Colombia Médica

English version

Versión español

OPEN ACCESS

Citation: Arboleda-Trujillo MA. **Psychiatric medicalization in university life.** Colomb Méd (Cali), 2024; 55(4):e1006757 https://doi.org/10.25100/cm.v55i4.6757

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EDITORIAL

Psychiatric medicalization in university life

Medicalización psiquiátrica en la vida universitaria

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In 2020, Lynn Cunningham and Wendy Ractliffe produced the documentary Medicating Normal [1)(,1)] (https://www.youtube.com/watch?v=BJ4F_ZF3u9M). Based on the testimonies of four US citizens, the filmmakers highlight the increasing prescription of psychotropic drugs for physical and psychological ailments inherent in everyday life. These ailments, quickly classified under psychiatric diagnoses, legitimised the use of increasingly potent drugs. The documentary is a critical reflection on the psychological, physical and social consequences of this process of medicalisation, as evidenced by the experiences of its protagonists.

Medicalisation, particularly in the field of mental health, can be analysed along three main dimensions, as Desviat [2] puts it. First, the tendency to pathologise common life experiences such as pain, sadness, dissatisfaction, frustration or personal limitations. Secondly, the equation of risk factors with disease, which implies a reductionist view of health. Finally, the broadening of diagnostic boundaries, leading to the excessive inclusion of human phenomena within clinical categories.

Such a situation had already been outlined in 2010 by Allen Frances [3,4], chair of the working group that drafted the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). At the time, Frances issued a "mea culpa" for having contributed to the popularisation of certain diagnoses in certain groups - such as attention deficit hyperactivity disorder (ADHD) - and warned of the even greater risks of the fifth version of the manual, in which the relationship between economic and institutional interests became more apparent.

Beyond the conclusions that point to the economic interests of the pharmaceutical industry and the medical complicity - in particular of some psychiatrists - as put forward by authors from different currents [5-9], an additional point of reflection should be proposed: the place of subjective responsibility in the face of everyday discomfort, especially in contexts where competition, constant change and high demands are the norm.

One of the priorities of the contemporary Western world is the demand for immediate and impersonal responses to the anguish and sadness caused by the various difficulties of everyday life. In this context, mental health systems, based on psychiatric positivism as an expression of the hegemonic medical model - of a biologicist, individualistic and ahistorical nature - privilege treatments that are fundamentally centred on pharmacological and behavioural interventions. This approach is imposed to the detriment of alternatives that, at least in theory, would require more time, commitment and complexity, such as psychotherapeutic processes or socio-community interventions [10-13].

As a logical consequence, fewer and fewer people are willing to tolerate psychological distress, and even fewer are willing to assume a subjective commitment to understanding or dealing with it. In many cases, the demand is translated directly into the search for an immediate pharmacological solution, without any critical reflection on the causes of the discomfort or on possible ways of dealing with it. This phenomenon is part of what Ribé Buitrón calls "the culture of collective submission" [14], in which the subject is positioned more as an object - especially a market object - than as an active and reflective subject [15].

In this framework, it is pertinent to return to the notion of the subject, to understand what a demand oriented towards subjective responsibility implies. Stolkiner, when referring to the subject, emphasises its condition as a historical being, characterised by the articulation between need and power. Necessity is linked to the common demands of the production and reproduction of life; potency, on the other hand, alludes to the capacity to subvert these needs and transcend the expected [7].

This concept coincides with the proposal of Colina and Marín [13], who distance themselves from intermediate approaches such as "eclecticism" or the "biopsychosocial" model, which they claim are ultimately based on biological determinism. Instead, they propose the concept of critical subjectivism, understood as "a theoretical and practical orientation that combines an interest in the subjectivity of clinical manifestations and care criticism that promotes respect, radically defending freedom, true autonomy and personal emancipation" [13]. In clinical terms, this perspective is expressed more in deal than in treatment.

At this point, it is appropriate to analyse the role played by the training of psychiatrists in the processes of medicalisation in the field of psychiatry. Firstly, there is a close relationship between the academic and care practices in psychiatric hospitals and their need to survive in an environment regulated by the logic of the health market. This situation encourages them to favour rapid responses using psychotropic drugs and standardised or manualised therapies [16].

Secondly, it highlights the historical effort of the psychiatric discipline to consolidate itself as a practice with a technical-scientific basis that legitimises its therapeutic interventions [16,17]. Despite the failure of the so-called "decade of the brain" (1990-2000) to provide conclusive explanations for psychological suffering, this impulse led to a biological reductionism. In the academic field, this approach has led to a descriptive, aseptic and rapidly applied psychopathology, which Tizón calls "biocommercial psychopathology" [16], and which is the basis of the diagnoses proposed by the DSM and of the clinical decision-making algorithms.

From this perspective, the only possible way to train future professionals oriented towards an approach centred on deal, and not only on treatment - as Marín and Colina propose - requires starting from a psychopathology focused on human suffering, rather than on the illness itself [13,16]. Only in this way will it be possible to genuinely accommodate care.

The presence of medical discourse in everyday life is also evident in contexts such as the university, especially in relation to issues linked to mental health - or, more precisely, mental illness. The growing interest in the mental health of university students in recent years is evidenced by the increase in the number of publications focused on demonstrating the prevalence of mental distress in this population, as well as identifying its determinants and the risks associated with self-harming behaviours [18-20].

Those of us who work in the field of mental health in university contexts recognise that this visibility has contributed to relevant transformations, such as the reformulation of institutional narratives, the incorporation of related content in curricula, the implementation of contextualised preventive actions and the development of early interventions in situations of potential risk to the lives of students.

However, this process has also had collateral effects which, as in other social spheres, have led to the psychiatrisation of phenomena such as academic stress. In many cases, there has been a confusion between psychological suffering - understood as an inherent manifestation of life processes - and mental illness. Similarly, the strengthening of individual and collective strategies has been replaced by processes of psychologisation and psychiatrisation.

Consequently, there is a growing tendency among students to perceive themselves as "limited" in coping with the demands of academic life, with intense dichotomous (all-or-nothing) emotional responses to any sign of failure or frustration. This is compounded by an increase

in psychiatric diagnoses, the use of psychotropic drugs and the issuing of medical incapacities in the university community. All in all, a process is configured whereby the subject is blurred, replaced by the category of "sick individual", thus reinforcing a pathologised identity.

It is essential to promote a rational use of the mental health clinic, guided by a deeper and more situated understanding of psychological distress. This requires a subjective involvement that recognises the existential dimension of suffering, as well as a shared responsibility - individual and collective - in addressing it. Psychic pain, far from being automatically pathologisable, must be understood as a constitutive part of the human experience. In this sense, it is a priority to reinforce personal, family, community and institutional coping strategies, considering specialised professional intervention as a complementary resource to be resorted to when previous support networks have proved insufficient.

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