INVESTIGATION ARTICLE

Mental illness and mental health problems: a critical analysis of reports on the relationship between covid-19 and depression.

Enfermedades y problemas de salud mental: un análisis crítico a los reportes de la relación entre covid-19 y depresión.

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ABSTRACT

Introduction *In the context of the analysis of the psychological repercussions associated with the COVID-19 pandemic, studies reporting high rates of depression in the general population have become particularly important.* ***Methods:*** *We performed a critical non-systematic review of publications.* ***Results:*** *In accordance with Horwitz and Wakefield, we argue that these investigations present methodological problems derived from the application of a diagnostic method based on the identification of non-specific symptoms and, secondly, that their results are interpreted without reference to the epidemiological context itself in which these manifestations could be expected reactions.* ***Conclusions:*** *In addition to emphasising a more rigorous use of terms and concepts of the speciality, we argue that it is necessary to rescue the importance of clinical judgement and to approach psychic suffering from a broader approach as a counterbalance to increasing medicalisation.*

Keywords: *Depression; COVID-19;Stress, Psychological; Medicalization*

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Received: 01-08-2023
Approved: 04-01-2024

Authorship statement: Authors approved this submission.
Conflicts of interest: The authors declare that they have no conflicts of interest that could bias the content expressed in this article.
Funding: Self-funded article, did not receive funding from any project or agency.

1. Mental health in a troubled world

The pandemic caused by the outbreak of the SARS-CoV-2 coronavirus has had a significant impact on our societies and ways of life, including the UN warning that, in the absence of policies specifically designed for this context, the pandemic could exacerbate social problems such as economic inequality, exclusion and discrimination of minorities[1] and concerns about potential economic crises given the restrictive policies on the exchange of goods and services worldwide and the drastic reduction of jobs in some productive sectors[2].

In addition to socio-political concerns, there is a need for research into the potential impact the pandemic may have on the mental health of the general population, in order to prevent aggravation of its negative effects. In this sense, the psychological impact of pandemics (such as Ebola, N1H1, and equine fever, among others) goes beyond the mere fear of infection. It also includes the fear of losing loved ones and the general feeling of insecurity, anxiety, and vulnerability[3].

However, in the specific context of analyzing the psychological impact, a special place has been given to studies reporting high rates of depression in the general population observed in the context of the pandemic[4-7]. In this article, we critically review this association and, following Horwitz and Wakefield[8], we argue that these studies suffer from methodological problems arising from the application of a diagnostic method based on the identification of non-specific symptoms and, secondly, from the interpretation of their results without reference to the epidemiological context in which manifestations such as these, could be the expected reactions. In addition to emphasizing a more rigorous use of terms and concepts of the specialty, we propose that it is necessary to rescue the importance of clinical judgment and to approach psychic suffering from a broader approach as a counterbalance to increasing medicalization.

2. Scientific Reports and Publications Worldwide

In the recent past, several studies have reported an increase in the number of cases of depression associated with the COVID-19 pandemic and the various public health measures that have been implemented in the general population throughout the world. As an illustration of this point, we will consider articles published in the first half of 2021, Gasteiger et al. [9] reported the results of an online survey applied to 681 adults from the general population of New Zealand, using the Patient Health Questionnaire (PHQ-9) as an index of depression, which led them to find significantly elevated levels. Another web-based survey[10] of 2773 Swiss adolescents aged 12-24 years using the S-YESMH found that more than half of the women and about two in five of the men reported mild to severe depressive symptoms, while another study, in this case, of Australian adolescents contacted through social networks and who completed the Kessler-6 (K6) scale reported that slightly less than 50% of the sample scored above the threshold indicating psychological distress indicative of mental illness(11).

In Ecuador, 626 adults completed the Depression, Anxiety, and Stress Scale-21 Items (DASS-21) questionnaire via the Internet; approximately 17.7% of respondents reported moderate to very severe levels of depression[12]. In comparison, in a sample of 25,065 adults from the general population in 35 countries from all continents, [13] more than 25% of participants reported moderate to very severe depressive symptoms. In addition, participants from the United Kingdom[14] and Germany [15] completed an online survey assessing their mental health using the Symptom-Check-List-27 (SCL-27) [14]. From this study, 48.7% of respondents in the UK and 33.5% of respondents in Germany were above the cut-off point for depressive symptoms.

A search of electronic databases encompassing the period between January and June 2020 and considered observational studies using validated measurement tools and reporting data among the general population - including information from 32 countries and 398,771 participants - estimated a global prevalence of 28.0% for depression. The same study highlighted the disparity of results between countries due to economic differences that seem to have an impact on the prevalence of mental health problems[15]. In addition, the study warns of differences in results obtained using different methodologies. Finally, a meta-analysis[16] of studies with the following inclusion criteria; cross-sectional design, reporting of depressive symptoms with any standardized scale or instrument, and having been conducted in South Asia, found a prevalence of 34% of depression

considering a total sample of 37437 subjects.

The "Thermometer of Mental Health in Chile ACHS-UC"[17] is a longitudinal study with a random sample of 1400 individuals, representative of the urban population between 21 and 68 years of age. This study was conducted through telephone interviews. Its main indicators in the field of mental health are constructed from internationally validated methodologies, and in the specific case of depressive symptoms, the PHQ-9 was used. In November 2020, 37.9% of those interviewed in this study reported depressive symptoms during the last two weeks, while in January 2021, 46.7% did so.

What do the studies cited have in common? Besides the high figures of depression reported in the context of the pandemic, these investigations were conducted in a cross-sectional manner with instruments designed for screening and not for the diagnosis of depression; many of these studies - if not all - were conducted without face-to-face contact with the interviewees and without considering the duration, intensity and functional repercussion of the symptoms included. Following Horwitz and Wakefield[8], there would be two fundamental methodological and nosological problems that would lead to a misinterpretation of the results of these studies. First, basing the diagnosis of depression on the presence of non-specific symptoms and, second, and paradoxically, in the epidemiological situation described, the lack of reference to the context in which these symptoms could be expected reactions.

3. Research Studies and Diagnostic Criteria for Depression

The introduction of classification systems for psychiatric disorders based on symptom recognition - such as the Feighner[18], DRC[19], ICD[20], and DSM[21] criteria - has sought to operationalize and increase the reliability of the diagnostic process for mental disorders, including depression. Whereas, in the past, the psychiatrist sought to clarify what was happening in the patient's internal subjectivity, current diagnoses focus on the identification of external symptoms present in the individual, thus changing the diagnostic process from the recognition of a prototypical clinical picture to the identification of a set of symptoms.

However, using instruments focused on detecting symptoms facilitates obtaining standardized and objective results with high inter-examiner reliability[22]. This is because subjective elements that could contaminate the diagnostic work are minimized. On the other hand, these instruments aim to reduce the cost and time required for the studies, including the training and clinical experience of the interviewer [8]. Although this change has apparently facilitated research, along with reliability and interclinical communication, it also seems to bring with it certain difficulties:

a. polythetic diagnoses: with neither necessary nor sufficient symptoms by themselves, two or more subjects with different combinatorics of symptoms may receive the same diagnosis.

b. artificial decision thresholds: no categorical differences exist between those who meet the diagnostic criteria and those who do not.

c. diagnostic reification. cases with fewer symptoms than required are no longer considered as non-depression and become "mild" or "at risk" cases, creating new categories of pathology.

d. non-specific manifestations. The type of manifestations included in the questionnaires (low energy, sleep problems, lack of concentration, etc.) are common in healthy people.

The aforementioned operative diagnostic process, based on the detection of symptoms, has allowed the introduction of multiple diagnostic instruments, including abbreviated and self-applied scales, consisting of lists of manifestations that must be present in a minimum number to meet the criteria for inclusion in a given diagnostic category[23-25].

The ease of use of these instruments has led to their frequent use in depression screening studies in the general non-consulting population. For example, prior to the pandemic, over 55% of a sample of medical students in Pakistan were found to be severely or moderately depressed[26], as were 60% of cab drivers in New Delhi[27] in studies using the DASS-21 scale. Using the HAD, almost 40% of depressive symptoms were reported in a sample of those working in a higher education institution in Brazil.[28] A cross-sectional study with 7524 participants, in randomly selected samples in 4 South American cities, assessed the presence

of Major Depressive Episode (MDE) using the Patient Health Questionnaire (PHQ) [9], finding a prevalence of 15%[29]. In Chile, the 2017 Health survey estimated that 15% of the sample presents depression using the CIDI SHORT FORM, but the same study corrects the prevalence to 6.2% using DSM-IV criteria[30].

The high figures of depression found by these studies could reflect the use of a methodology with less demanding criteria by not considering, for example, the functional impact of the symptoms or the context in which they occur. Moreover, in many studies, cases that do not reach a diagnostic threshold are considered mild, on the understanding that they are part of a pathological spectrum and/or represent risk conditions for a future depressive episode, despite the fact that there is evidence that mild depressions may become asymptomatic during the following year[31]. Another possible interpretation is that common manifestations in the general population, more frequent, precisely when individuals are subjected to stressful situations, are being diagnosed as depression.

4. Taking Depression Seriously: What is and What is not a Psychiatric Disorder?

Kraepelin, the founder of modern psychiatric nosology, established the need to distinguish between pathological processes (Krankheitsprozessen) and clinical pictures (Zustandsbilden). Without downplaying the importance of the clinic, he based the diagnosis on pathological processes[32] since not all clinical pictures represent diseases as such[33]. There is, for example, evidence that situations of intense and sustained emotional stress can trigger a neurobiological response consisting of elevated circulating cortisol levels, increased proinflammatory activity, decreased neuronal tropism, and alterations in neurotransmission, which have been correlated with the clinical picture of depression[34,35]. Also, subjects who experience emotional reactions considered normal in the face of situations of loss, present the same external manifestations of depression but with a different clinical course and prognosis. Not clarifying the relations between the clinical picture and the pathological process can have profound individual and social consequences.

In order to increase reliability, improve communication, and facilitate the diagnostic process, current classification systems have adopted a pragmatic and atheoretical stance focused on clinical pictures and their symptoms. This implies the progressive abandonment of the underlying pathological processes. This vision also facilitated the emergence of diagnostic instruments for the detection of symptoms, assuming a priori a connection with a disorder (pathological process) and ignoring the context in which the manifestations originate[8]. Over time, this has resulted in an increasing loss of validity of the diagnostic categories, compromising in the process, the other essential functions of medicine: determining a prognosis and establishing a treatment[36].

However, despite the criticisms, the latest version of the DSM [21] establishes conditions for the diagnosis of depression:1. depressed mood or anhedonia must always be present; 2. the symptoms must be present for a minimum period of two weeks and 3. there is a significant functional impact. It then adds that these same manifestations may be considered appropriate in situations where the subject is experiencing significant losses and that further diagnosis of depression requires clinical judgment and consideration of the person's history and cultural norms. Does this mean that clinical judgment will take precedence over the operative criteria or that the diagnosis of major depression will have to be made whenever all criteria are met, and the exercise of clinical judgment will be limited to borderline or subthreshold cases? [38]. In any case, none of the DSM conditions is taken into account in the studies that detect depression in the general population.

Without defining a biological or psychological origin, Wakefield[39] has proposed that depression would be a detrimental dysfunction of the loss response mechanism, which can be identified by the loss of relationship with the subject's context, evidenced by excessive duration, intensity, or absence of causal environmental factors. Although not yet clarified, the internal dysfunction is essential to define the disorder, while the absence of association with the context is evidence of the same. In this sense, it should be noted that an environmental factor can provoke a prolonged and/or disproportionate maladaptive response, indicating not only the alteration of the mechanism but also the damage this causes to the sufferer.

5. The Medicalization of Human Existence

Up to this point, the main focus on the consequences of the abandonment of diagnostic systems based on the recognition of pathological processes and their replacement by the identification of symptoms has been primarily conceptual, including also some methodological aspects concerning the results of the application of this practice to the non-consulting population. However, our analysis opens a broader consideration of the phenomenon, inscribed in the context of a process of medicalization of human existence, from which psychiatry does not seem to be alien.

In the Dictionary of Public Health, Kishore [40] considers that many issues, such as the normal phases of the reproductive and life cycle of women (menstruation, pregnancy, childbirth, menopause), old age, unhappiness, loneliness, and isolation due to social problems, as well as poverty or unemployment, have begun to be considered as medical entities. In particular, three beliefs associated with medicine contribute to generating a medicalized life and are implicit in population studies of depression: first, that medicine, being science, can predict the future; second, that prevention is better than cure, and that prediction is the best prevention; and third, that there is or may come to be, a medicine or a curative procedure for every ailment[41].

The practical consequences of this process are not new; family physicians interviewed during the English DeStress Project study[42] estimated that between 10% and 50% of their patients came for consultation for social/structural problems rather than medical problems per se. Nevertheless, 81% of the patients interviewed received antidepressant medication at some time in their lives. This last figure is consistent with the increasing use of these drugs worldwide, especially in milder cases where the evidence of benefit is more controversial[43,44] and prescribed mostly by non-specialists.

Although there are data indicating that antidepressants would have similar effects on the brains of people with depression and with "normal" sadness [45], so that there would be no justification for not using them in all cases of psychological distress[46]; this is not the same as the treatment of a disorder. There is an essential difference between considering people's emotional responses as expected reactions to events and qualifying them as indicative of a pathology to be treated individually in a medical context.

People who suffer the emotional consequences of adverse events could benefit more from help, including medical help, which, for example, tends toward normalization, understanding that their reaction is to be expected in the context; explanation, relating cause and effect; understanding or searching for the meaning that sadness could have for the individual or coping with or modifying the causes that give rise to it. In this sense, the low number of subjects who sought medical help, despite reporting depressive symptoms in the mental health thermometer study[17], could indicate that many people seek psychiatric help only once they are convinced that their problem is due to an internal alteration and not to the effect of stressful situations[47].

6. By way of Conclusion: Role of academia and the Language Problem

The discussion as to what is a depressive disorder, and specifically, what distinguishes a depressive disorder from "normal" sadness, is extensive and far from reaching a consensus. In this context, it is possible to distinguish at least three approaches[48]. On the one hand, the "neo-Kraepelians" seek to define depression with medical terms and with a clear distinction from normality[49]. On the other hand, as proposed by Wakefield[39], the contextual approach alludes to an internal disturbance but emphasizes the importance of the intensity and duration of symptoms and the absence of an apparent cause. Others, more pragmatic, are inclined to use the term simply for practical purposes[50]. In either case, however, it is necessary to adequately define the diagnostic categories, maintain the coherence of the criteria that give rise to them, and make explicit the areas in which they apply.

From a purely methodological point of view, in addition to what has been pointed out regarding diagnosis based on the recognition of symptoms, without consideration of the context, the central reservations regarding population-based screening studies are the comparability between the clinical and non-consultant population, the sensitivity and specificity of the scales used for screening and the correlation of their results with those obtained using official diagnostic instruments. Although it is a minority view, concerns of this type have

influenced the emergence of opinions against depression screening in the general population[51] and in primary care[52].

It has been argued that individuals whose symptoms are not present in sufficient quantity and/or duration to receive a diagnosis of depression should be considered at risk for the development of depressive symptoms in the future and thus fall within the realm of medical concern. However, the position that mental disorders exist on a continuum with normality generates an increase in diagnostic difficulty as the need arises to define two thresholds, one in relation to pathology and the other in relation to normality[53].

Studies report a very significant number of people with intense emotional reactions during the time of the pandemic, should this concern us? Clearly, but this does not necessarily imply that these people have psychiatric disorders. Health, including mental health, refers to a complex state of balance and well-being for the individual, not just the absence of illness. Therefore, it may be affected by a wide range of individual and social factors, which give rise to "mental health problems" but not necessarily "mental health disorders (illnesses) ."The confusion between the two concepts creates problems for research, therapeutics, and the implementation of public policies, especially when the WHO itself calls for psychiatrists to be involved in promoting the mental health of the general population[54].

Part of the problem stems from the careless use of concepts. Although many of the studies discussed acknowledge the use of screening instruments and that the diagnosis depends on clinical confirmation, they use terms such as emotional manifestations, depressive symptoms, and depression interchangeably, even in the titles of the articles, which are then picked up and disseminated by the media and adopted by the general population, without taking into account their different meanings.

The fact is that the term depression is usually associated with the individual search for help from a mental health professional and overlooks the individual's capacity to overcome the situation and the social responsibilities in the generation of the conditions that generate the malaise. The complexity of the issues raised and the importance of the decisions made in this area should challenge the discipline by placing a new emphasis on clinical skills and the responsibility of medical judgment to distinguish between depression and "normal" responses to psychosocial stressors.

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