Humanity is experiencing an epidemic. Recent estimates suggest that about 13% of the world’s population – more than 1 billion people – suffer from a mental health condition at any given time (James et al., 2018). In the country of writing, Australia, up to one in five individuals meet criteria for a psychiatric diagnosis, with nearly half of the population having a mental illness at some point throughout their lives (Australian Bureau of Statistics, 2007).

Moreover, prevalence rates of mood disorders and suicide continue to increase, year after year (Twenge et al., 2019). With so many touched by the heavy hand of mental ill-health, protecting the freedoms of this growing global population represents a pertinent and pressing issue.

In some respects, it is quite easy to see how those with mental health problems have their freedoms constrained. Involuntary psychiatric hospitalization remains a controversial and contended practice, although is still commonly employed worldwide. Even when treatment is ‘voluntary’ it is clear that mentally ill individuals sometimes do not have the freedom to choose the nature of their treatment. For example, therapeutic engagement is often leveraged with the threat of incarceration (Lamberti et al., 2014) and individuals are thus coerced into taking psychotropic medications with burdensome side-effects. It should also be noted that, in addition to the freedom constraints imposed by treatment, psychopathological symptoms themselves have deleterious effects on many of the basic freedoms outlined by the Human Freedom Index (Vásquez & Porčnik, 2019), such as the ability to communicate freely with others, engage in meaningful employment, or feel safe during everyday life. Overall, individuals with mental illness lead lives constrained in numerous respects, including reduced employment prospects, stigmatization, social isolation, and restricted opportunities to participate in society (Kelly, 2006).

Yet, there is one structure of power which remains largely overlooked by broader society, which imprisons the mentally unwell, not with physical restraints or psychoactive chemicals, but with epistemology and labels. The purpose of this essay is to address this system of oppression that, due to its deep subtlety often lays hidden, yet which continues to pervasively constrain the freedoms of individuals struggling with mental ill-health – the process of over-medicalization.
The Medical Transformation of Humanity

The term *medicalization* refers to the process through which non-medical (human) problems become defined as medical problems (Conrad, 2013). Medicalization itself is not inherently malicious. In fact, medicalization often aims to provide help to individuals who may be suffering. The medicalization of children with impulsivity and attention difficulties as having a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD), for example, can be considered a humanitarian aspiration – medical help can support these children to succeed within an educational system that demands long periods of sustained concentration (and, later on, a broader capitalist system that demands productivity and obedience). In this way, transforming social problems into medical ‘diseases’ can serve to reduce blame, elicit care, and offer hope for sufferers.

Nevertheless, philosophers, sociologists, and psychiatrists alike have highlighted how the medical system can be, at times, employed as a mechanism for social control (Foucault, 1961; Szaz, 1974; Conrad, 2007). Historically, the psychiatric tradition has colluded with systems of oppression, restricting the freedoms of those who demonstrate deviant behaviour, either physically (involuntary hospitalization), chemically (psychoactive medication), or socially (stigmatization). Psychiatry’s willingness to collaborate with oppressive powers is epitomized in the example of ‘dраОетомания’ – a 19th Century psychiatric ‘disorder’ assigned to slaves who had a ‘tendency’ to run away from their owners (Schwartz, 1998). If we turn to contemporary psychiatry, it is easy to see how the medicalization of deviant childhood behaviour as ‘ADHD’ has been used to compel children into conformity with the expectations of the educational system.

Beyond the role of the medical system for social control, over-medicalization also displaces responsibility away from socio-political factors and onto the sufferers themselves. Indeed, examining mental health problems through the clinical lens emphasises individual factors while obscuring the social and economic context within which these factors exist, such as culture, gender, race, education, or economic status. In his analysis of the concept of freedom, Sen (1999) concludes that the central element of personal freedom is individual agency – that is, the opportunity to act according to one’s own values, even if these values depart from those of broader society. Whilst employing a medical perspective does not directly limit physical freedoms per se, by demanding individual change (rather than social change) this paradigm sacrifices the sufferers’ individual agency in favour of avoiding systemic rectification. In addition, the medical approach towards pharmaceutical symptom management (rather than addressing underlying social causes) has also been suggested to contribute to increased levels of national and global inequality (van Dijk et al., 2016), which has obvious consequences for collective freedom.

Whilst there has been significant progress in addressing the negative stigma associated with mental illness, individuals diagnosed as mentally disordered nevertheless continue to experience a level of maltreatment and social discrimination. Psychiatric diagnoses have historically been abused as a means to socially alienate persons who do not conform to society’s expectations (e.g. female hysteria, homosexuality, ADHD) (Szaz, 1974) and, importantly, negative stigma towards mental illness has been demonstrated to reduce one’s feelings of individual agency (Arboleda-Florez, 2003; Miller & Major, 2000).

Additionally, medical diagnoses can not only elicit negative attitudes from others, but may also contribute to a negative perception of oneself, leading to a self-fulfilling cycle whereby an individual may unconsciously contribute to their own oppression (Corrigan & Rao, 2012).

The medical system unquestionably plays a vital role in our society. Nevertheless, the over-medicalization of human experience poses a subtle, yet significant, threat to the personal
freedoms of an increasing number of people. Medicalization can impede freedom through its oppression of nonconformity, its deleterious effects on individual agency, and the stigma associated with diagnosis. It is clear that a recalibration of established understandings of freedom for individuals with mental health concerns is needed, which necessitates appropriate regulation of the medicalization process and a fundamental restructuring of our mental healthcare system.

**Recalibrating the Medical Machine**

Over the last several decades great strides towards enhancing the freedom of those with serious psychological disorders have been made (for example, the introduction of independent mental health tribunals to review involuntary hospitalizations). Yet, such steps have largely focused on the more visible restrictions placed on the mentally unwell. Little attention has been awarded to the ways in which the creeping over-medicalization of human suffering suppresses freedom – perhaps due to the illusive and complex nature of this phenomenon. Below I will attempt to outline several processes through which over-medicalization of human experience may be addressed.

**Empowering Agency Through Treatment**

As noted above, psychiatric symptoms themselves impair personal freedoms. Efficacious treatment is therefore imperative for the emancipation of those suffering from mental ill-health. However, while treatment naturally aims to ameliorate the harmful consequences of psychiatric symptoms, it also potentially impairs freedom in other respects (e.g. side-effects, hospitalization). Psychotherapy (that is, talking therapy) is a participatory process driven by individual agency, and thus is a treatment modality that inherently emphasises the enrichment of personal liberties (Szasz, 1974). In terms of symptom improvement, psychotherapy is also generally as effective and reliable as pharmacotherapy, despite being prescribed less often (e.g. Cuijpers & Gentili, 2017). A fundamental shift towards psychotherapy as the first-line treatment of choice is thus an important first step towards enhancing agency for individuals with mental health problems.

A central factor driving psychiatrists’ preferences for pharmaceutical treatment is the insufficiency of psychotherapy training. In the Australian medical system, it is well known that adult psychiatrists have a strong preference for pharmacotherapy. In contrast, child psychiatrists are more likely to undertake individual and family psychotherapy before attempting pharmaceutical intervention. Despite working within the same area of expertise, studying at the same universities, and existing within the same cultural context, child psychiatrists are more likely to rely on psychotherapy largely because of one simple factor: better training. This example suggests that, with appropriate training, medical professionals elect to practice interventions which facilitate patient empowerment rather than ‘band-aid’ pharmaceutical symptom management. Thus, a renewed focus on psychotherapeutic training in medical educational institutes (particularly, psychiatry training courses) is a crucial initiative for promoting unoppressive treatment approaches towards ameliorating mental suffering.

**Decoupling Diagnosis from Treatment**

Assigning medical labels (i.e. diagnoses) to human problems can impede personal freedoms by stigmatizing the individual and obscuring the social forces that underlie their problems. Yet, in Australia (and most other nations) individuals are required to obtain a medical diagnosis in order to access treatment. The requisite of diagnosis for receiving treatment thus remains a significant obstacle to the emancipation of sufferers.

Fortunately, this systemic issue would not be difficult to address as it stems from largely arbitrary grounds – a combination of medical tradition and administrative convenience. In order to provide access to treatment, health
service providers (both public and private) typically rely on the expertise of the medical professional to provide a diagnosis and expected length of treatment. Practically speaking, it makes no difference whether a diagnostic label is assigned or not, as the treating professional remains the gatekeeper of treatment access. Assigning a diagnostic label is a trivial process which merely acts to medicalize the patient.

If health providers were to simply remove the requirement of ‘diagnosis’ in order to access services, there would be no tangible changes to how these services are managed or utilized. In the current system, clinicians feel obligated to assign arbitrary diagnoses to their patients irrespective of clinical value so as to make them eligible to access treatment (as I can attest to from personal experience). This simple proposal, whilst not completely dissolving the surge of over-medicalization in mental health, would be felt immensely by those suffering from emotional difficulties, protecting them from the shackles of de-humanizing medical labels and empowering them to be defined according to their own values.

**Striving for Freedom: Stepped-Care**

In summary, if we are to recalibrate our conceptions of freedom for the mentally unwell, then there is a need for effective and humane psychological treatment that is not contingent upon diagnostic labels. This would require a fundamental restructuring of our mental healthcare system as a whole.

A ‘stepped-care health model’ refers to a hierarchical system of treatments matched according to the individual’s needs (Department of Health, 2019), ranging from low-intensity self-help programs to high-intensity clinician-administered intervention. Stepped-care models aim to service the entire population, with individuals having the freedom and flexibility to move between stages as required. Consequently, unlike current Western medical systems (which are contingent upon dichotomous conceptions of illness, e.g. ‘sick’ or ‘not sick’), stepped-care models conceptualise mental illness as existing on a spectrum, thus inherently discouraging unhelpful medical labelling.

Stepped-care models of mental healthcare help ameliorate the stigmatization that results from diagnostic labelling, whilst simultaneously providing efficacious treatment to those in need. Further, these models have compelling precedents – when implemented with strong governmental backing, as has been done in the United Kingdom, the stepped-care approach has been evidenced to deliver enormous health *and* economic benefits to society (Layard & Clark, 2014). This paradigm of psychiatric care empowers individuals to seek help without the fear of being labelled as ‘mentally disordered’, effectively de-medicalizing the experience of psychological problems and addressing the constraints to personal freedom that accompany mental ill-health. As such, the implementation of the stepped-care approach has been demonstrated to be a highly feasible step towards the tacit emancipation of human suffering.

**Conclusion**

The over-medicalization of mental ill-health is no doubt a complicated problem. Yet, it is crucial that we face this problem head on. By treating various emotional and social problems as medical ‘diseases’, we risk subjecting a growing population to a medical system which can inadvertently suppress personal freedoms, oppress diversity, and stigmatize nonconformity.

Humans deserve the freedom to define themselves according to their own values, rather than the values assigned to them by the medical machine. The over-medicalization of human suffering threatens this basic personal freedom.

This is not to say that diagnosis and medicalization are inherently harmful or that sufferers do not deserve help, but rather that we must be cautious in our approach towards bettering the lives of the unwell. The medical
system has a responsibility to provide efficacious treatment that empowers individual agency, and medical professionals can be enabled to administer such treatment if they are provided with sufficient training. It is also vital that access to treatment is not contingent upon diagnostic status. A major reorganisation of existing mental healthcare structures (in this essay illustrated as the stepped-care model) is needed to integrate these principles into our medical system and fundamentally recalibrate the freedoms of those who are suffering.

References