



Sadness or depression: Making sense of low mood and the medicalization of everyday life



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ARTICLE INFO

Article history:

Received 3 June 2016

Received in revised form

11 April 2017

Accepted 13 April 2017

Available online 15 April 2017

Keywords:

The Netherlands

Medicalization

Depression

Everyday life

Observational methods

ABSTRACT

This research focusses on low mood as a generic category in everyday social interactions, outside the clinical realm and among non-patients. We examine if and how a clinical depression label and treatment are employed when low mood occurs in everyday life, which enables us to analyze the extent and content of medicalization and brings to the fore the interactional mechanisms and cultural concerns that potentially drive medicalization. The analysis is based on 316 observations of everyday life in the Netherlands. We observed and recorded interactions in which low mood was spontaneously expressed.

Our paper shows that the clinical depression label resonates widely even if low mood is not fully medicalized. People de-medicalize low mood, and low mood can be un-medicalized. Our analysis thus suggests that dominance is not achieved, which nuances Horwitz and Wakefield's claim that the clinical category of depression has come to encompass all forms of low mood. Moreover, uncertainties about the meaning of low mood *and* about the depression label remain pragmatic concerns of everyday life.

The cultural norm of happiness and active citizenship are very prominent in everyday life across medicalized and un-medicalized interactions. These norms thus seem to be a necessary but insufficient condition for medicalization. While pragmatic concerns do not seem to trigger medicalization either, one specific type of concern is consistently related to medicalization: relational conflicts.

In sum, the cultural construction of low mood is not dominated by a single medical approach; however, it mirrors the diversity and uncertainties within and around the medical field.

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1. Low mood in everyday life

This article analyzes everyday interactions to determine how low mood is communicatively addressed and which pragmatic concerns are relevant to it. In this study, low mood designates a generic and etic category that includes emic expressions such as prolonged depression or mildly feeling down.

This article scrutinizes the “medicalization of life” (Conrad, 2007; Crawford, 1980; Szasz, 2007) hypothesis that the expansion of medical diagnosis and treatment transforms common understandings of low mood. In particular, it addresses Horwitz and Wakefield's (2007) claim that people have “lost” the ability to experience “normal sadness” and approach low mood largely as clinical depression. Horwitz and Wakefield convincingly show how

the diagnosis and treatment of depression have come to include increasing instances of low mood. Decontextualized diagnostic criteria were gradually applied to outpatient populations and thereby imported into the community, according to Horwitz and Wakefield. However, the uptake of medical registers in communities is beyond the scope of these authors' research. Whether “normal sadness” is indeed considered to be “clinical depression” must be examined.

Horwitz and Wakefield urge social scientists to distinguish between normal and pathological sadness, particularly with the goal of criticizing the overexpansion of diagnostic categories. In this research, a different approach is followed: we include all expressions of low mood and attempt to see if a medicalized “idiom of distress” (Nichter, 2010) is at work and, if so, in which situational contexts (Bell, 2016).

Medicalization might be limited (Williams and Calnan, 1996), and de-medicalization is studied (Torres, 2014). However, medicalization research has focused largely on patients, pills and professionals and neglected whether diagnosis and treatment are

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relevant among non-patients, outside the clinical realm, at home, in public or during work. Most medicalization research has focused on situations in which medicalization has already taken place. This is a crucial omission because, for medicalization to occur, it needs to settle in everyday life.

2. Low mood and depression

Cross-culturally and over time, humans have addressed low mood and the category of depression in various ways (Kirmayer, 2001; Kleinman, 1985; McPherson and Armstrong, 2009). Moreover, the speed by which depression diagnosis has risen, along with the marketing of anti-depressants and the lack of bio-genetic explanations of depression, further emphasize the interpretive flexibility of diagnosis and treatment. Flexibility, however, seems less pronounced in light of phenomenological studies that show regularities in illness careers (Kangas, 2001; Westerbeek and Mutsaers, 2008), biographical disruption and existential suffering (Karp, 1994; Ratcliffe, 2014).

We acknowledge that human distress arises in a dialectical relation between nature and nurture (Kleinman, 1985 p.11). Low mood can become a pragmatic concern in mundane interactions which may lead to medicalization, given the availability and dominance of medical categories. In interactions, low mood can be considered pathological depression, common sadness or another condition entirely.

By focusing on life outside the clinical realm, we can more easily observe whether broader cultural concerns enter the medicalization of low mood and whether depression labelling and treatment become a cultural code. From a cultural perspective, one would expect a gradual fit between culture and diagnosis since disease categories can become ways of experiencing illness and, over time, “we learned approved ways of being ill” (Kleinman et al., 1978, p. 252). In Western countries, suffering might be a partial result of low mood undercutting the norms of active citizenship and a responsible and happy life (Petersen, 2011; Philip, 2009; Rose, 2007).

In the case studied in this paper, mental health institutions are rife with uncertainties. There is uncertainty about the meaning and validity of depression diagnosis and treatment (Fox, 1957; Kokanovic et al., 2013). Depression diagnosis and treatment have been critically assessed publicly, and the medicalization critique, which is half a century old, might have become a common cultural repertoire by now. By focusing on everyday interactions in which low mood is relevant, this research illuminates the pragmatic concerns that may drive medicalization, given the ontological uncertainty surrounding depression labelling.

Our analysis is based on 316 observations in the Netherlands. We encountered mourning after loss, joblessness, stress, violence, marginalization, substance abuse, somatic conditions, broken dreams and doubts about life choices in relation to low mood. People report themselves or others feeling a lack of energy, being unable to get out of bed for days, anxiety, avoiding contact, distrust, uselessness, suicidal thinking, lack of sleep, panic, lack of an appetite, hypersensitivity and tension or anger. Sometimes, only a light reference to one of these phenomena is made, while on other occasions, long spells of suffering were reported.

We searched for communicative references to low mood and analyzed if and how medical terms and treatments were implied. While the use of the word “depression” might point to medicalization, it is also used to refer to bad weather or a lazy morning. Therefore, a large part of this research involved the repeated interpretation of the meaning of words in context. As shown below, this is also what people do themselves: attending to interactions illuminates the shifting uncertainties about (medical) categories in everyday life.

3. Medicalization between institutions and pragmatic concerns

In response to the global increase in many (mental) health diagnoses, diversity in prevalence statistics, a lack of biological explanations and the mega-marketing of pharmaceuticals, social science scholars have developed theories of ‘medicalization’ (Conrad and Schneider, 1992), ‘bio-medicalization’ (Clarke et al., 2003) and ‘pharmaceuticalization’ (Abraham, 2010). Medicalization describes a process by which formerly non-medical problems come to be defined and treated as medical problems. Studies have focused on the power of medical professionals, biomedical researchers, pharmaceutical firms, policy-makers and activists to turn normal behavior into medical conditions.

Research has provided us with manifold insights into the social construction of health conditions and has often highlighted the downsides of medicalization: the regulation of deviant behavior (Scheff, 1970) and unwanted effects, such as stigma (Goffman, 1961), rising costs (Conrad et al., 2010) and damaging treatment (Illich et al., 1975). Classic medicalization studies often followed an institutional approach and were largely based on top-down models of social control. In response, scholars influenced by Foucault pointed to the diversity in clinical practice and the productive side of medical authority (Hacking, 2007; Rose, 2007). Nevertheless, Lupton identified a major deficiency in Foucauldian approaches to medicalization, which “neglect examination of the ways hegemonic medical discourses and practices are variously taken up, negotiated or transformed by members of the lay populace” in everyday life (Lupton, 1997 p.94). Existing bottom-up studies have reported that patients inform their doctors about how to interpret symptoms, that activists influence medical practices (Brown et al., 2004; Epstein, 1996) and that knowledge of diseases spreads through local networks (Liu et al., 2010). People seem ‘eager for medicalization’ (Becker and Nachtigall, 1992), claiming institutionally unrecognized conditions (De Graaff and Bröer, 2012; Dumit, 2006). Pharmaceuticals in everyday life have been the subject of recent research (Bell and Figert, 2012; Coveney et al., 2012; Graf et al., 2014; Hardon et al., 2013). Studies like these show that, while ‘classic’ medicalization sought to separate the working population from the sick, healthy people are now additionally encouraged to maximize their physical and emotional well-being through self-medication.

Nevertheless, most studies conducted to date have focused on patients, professionals and treatments as the starting point for analysis and theorizing. In these cases, medicalization has already taken place to a significant degree. Retrospective interviews offer some access to the process leading up to the diagnosis or help seeking. However, those who do not seek diagnosis or treatment are overlooked, which can easily lead to overestimating and misconstruing medicalization. Recent analyses of self-help books (Barker, 2014; Philip, 2009), for example, suggest addressing medicalization in everyday life, but they do not address the actual uptake of self-help registers. Medicalization must take root in commonly held assumptions among people who have not yet been exposed to doctors, diagnosis or treatments, and studies in this respect are lacking.

Therefore, we propose shifting the analytic lens to everyday life and common interactions and then ask if and how medical categories and treatments are relevant. In this way, we can address the extent to which medicalization has affected life outside clinical encounters, include the experience of low mood, scrutinize interactional concerns about low mood and avoid top-down conceptions of medicalization, which enables us to scrutinize non-medicalization.

Everyday life refers to people’s mundane beliefs and practices (De Certau, 1984; Schutz, 1932; Scott, 2009). Following an

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