au/journal/2016/204/9/unfulfilled-promise-antidepressant-medications*

**The unfulfilled promise of the antidepressant medications**

*http://wiki.ubc.ca/Medicalisation_of_Distress [University of British Columbia]*

**The Medicalisation of Distress**

*https:/www.businessinsider.com.au/australians-are-taking-antidepressants-in-ever-increasing-quantities-2015-4*

**Australians are taking antidepressants in ever increasing quantities**

*https://www.ncbi.nlm.nih.gov/pubmed/18633696*

**Medicalising mental health: a phenomenological alternative.**

*https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3328934/*

**Medicalisation of Suicide**

*https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3440915/*

**Medicalising Distress, Ignoring Public Health Strategies**

*https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4201784/*

**Psychiatric assessment and the art and science of clinical medicine**

*https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3516018/*

**Depression: a major public health problem in need of a multi-sectoral response**

*https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3696230/*

**Psychosocial adversity and mental illness: Differentiating distress, contextualising diagnosis**

*https://www.ncbi.nlm.nih.gov/pubmed/18664236*

**The prevention of suicide in India and the developing world: the need for population-based strategies.**

*http://link.springer.com/chapter/10.1007%2F978-94-007-4276-5_4*

**The Medicalisation of Mental Disorder**

*http://onlinelibrary.wiley.com/doi/10.1002/9780470666630.ch10/summary*

**The Use and Misuse of Psychiatric Drugs: An Evidence-Based Critique**

**Chapter 10. Medicalising Distress**

*http://www.mcfarlandbooks.com/book-2.php?id=978-1-4766-6306-7*

**Peddling Mental Disorder: The Crisis in Modern Psychiatry**

*https://www.theguardian.com/society/2013/may/12/psychiatrists-under-fire-mental-health*

*https://www.theguardian.com/science/2013/may/12/dsm-5-conspiracy-laughable*

*http://www.huffingtonpost.com/allen-frances/can-we-replace-misleading-terms-like-mental-illness-patient-schizophrenia_b_7000762.html*

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## PAPERS

*https://www.ncbi.nlm.nih.gov/pubmed/18633696*

J Med Humanit. 2008 Dec;29(4):243-59. doi: 10.1007/s10912-008-9065-1.

**Medicalising mental health: a phenomenological alternative.**

Aho K[1].

…psychiatry's first priority is to suspend the prejudices that come with being a medical doctor in order to hear what the patient is saying. To this end, psychiatry can begin to understand the patient not as a static, material body with a clearly defined brain dysfunction but as an unfolding, situated existence already involved in an irreducibly complex social world, an involvement that allows the patient to experience, feel, and make sense of their emotional suffering.

*https://www.omicsonline.com/open-access/the_medicalisation_of_suicide_e104.php?aid=32427*

Journal of Psychiatry

**The Medicalisation of Suicide**

**M. Louis Ruffalo***

The medicalisation of suicide is not without consequence: it distorts our understanding of suicide, leads to the dissemination of false information about suicide, and contributes further to the stigma surrounding suicide and mental illness.

*https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3328934/*

Malays J Med Sci. 2011 Oct-Dec; 18(4): 78–83.

PMCID: PMC3328934

**Medicalisation of Suicide**

Saxby Pridmore

Medicalisation is the misclassification of non-medical problems as medical problems. A common form of medicalisation is the misclassification of normal distress as a mental disorder (usually a mood disorder). Suicide is medicalised when it is considered a medical diagnosis per se, when it is considered to be secondary to a mental disorder when no mental disorder is present, and when no mental disorder is present but the management of suicidal behaviour associated with distress is believed to be the sole responsibility of mental health professionals. In the West, psychological autopsies have led to the belief that all or almost all suicide is the result of mental disorder. However, there are reservations about the scientific status of such studies. The actions of psychological autopsy researchers, coroners/magistrates, police, policy writers, and grieving relatives all contribute. Medicalisation of suicide has the potential to distort research findings, and caution is recommended.

**Medicalising Distress, Ignoring Public Health Strategies**

*https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4201784/*

Indian J Psychol Med. 2014 Oct-Dec; 36(4): 351–354.
doi: 10.4103/0253-7176.140698 PMCID: PMC4201784

**Medicalising Distress, Ignoring Public Health Strategies**

P. Thangadurai and K. S. Jacob
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Psychiatry, which has medicalised many forms of human distress, argues for individual treatments and interventions. It has blurred the disease-illness divide, subcategorised clinical presentations, lowered the thresholds for diagnosis and introduced many new psychiatric "disorders." Its phenomenological approach to diagnosis and classification employs symptom checklists and symptom counts sans context. The medicalisation of distress is supported by the capitalistic project and the current political economy of health, fits in well with neoliberalism and allows the free market to expand its business interests. This essay contends that social and economic correlates of depression, anxiety and common mental disorders, despite robust evidence, are not emphasised. It argues that social and economic determinants of mental health demand public health and population-based strategies to prevent and manage common mental disorders in the community. Such approaches will impact a greater proportion of people than medical interventions.

Depression and anxiety, standard psychiatric diagnoses, are part of our vocabulary and popular culture. However, these terms are employed to highlight "idioms of distress," describe illness experience and to label diagnostic

categories. Their widespread, flexible and interchangeable use has blurred the boundary between distress and disease. The disease halo has been inappropriately transferred to many forms of human suffering. The medicalisation of distress has resulted in a focus on treating individuals. It has also resulted in ignoring the impact of social and economic stress on mental health resulting in very little emphasis on the need for and use of public health and population-based interventions

*https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3440915/*

**Psychiatric assessment and the art and science of clinical medicine**

Indian J Psychiatry. 2012 Apr-Jun; 54(2): 184–187.
doi: 10.4103/0019-5545.99538
PMCID: PMC3440915

K. S. Jacob

*https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3516018/*

Indian J Med Res. 2012 Oct; 136(4): 537–539.
PMCID: PMC3516018

**Depression: a major public health problem in need of a multi-sectoral response**

K.S. Jacob

**Multi-sectoral intervention**

The medical/psychiatric, psychological, social and economic causes of depression argue for a multi-factorial aetiology for the condition. Such a perspective calls for a multi-sectoral understanding of depression and mental health. It argues for a multi-pronged approach to intervention. Within such a framework, pure medical and psychiatric approaches to depression would be restrictive and ineffectual for the vast majority of depression seen in the community.

*https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3696230/*

Indian J Psychiatry. 2013 Apr-Jun; 55(2): 106–110.
doi: 10.4103/0019-5545.111444
PMCID: PMC3696230

**Psychosocial adversity and mental illness: Differentiating distress, contextualising diagnosis**

K. S. Jacob
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Presentations associated with psychosocial adversity, like most clinical phenomena,[16] often lie on a continuum with distress at one end and disease at the other. However, the absence of gold standards for diagnosis of psychiatric disorders, the lack of pathognomonic symptoms and the use of individuals' perception of unpleasant feelings and phenomena, which form part of the normal range of emotions, makes it difficult to separate distress from depression, anxiety and common mental disorders.[17]

The complexity of the challenge mandates the need to examine alternative approaches and solutions. Acknowledging the limitations of current approaches, placing clinical presentations within their psychosocial contexts, using clinical typologies and broadening and refining the research focus would be cardinal for the success of diagnosing and managing individuals with distress and psychiatric disorders. Employing public health approaches would be imperative in reducing the rates of distress and common mental disorders in populations.

*https://www.ncbi.nlm.nih.gov/pubmed/18664236*

Crisis. 2008;29(2):102-6.

**The prevention of suicide in India and the developing world: the need for population-based strategies.**

Jacob KS[1].

**Abstract**

Very high rates of suicide have been reported from India and the developing world. However, much of the debate on suicide prevention focuses on individuals, methods, site-specific solutions, or particular suicide prevention strategies. This article argues for population based approaches that focus on improving the general health of populations (e.g., macroeconomic policies that aim for social justice, schemes to meet basic human needs, organising local support groups within vulnerable sections of society, developing and implementing an essential pesticide list, addressing gender issues, and increasing public awareness through the mass media) rather than medical, psychiatric, and other strategies that target individuals (e.g., treatment of mental illness, counseling, etc.) in order to reduce high suicide rates in India and developing countries. Individual approaches will help people in distress and prevent individuals from committing suicide, but will not reduce population suicide rates.

PMID: 18664236
DOI: 10.1027/0227-5910.29.2.102

*https://www.mja.com.au/journal/2016/204/9/unfulfilled-promise-antidepressant-medications*

**The unfulfilled promise of the antidepressant medications**

Christopher G Davey and Andrew M Chanen

Med J Aust 2016; 204 (9): 348-350

*http://mds.marshall.edu/cgi/viewcontent.cgi?article=1013&context=psychology_faculty*

*https://www.brown.uk.com/depression/bentall.pdf*

## MEDIA ARTICLES

*https://theconversation.com/what-causes-depression-what-we-know-dont-know-and-suspect-81483*

**What causes depression? What we know, don't know and suspect**

*http://www.telegraph.co.uk/news/2017/05/21/doctors-reliant-depressionquestionnaire-designed-bypfizer-campaigners/?WT.mc_id=tmg_share_em*

**Doctors 'too reliant' on depression questionnaire designed by Pfizer, campaigners warn**

*https://www.brisbaneactcentre.com.au/2-popular-myths-about-depression/*

**6 Common Myths about Depression**

*https://pursuit.unimelb.edu.au/articles/australia-s-middle-aged-suicide-rate-a-cause-for-alarm*

**Australia's middle-aged suicide rate 'a cause for alarm'**

Nobel Laureate Sir Angus Deaton sounds a warning for Australia by Eoin Hahessy, University of Melbourne

## BOOKS / CHAPTERS

**The Medicalisation of Distress**

*http://onlinelibrary.wiley.com/doi/10.1002/9780470666630.ch10/summary*

*http://wiki.ubc.ca/Medicalisation_of_Distress*

**University of British Columbia**

**The Medicalisation of Distress**

…the pharmaceutical industry spends about 36% of its revenue on public advertising including via the Internet Antidepressants are the most commonly used drug treatment for those with depression despite many studies that have shown the drugs lack of effectiveness as compared with placebo experiments [6]. Although severe cases of depression may require antidepressants as a last resort, mild cases of depression often begin initial treatment with the prescription of drugs, which can lead to a poorer outcome for these patients and a higher risk of negative side effects [7].

**The Use and Misuse of Psychiatric Drugs: An Evidence-Based Critique**

**Chapter 10. Medicalising Distress**

Joel Paris MD Professor

Published Online: 12 JUL 2010

*http://www.mcfarlandbooks.com/book-2.php?id=978-1-4766-6306-7*

**Peddling Mental Disorder: The Crisis in Modern Psychiatry**

*https://www.amazon.com/Peddling-Mental-Disorder-Crisis-Psychiatry/dp/1476663068*

By Lawrie Reznek

**About the Book**

Psychiatry is a mess. Patients who urgently need help go untreated, while perfectly healthy people are over-diagnosed with serious mental disorders and receive unnecessary medical treatment. The roots of the problem are the vast pharmaceutical industry profits and a diagnostic system—the Diagnostic and Statistical Manual of Mental Disorders (DSM)—vulnerable to exploitation.

Drug companies have fostered the development of this system, pushing psychiatry to over-extend its domain so that more people can be diagnosed with mental disorders and treated with drugs.

This book describes the steady expansion of the DSM—both the manual itself and its application—and the resulting over-medication of society. The author discusses revisions and additions to the DSM (now in its fifth edition) that have only deepened the epidemics of major depression, premenstrual dysphoric disorder, social anxiety disorder, attention deficit disorder and bipolar disorder.

**About the Author(s)**

Lawrie Reznek is an associate professor of psychiatry at the University of Toronto and has written a number of books on the philosophical foundations of psychiatry

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Ebook ISBN: 978-1-4766-2272-9
notes, bibliography, index
272pp. softcover (6 x 9) 2015

**De-Medicalising Misery**

*http://www.palgrave.com/us/book/9780230242715*

**De-Medicalising Misery**

**Psychiatry, Psychology and the Human Condition**

Editors: Rapley, M., Moncrieff, J., Dillon, J. (Eds.)

Psychiatry and psychology have constructed a mental health system that does no justice to the problems it claims to understand and creates multiple problems for its users. Yet the myth of biologically-based mental illness defines our present. The book rethinks madness and distress reclaiming them as human, not medical, experiences.

**Challenges to the modernist identity of psychiatry! User empowerment and recovery**

Pat Bracken & Philip Thomas

In K. W. M. Fulford (ed.), The Oxford Handbook of Philosophy and Psychiatry. Oxford University Press. pp. 123 (2013)

**Abstract**

This chapter argues that the modernist agenda, currently dominant in mainstream psychiatry, serves as a disempowering force for service users. By structuring the world of mental health according to a technological logic, this agenda is usually seen as promoting a liberation from "myths" about mental illness that led to stigma and oppression in the past. However, it is argued that this approach systematically separates mental distress

from background contextual issues and sidelines non-technological aspects of mental health such as relationships, values, and meanings. This move privileges the gaze of the expert doctor who is trained to understand distress in terms of psychopathology. But, as this move empowers the doctor, it disempowers the service user. In part this is because the priorities of modernist psychiatry are generally at odds with the interests and concerns of services users, particularly those who see themselves as survivors of the mental health system. The chapter examines the implications of this for the psychiatrist's role in working with survivors towards recovery.

**Making the World Go Away, and How Psychology and Psychiatry Benefit**

**Chapter**

**De-Medicalising Misery**

pp 27-43

**Making the World Go Away, and How Psychology and Psychiatry Benefit**

Mary Boyle

**Abstract**

This chapter is based on two propositions. The first is that if we are ever to de-medicalise misery, then both the impact of people's environments and their life experiences, as major causes of emotional distress, and the social significance of these connections will have to be made more prominent. The second proposition is that both psychiatry and clinical psychology so avoid giving prominence to people's contexts in their theory, research and practice that we might reasonably ask why. Are they acting in accordance with evidence, has research demonstrated that life experience is not very important or, given what we know of the links between avoidance and fear, are psychiatry and clinical psychology actually rather fearful of context? This matter can be settled quickly. The evidence that what has happened and is happening to people in their lives plays a major role in creating various forms of emotional distress and behavioural problems – including psychosis – is very strong (Bentall, 2003; Read et al., 2005; Stoppard, 2000; Tew, 2005; Wilkinson & Pickett, 2009). As Bentall (2003) and Falloon (2000) have pointed out, this evidence is stronger than any we have for genetic or biological causes. So, if context is not at the forefront of psychiatric and clinical psychological theory and practice, then the avoidance is likely to be associated with something other than neutral presentation of evidence.

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