

How to understand and reduce the high prevalence of psychiatric disorders

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Editorial

Since the first waves of representative community surveys of mental disorders, prevalence estimates of psychiatric disorders have been so high as to generate criticism of their believability. Those who have found these estimates shocking conceive mental health as a statistical deviation from *normal* where only a few should experience diagnosable pathology and thus psychiatric disorder is viewed as a rare, severe phenomenon that clearly separates the *ill* from the *normal*. The second generation of epidemiological surveys included measurements of impairment in order to address the criticisms of the first generation and despite this, the prevalence estimates of significantly impairing psychiatric disorders remained high.¹ A meta-analysis of epidemiologic surveys conducted between 1980 and 2013 documents a pooled estimate of 1 in 5 adults (from 155 surveys in 59 countries) meeting criteria for a common psychiatric disorder in the prior 12-months and almost 30% meeting criteria in their lifetime (in 85 surveys from different regions of the world).² The World Mental Health Surveys in 17 countries report a projected lifetime prevalence risk between 18-55%.³ Estimates in children and adolescents are even higher with an 8-year incidence of 39% in Mexican adolescents and a cumulative prevalence of 83% by age 21 in U.S. youth.^{4,5} Furthermore, longitudinal studies show even higher cumulative prevalence rates than cross-sectional studies and the greater the number of measurement points the greater the cumulative prevalence.^{5,6}

Those who continue to be skeptical of these estimates should consider this. Nearly the entire population can be expected to be physically ill at some point in their life. If a representative epidemiologic survey was done to estimate the lifetime prevalence of experiencing any physical illness in the population, no one would be alarmed to find rates close to 100%. In fact, it would be considered silly to even carry out such a survey. Longitudinal studies would find higher rates than cross-sectional studies because many people forget about common illnesses in their past, especially ear-

ly-life illnesses. The combined lifetime risk of major chronic physical conditions such as cardiovascular disease or cancer is over 80% in industrialized countries.⁷ So why should we be surprised that a large proportion of the population will at some point suffer one or more of numerous psychiatric disorders?

One important qualification that should be noted is that epidemiological surveys have found lifetime prevalence to be higher in Westernized, English-speaking and/or high income countries than in low income countries and non-Western settings. This pattern is evident in the meta-analysis cited above and in more recent publications from the World Mental Health Surveys.^{2,8} Nonetheless, given the amount of evidence from cross-sectional and longitudinal surveys over several decades in various regions of the world, it is undeniable that large proportions of many populations worldwide will experience psychiatric symptomatology and meet criteria for psychiatric disorders as classified by current nomenclature at some point in their lifetime.

So how can we understand the high prevalence of psychiatric disorder in many countries? More and more disorders have been added to each new edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) generating a controversy over the medicalization of human experience.⁹ Is, for example, disruptive mood dysregulation disorder, a new disorder in DSM-5, the medicalization of normative childhood tantrums? How frequent must a tantrum be to differentiate pathology from normal child behaviors? Indeed, our current diagnostic systems are imperfect and many symptoms fall on a continuum of normal to pathological rather than qualitatively distinguishing pathology from health. However, the *medicalization* explanation for the high prevalence of psychiatric disorders discounts and diminishes the suffering of those who experience distress (whether or not you believe distress to be a *psychiatric disorder* or the *medicalization of normal suffering*) and thus fails to promote actions to alleviate these problems endorsed

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by many. Furthermore, Steele et al., in their meta-analysis of psychiatric epidemiology surveys, found that a greater number of disorders did not represent greater prevalence estimates overall.²

Given that more than half the population in some countries, more than a third in Mexico,¹⁰ is expected to experience a psychiatric disorder by the age of 65, one could alternatively conclude that we live in a mentally sick society or that our society is making us mentally ill. Despite failing to consider contributing biological factors, the concept of a mentally ill society is useful in so much as it promotes focusing on and taking action to reduce the social determinants of ill health. The social determinants of mental health are underappreciated in public policy and planning aimed at the prevention and treatment of mental disorders. We need to think outside the box in terms of what constitutes a mental health prevention and/or intervention program and foment the inclusion of multiple sectors (education, labor, justice, economy, social development, etc.) in addressing mental health issues. We may do more to alleviate these emotional and behavioral expressions of suffering known as psychiatric disorders by reducing poverty, violence and social isolation and increasing quality of life, social cohesion, educational and employment opportunities, supporting families and positive childrearing practices, enacting laws that ensure healthy work environments, and assuring human rights than focusing on the psychiatric treatment of individuals. This is not to say that individual treatment, whether it be medication or psychotherapy, is not important, because it is and should be universally available to those in need, but as a society we should and could do more.

Whether the high prevalence of psychiatric disorder represents the medicalization of human experience or the expression of a mentally sick society, should not distract us from the more important question. If we know that a majority of our population will at some point experience emotional and behavioral distress and suffering, and we have the means to alleviate that suffering as we do for many of these conditions, why aren't we doing so and what should we be doing?

To improve the mental health of the population we first must challenge the stigmatization of these disorders; to do so we need a new understanding of psychiatric disorder to be conceived not as severe rare deviations from the norm of which we should be afraid, nor minimized as the medicalization of normal suffering which is not entitled to receive whatever alleviation the current technology can offer. Rather, psychiatric disorders should be conceived as emotional and behavioral manifestations of suffering due to a combination of biological underpinnings and social determinants, that many if not most people, will at some point experience to some degree, that are worthy of intervention and that should carry as little stigma as high blood pressure or influenza. Second, we must tackle the social determinants of

ill health in alliance and coordination with multiple sectors outside of the healthcare sector. Third, we must assure timely access for all. Only a minority of those with a psychiatric disorder receives services, of those that do many do not receive minimally adequate services and most take years to get into treatment. In the case of Mexico, more than a decade from the beginning of symptoms to reach treatment.^{11,12} Finally, we must promote integrative approaches to treatment that consider the patient holistically and his or her mental and physical health needs simultaneously.

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