Special Communication

Medicalisation of Suicide

Saxby Pridmore

Department of Psychiatry, School of Medicine, University of Tasmania, Private Bag 27, Hobart, Tasmania, Australia 7001

Submitted: 14 Apr 2011
Accepted: 22 Jun 2011

Abstract

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.

Keywords: *depression, mental health, prevention, suicide, terminology, Western world*

Introduction

In the West, suicide has been viewed differently over time. When Greece was the centre of the Western civilisation, suicide was viewed as a moral response to disgrace and an appropriate method of making a political statement. Later, throughout Europe, suicide became a legal matter, a disgraceful act, an insult to God, and a legally punishable offence. The bodies of people who had completed suicide were desecrated, they could not be buried in graveyards with others, and their estates could not be inherited by their families, but were forfeited to the state. In 1821, the influential French physician Esquirol (1) declared that suicide was a medical problem. Since about that time, throughout the West, suicide has been understood in terms of mental disorder. This paper contends that, while suicide is more common among people with mental disorder, it also occurs in people without mental disorder, and medicalisation prevents a more comprehensive view of this behaviour. Countries in Asia are now conducting important studies in this field, and the view that all suicide is due to mental disorders needs to be approached with caution.

The concepts which underpin this paper include that suicide is medicalised when any of the following apply: 1) suicide is believed to be a medical disorder per se, 2) suicide is believed to be the direct result of a medical disorder when no medical disorder actually exists, and 3) the management suicidal behaviour that is not associated with severe mental disorder is deemed to be the role and responsibility of mental health professionals.

The first circumstance can be immediately excluded because suicide is not a medical diagnosis; it is a legal finding. The second and third circumstances frequently depend on the medicalisation of distress, that is, distress is misclassified as a mental disorder. Therefore, the medicalisation of distress needs also to be examined.

Medicalisation

Medicalisation is the misclassification of non-medical problems as medical problems (2). It has been discussed over recent decades in the Western social science literature (3). The Asian literature (4), however, suggests some awareness and resistance to this process.

Van Praag (5) described medicalisation as a process by which "normal" human behaviour and experience is "re-badged" as a series of medical conditions. Chodoff (6) stated that "the human condition" is medicalised by application of a "diagnostic label to various unpleasant or undesirable feelings or behaviors" which are, in reality, "inescapable aspects of the fate of being human".

Examples include 1) shyness being classified as "social anxiety", 2) promiscuity being classified as "sexual addiction", 3) everyday worrying being

classified as "anxiety disorder", and 4) low sexual desire in females being classified as "female sexual arousal disorder".

When medicalisation occurs and a medical explanation is accepted, it follows that a treatment will be provided (7). Examples include when ordinary emotional distress is classified as psychiatric disorder and treated with psychotropic medication, and when ordinary physical conditions (such as baldness and overweight) are classified as pathological states and treated with surgery.

A number of factors prepared the way for the emergence of medicalisation. Most prominent among them are 1) the universal acceptance of a very broad definition of health, and 2) the absence of precise definitions for the terms mental health, mental disorder, and mental health problems.

The World Health Organization (WHO) defined "health" as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". Well-being, in turn, is defined as "a contented state of being happy, healthy and prosperous" (8). Thus, the terms health and well-being are interchangeable. More recently, the WHO Commission on Social Determinants of Health (9) advocated not only for healthy lives, but also for all individuals to live a "flourishing life". Thus, very high expectations are encouraged, and a hangover following drinking or a loss of money at the races, both of which impact on happiness or well-being, could be classed as health issues needing treatment.

"Mental health" has also been described in positive, optimal terms. For example, one authority states, "In general, mentally healthy individuals value themselves, perceive reality as it is, accept its limitations and possibilities, respond to its challenges, carry out their responsibilities, establish and maintain close relationships, deal reasonably with others, pursue work that suits their talent and training, and feel a sense of fulfillment that makes the effort of daily living worthwhile" (10).

Very importantly, "mental disorder" lacks a satisfactory definition. The Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV, 11) states "... no definition adequately specifies precise boundaries for the concept of mental disorder" (p. xxx). In the absence of a definition, it provides a description which begins "...each of the mental disorders is conceptualized as a clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is associated with present distress or disability..." (p. xxxi). This description employs vague, undefined terms including "clinically significant", "psychological syndrome", and "distress". Using this description, it is impossible to differentiate mental disorders from normal human experiences such as guilt and grief, although the man in the street and most health professionals believe a distinction can and should be made.

The category "mental health problem" has been used (and may have been invented) in Australia (12). An Australian Government publication (13) states, "A mental health problem also interferes with how a person thinks, feels, and behaves, but to a lesser extent than a mental illness. Mental health problems are more common and include the mental ill health that can be experienced temporarily as a reaction to the stresses of life". Thus, the temporary reactions to the stresses of life have, in Australia at least, been designated as forms of "ill health" and thereby, the responsibility of the mental health services.

Medicalisation was initially blamed on doctors, who were described as attempting to increase their power (and the term "medical imperialism" was coined). However, balanced views now identify many "drivers" of medicalisation (14), including drug companies who seek to sell their products (15). Other drivers include the advantages of the sick-role; Mechanic (16) described the benefits of the sick role as relief from the responsibility of caring for oneself and family, and from going to work. Other commentators believe governments encourage medicalisation as a means of dealing with difficult social problems (for example, lowering unemployment figures by placing people on sickness pensions).

The WHO has a broad view of "health" and advocates a "flourishing life". However, health departments have little influence over most of the things that foster a "flourishing life": freedom, democracy, fairness, justice, educational and employment opportunity, affordable housing and transport, et cetera. Medical practitioners and services have extended their traditional roles to remove, wherever possible, distress associated with the "human condition". The minimisation of distress is, of course, desirable; whether this should be achieved via medicalisation, which distorts some medical tenants, is a matter for debate.

This section closes with the Buddha on the ubiquity of pain in life: "Birth is painful; old age is painful; sickness is painful; death is painful; sorrow, lamentation, dejection, and despair are painful. Contact with unpleasant things is

painful; not getting what one wishes is painful" (The Sermon at Benares). A current challenge is to decide which human problems are health problems and which, if any, are not.

Distress Medicalised into Depression

The term "depression" has at least two meanings, one is colloquial and another is technical. In contemporary discussions, the term "depression" is frequently used without clarification about which meaning is intended. This is a leading contributor to medicalisation of distress.

The colloquial meaning of "depression" is low mood/spirits of any degree, and as a result of any cause. At one extreme, it can be applied when the mood is slightly lowered for a brief period, as the result of a trifling loss. At the other extreme is more severe lowering of mood, as the result of a great loss.

When used in a technical sense by mental health professionals, the term "depression" is used to refer to a mental disorder (or sickness) featuring low mood/spirit most often called major depressive disorder (MDD). This is a serious and usually recurring disorder, characterised by episodes which often last months, but which may be shortened by treatment. Early episodes of mood disorder may be triggered by unhappy events such as loss and later episodes (relapses) may occur without detectable triggering events (losses).

Most importantly, the diagnosis of MDD can only be made when, in addition to persistent depressed mood or loss of the ability to experience pleasure, other symptoms are present. For a diagnosis to be made, at least four additional symptoms are required: these include a significant change in appetite, sleep problems, agitation or retardation, loss of energy, feelings of worthlessness, inability to concentrate, and thoughts of suicide (11).

A common example of the way distress is medicalised is when an individual who is distressed by an everyday event (for example, a cheating lover) reports that he/she feels "depressed", and this is taken to indicate "depression" in the mental disorder sense, even though the other diagnostic criteria have not been satisfied. Accordingly, the sick role is granted (paid leave from work and psychotropic medication become options). The individual may not claim the sick role; it may be that well-meaning others who observe the distress, with good intentions, thrust the sick role on the individual. There may be some initial advantages to the distressed individual in the form of increased social support, but in the long term, the disadvantages of the sick role out-weigh any advantages.

A major facilitating factor in the medicalisation of distress is that the DSM-IV (11) pays no attention to the context in which symptoms occur (except in the case of bereavement). If your house burns down, your spouse runs off, and you are diagnosed with cancer, all in the same week, as long as you have five MDD symptoms for two weeks, you can be diagnosed with MDD. The making of such a diagnosis is justified (according to the DSM-IV), even though your friends believe you are dealing very well with a nasty run of bad luck. Horwitz and Wakefield (17) make this criticism in their important monograph, *The Loss of Sadness: How Psychiatry Transformed Normal Sorrow into Depressive Disorder*.

How Suicide is Medicalised

Suicide is not a medical diagnosis; it is a legal finding. The central features are that the death occurs as a result of actions taken by the deceased, and these actions were taken with the intention of causing death.

As mentioned, Esquirol (1) was influential in the medicalisation of suicide in the early 19th century (18); others describe this process commencing in the late 18th century. Our concern here, however, is with current practices.

Much Western academic writing has contributed to the medicalisation of suicide. For example, Moscicki (19) states that "a psychiatric disorder is a necessary condition for suicide to occur", and Jamison (20) states that there is "unequivocal presence of severe psychopathology in those who die by their own hand". Some authors state that a psychiatric disorder is present in 100% of cases of suicide (21,22), and estimates of above 90% are widely reported (23,24). These findings are based on psychological autopsies: evidence is gathered about the thinking and actions of the deceased, and conclusions are drawn as to whether or not a mental disorder was been present. These are retrospective studies, and there are serious reservations about their validity and reliability (25–27) and the quality of the diagnostic instruments that are used (28). Thus, the scientific quality of psychological autopsies is not proven.

Even if the methodological issues could be overcome with certainty, the possibility remains that distress may be medicalised and recorded as a mood disorder. It is reasonable to assume that

all those who complete suicide are distressed, and therefore, psychological autopsy provides the opportunity for misclassification.

Recent Asian psychological autopsy studies have provided different results. An Indian study (29) found mental disorder in less than 40% of decedents, and studies of young people in China (30,31) have found an Axis I disorder in less than 50% of decedents. A report from Korea (32) found that "the current suicide epidemic in Korea has social origins". Given the potential for psychological autopsies to medicalise distress, findings that psychiatric disorder is present in less than 50% of the deceased suggests that medicalisation of suicide is much less common in Asia than in the West.

Another opinion, based not on psychological autopsies but on historical documents and qualitative material, acknowledges that suicide is more common among those with mental disorder, but holds that suicide can, and likely frequently does occur, in the absence of mental disorder (33,34). It should be mentioned that Western sociological autopsies and reviews have provided support for social factors contributing to suicide (35–37).

In addition to the psychological autopsy studies, a range of other actions encourage the medicalisation of suicide.

Officials (coroners, magistrates, et cetera, depending on local regulations) closely examine cases of suicide for evidence of health professional negligence or neglect, and frequently make negative findings (usually considered by the involved health professionals to be unjustified). By this process, officials reinforce the view that suicide is a psychiatric phenomenon and a matter of medical responsibility. Newspapers report these findings and supplement them with additional details. The police medicalise suicide by seeking to transfer everyone they apprehend who mentions suicide into the hospital system. They are motivated by the reasonable desire to avoid the hassles associated with a death in custody.

Suicidal thoughts (whether arising out of mental disorder or non-disorder distress) are terrifying to the individual and his/her associates, leading to a rush to a place of "safety" (the hospital). This is an understandable and often appropriate response in contemporary life, but can also be viewed in the context of medicalisation.

Self-help groups, some researchers and clinicians, and policy writers promote the notion that suicide is universally the result of mental disorder, because mental disorder is potentially treatable, and this notion allows the welcome belief that a path to suicide prevention is readily available.

When suicide has occurred, family members may prefer to believe and promote the explanation that the deceased must have suffered an unrecognised or untreated mental disorder, as a means of deflecting responsibility away from the deceased and survivors.

The great disadvantage of all-suicide-is-caused-by-mental-disorder thinking is that important social, cultural, economic, and political factors, about which much might be done, are neglected in favour of the medical solution. Relevantly, the medical solution has been the focus of national suicide prevention strategies around the world, but none of these have reduced national suicide rates (38).

Another disadvantage of the medicalisation of suicide is that it leads to suicidal behaviour becoming a socially acceptable response to distress (certainly, this is the case among young people in the West). Thus, medicalisation of suicide makes suicidal responses more, rather than less, likely.

Those individuals who have a mental disorder and are at a risk of suicide should receive all possible help. At times of acute risk, they should be kept as safe as possible and the mental disorder treated. Special supervision and support may be necessary and involve admission (at times, involuntary) to the hospital. The individual who has lost all interest in food and fluid may need special treatment for malnutrition and dehydration, with a view to preserving life long enough for treatment to take effect, and emergency electroconvulsive therapy may be necessary. This is not medicalisation, but appropriate medical care.

Support can come from family, friends, clergy, teachers, and a range of people with experience of the world. However, the traditional extended family and religion currently provide less social support than formerly (certainly in the West), and scholars (39,40) describe medicalisation as compensating for this social change.

Limitations of This Paper

The limitations of this study include that it is the opinion of one individual, and as such, incorporates biases. Nevertheless, it is based on decades of clinical observations by a trained psychiatrist. It takes a rigid view on the nature of mental disorders. It conceptualises the responsibilities of mental health services as primarily the treatment of mental disorders,

while current thinking is tending to broaden these out to include mental health and mental health problems. More flexible views of the responsibilities of mental health services have been described (41).

Summary

Medicalisation is the misclassification of non-medical problems as medical problems (2). It leads to poor outcomes and distorts our understanding of phenomena. The medicalisation of distress and suicide deserves close consideration.

Suicide is a piece of behaviour that is a final common pathway out of various distressing situations/predicaments (34). One of these distressing situations/predicaments is serious mental disorder, particularly MDD, especially when the disorder is untreated or unresponsive to treatment. The distress associated with a predicament, however, may not meet the diagnostic criteria of a mental disorder. Importantly, the High Court of Australia has found that suicide "may or may not involve mental illness" (42).

Medicalisation is facilitated by the very broad WHO definition of health, and the very imprecise DSM-IV definition of mental disorder.

It is frequently unrecognised that medicalisation (for example, treating a distressed person as if they are sick as an act of kindness) is stigmatising and often disadvantageous to the development of that individual.

Suicide can be medicalised via different processes, including being considered synonymous with mental disorder, by concluding that it has been triggered by a mental disorder when no such disorder exists, and by suicidal behaviour that is not the result of mental disorder being cast as the role and responsibility of mental health professionals.

In the West, psychological autopsies have been influential in the medicalisation of suicide: they have frequently found that 100% of those who completed suicide have suffered mental disorder. The psychological autopsy method, however, has scientific limitations. In Asia, psychological autopsies have found mental disorders less commonly (often in less than 50% of cases). These differences may be attributable to greater medicalisation in the West, but other cultural factors are probably also important.

Other actors also play a role in the medicalisation of suicide, including coroners, police, self-help groups, some researchers and clinicians, policy writers, and grieving families.

Correspondence

Professor Dr Saxby Pridmore
MB, BS, BMedSc (Tasmania), DPhysio (Melbourne), MD (Tasmania), AM
Department of Psychiatry
School of Medicine
University of Tasmania
Private Bag 27, Hobart
Tasmania, Australia 7001
Tel: +61 0409 825 029
Fax: +61 03 6226 4777
Email: s.pridmore@utas.edu.au

References

1. Esquirol J. Suicide. In: Societe de Medecins et de Chirurgiens. *Dictionnaire des sciences medicales. Volume LIII*. Paris (FR): CLF Panckouke; 1812–1822.
2. Zola IK. Medicine as an institution of social control. *Sociol Rev*. 1972;**20(4)**:487–504.
3. Watters E. *Crazy like us: The globalization of the American psyche*. Melbourne (AU): Scribe Publications; 2004.
4. Lee S. Diagnosis postponed: Shenjing shuairuo and the transformation of psychiatry in post-Mao China. *Cult Med Psychiatry*. 1999;**23(3)**:349–380.
5. Van Praag HM. Nosologomania: A disorder of psychiatry. *World J Biol Psychiatry*. 2000;**1(3)**: 151–158.
6. Chodoff P. The medicalization of the human condition. *Psychiatr Serv*. 2002;**53(5)**:627–628.
7. Aho K. Medicalizing mental health: A phenomenological alternative. *J Med Humanit*. 2008;**29(4)**:243–259.
8. World Health Organization. *Constitution of the World Health Organization*. Geneva (CH): World Health Organization; 1946.
9. Commission on Social Determinants of Health. *Closing the gap in a generation: Health equity through action on the social determinants of health. Final report of the Commission on Social Determinants of Health*. Geneva (CH): World Health Organization; 2008.
10. Hales D, Hales RE. Caring for the mind: *The comprehensive guide to mental health*. New York (NY): Bantam Books; 1996.
11. American Psychiatric Association. *Diagnostic and statistical manual of mental disorders: Fourth edition: Text revision*. Washington (DC): American Psychiatric Association; 2000.
12. Australian Health Ministers. *National mental health policy*. Canbera (AU): Australian Government Publishing Service; 1992.
13. *What is mental illness*? Canberra (AU): Mental Health and Workforce Division of the Australian Government Department of Health and Ageing; 2007.

14. Conrad P. *The medicalization of society: On the transformation of human conditions into treatable disorders*. Baltimore (MD): John Hopkins University Press; 2007.

15. Doran E, Henry D. Disease mongering: Expanding the boundaries of treatable disease. *Intern Med J*. 2008;**38(11)**:858–861.

16. Mechanic D. *Medical sociology: A selective view*. New York (NY): Free Press; 1968.

17. Horwitz AV, Wakefield JC. *The loss of sadness: How psychiatry transformed normal sorrow into depressive disorder*. New York (NY): Oxford University Press; 2007.

18. Watts JR, editor. *From sin to insanity: Suicide in early modern Europe*. Cornell (NY): Cornell University Press; 2004.

19. Moscicki E. Identification of suicide risk factors using epidemiologic studies. *Psychiatr Clin North Am*. 1997;**20(3)**:499–517.

20. Jamison KR. *Night falls fast: Understanding suicide*. New York (NY): Vintage Books; 1999.

21. Dorpat T, Ripley H. A study of suicide in the Seattle area. *Compr Psychiatry*. 1960;**1**:349–359.

22. Ernst C, Lalovic A, Lesage A, Seguin M, Tousignant M, Turecki G. Suicide and no axis I psychopathology. *BMC Psychiatry*. 2004;**4**:7.

23. Bertolote J, Fleischmann A, De Leo D, Wasserman D. Psychiatric diagnoses and suicide: Revisiting the evidence. *Crisis*. 2004;**25(4)**:147–155.

24. Scocco P, Marietta P, Tonietto M, Dello Buono M, De Leo D. The role of psychopathology and suicide intention in predicting suicide risk: A longitudinal study. *Psychopathology*. 2000;**33(3)**:143–150.

25. Selkin J, Loya F. Issues in the psychological autopsy of a controversial public figure. *Prof Psychol*. 1979;**10(1)**:87–93.

26. Ogloff JRP, Otto RK. Psychological autopsy: Clinical and legal perspectives. *St Louis Univ Law J*. 1993;**37**:607–646.

27. Tu WQ, Zhao H. Psychological autopsy and its limitations in application. *Fa Yi Xue Za Zhi*. 2009;**25(5)**:380–382.

28. De Leo D, Evans R. *International suicide rates and prevention strategies*. Cambridge (MA): Hogrefe & Huber; 2004.

29. Manoranjitham SD, Rajkumar AP, Thangadurai P, Prasad J, Jayakaran R, Jacob KS. Risk factors for suicide in rural south India. *Br J Psychiatry*. 2010;**196(1)**:26–30.

30. Zhang J, Xiao S, Zhou L. Mental disorders and suicide among young rural Chinese: A case-control psychological autopsy study. *Am J Psychiatry*. 2010;**167(7)**:773–781.

31. Li XY, Phillips MR, Zhang YP, Xu D, Yang GH. Risk factors for suicide in China's youth: A case-control study. *Psychol Med*. 2008;**38(3)**:397–406.

32. Kim MH, Jung-Choi K, Jun HJ, Kawachi I. Socioeconomic inequalities in suicidal ideation parasuicides and completed suicides in South Korea. *Soc Sci Med*. 2010;**70(8)**:1254–1261.

33. Pridmore S, McArthur M. Suicide and reputation damage. *Australas Psychiatry*. 2008;**16(5)**:312–316.

34. Pridmore S. *Suicide and predicament: Life is a predicament* [Internet]. Bentham Publishers; 2010 [cited 2011 MMM DD]. Available from: http://www.bentham.org/ebooks/9781608051694/index.htm.

35. Cavanagh JT, Owens DG, Johnstone EC. Life events in suicide and undetermined death in south-east Scotland: A case-control study using the method of psychological autopsy. *Soc Psychiatry Psychiatr Epidemiol*. 1999;**34(12)**:645–650.

36. Shiner M, Scourfield J, Fincham B, Langer S. When things fall apart: Gender and suicide across the life-course. *Soc Sci Med*. 2009;**69(5)**:738–746.

37. Foster T. Adverse life events proximal to adult suicide: A synthesis of findings from psychological autopsy studies. *Arch Suicide Res*. 2011;**15(1)**:1–15.

38. Pouliot L, De Leo D. Critical issues in psychological autopsy studies. *Suicide Life Threat Behav*. 2006;**36(5)** :491–510.

39. Summerfield D. Cross-cultural perspectives on the medicalization of human suffering. In: Rosen GM, editor. *Posttraumatic stress disorder. Issues and controversies*. Chichester (UK): John Wiley & Sons Ltd; 2004. p. 233–245.

40. Jacob KS. The prevention of suicide in India and the developing world: The need for population-based strategies. *Crisis*. 2008;**29(2)**:102–106.

41. Jacob KS. The cultures of depression. *Natl Med J India*. 2006;**19(4)**:218–220.

42. Stuart vs Kirkland-Veenstra [2009] HCA 15 (High Court of Australia). In: McDonald B, Anderson R, Yeo S. Case supplement for cases on Torts: 4th edition. Sydney (AU): The Federation Press; 2009.