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ESSAY

The medicalization of suffering and the overdiagnosis of depression

A medicalização do sofrimento e o sobrediagnóstico da depressão

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ABSTRACT The use of diagnostic manuals and the statistical effort to catalog mental illnesses and disorders have been the subject of reflection for various health and social science researchers. Although there is an effort to universalize and transculturalise psychodiagnostic categories, there is also a need to abandon an exclusively biological model, giving way to a cultural understanding of the manifestations of psychological suffering. Depression has been treated as an epidemic by a variety of international health actors, leading to an exponential increase in pharmacological prescriptions and significant costs for health systems. Contrary to this warning, a substantial body of theory suggests a global trend towards the medicalization of human suffering in the experience of depression, resulting in overdiagnosis of the condition that has adverse consequences for users of health services. Based on an ethical, methodological, and scientific concern to promote critical science and good clinical practice, this essay seeks to discuss the factors that contribute to shaping the process of medicalizing depression, how the diagnosed individual can be decentralized from their experience, and how the processes of formulating a diagnosis and clinical intervention are influenced by theoretical, economic, social, political and circumstantial factors, leading to individualization of social and contextual problems.

KEYWORDS Depression. Overdiagnosis. Overtreatment. Medicalization. Suffering.

RESUMO *O uso de manuais diagnósticos e o esforço estatístico para a catalogação de transtornos mentais têm sido tema de reflexão para gerações de profissionais e pesquisadores. Embora haja um esforço para universalizar e transculturalizar categorias psicodiagnósticas, também há necessidade de abandonar um modelo exclusivamente biológico, dando espaço para uma compreensão cultural das manifestações do sofrimento psíquico. A depressão vem sendo tratada como uma epidemia por variados atores internacionais da saúde, levando a um aumento exponencial de prescrições farmacológicas e a custos significativos para os sistemas de saúde. Contrariando esse alerta, um conjunto teórico substancial sugere uma tendência global de medicalização do sofrimento humano na experiência da depressão, resultando em um sobrediagnóstico do quadro que traz consequências adversas para os usuários dos serviços de saúde. A partir de uma preocupação ética, metodológica e científica para promover uma ciência crítica e uma boa prática clínica, este ensaio busca discutir os fatores que concorrem na configuração do processo de medicalização da depressão, como o indivíduo diagnosticado pode ser descentralizado de sua experiência e como os processos de formulação de diagnóstico e intervenção clínica são influenciados por fatores teóricos, econômicos, sociais, políticos e circunstanciais, levando a uma individualização de problemas sociais e contextuais.*

PALAVRAS-CHAVE *Depressão. Sobrediagnóstico. Sobretratamento. Medicalização. Sofrimento.*

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Introduction

Among the elements of human experience that humanities and social sciences seek to understand and explain, suffering – be it physical, social, emotional or existential – stands out as something that pervades existence. Western medicine, established as a professional category for suffering relief has traditionally acted on the distinction between the body and 'soul' or 'spirit', making physical care possible without deranging the religious domain. The dichotomous separation between physical and mental in medical practice persists in understanding sensations, emotions, and subjectivity as something that, whenever not found in the body, are not relevant to the field of health[1].

The difference between pain and suffering is a powerful theoretical advance allowing the understanding of suffering as something that encompasses different fields of a phenomenon experience, not just a nerve response to a physical stimulus[2]. Social and existential dimensions of suffering contribute to the understanding of the importance of localizing the individual historically[3] and to the perception of elements of uneasiness, unhappiness, disorder and injustice as elements conditioned by culture, socialization, representation and symbolization of the condition of existence[4]. Man's search for mastery of nature is portrayed in the idealization of a state of complete well-being, happiness and health, in which it would be possible to control and improve aspects of existence and exclude the components of life suffering[5], also creating new categories for psychic suffering that surpass the old 'moral pain', merely somatic, as new forms of suffering in modern and technological society[6]. In the field of psychiatry, the initiative to encompass the new contemporary forms of suffering leads to the increase of diagnostic classes and categories in an attempt to track uneasiness in subjectivity, erasing conditions pertaining to human beings, such as sadness, aspiring the universality of diagnostic processes and treatments[7].

As a field that is simultaneously philosophical, scientific, technological, political and practical, health also represents great interest to the common discourse, central to the social imaginary. Canguilhem[8] formulates his notion of pathology and normality concepts, as well as describes the experience of the individual identified as sick in his own therapeutics. He concludes that what is considered normal is an extension or display of the norm, and that the use of statistics as a reference for the formulation of attributing criteria as to health and disease tends to disregard the individuality of the patient:

> If it is true that the human body is, in a certain sense, the product of social activity, it is not absurd to suppose that [...] in the human species, statistical frequency does not only translate a vital normativity but also a social normativity. A human trait would not be normal because it is frequent; but it would be frequent because it is normal[8(51)].

The preparation of national and international diagnostic manuals and the statistical effort to catalog mental diseases and disorders – such as the Diagnostic and Statistical Manual of Mental Disorders (DSM-V), created by the American Psychiatric Association (APA), or the International Classification of Diseases (ICD-11), published by the World Health Organization (WHO) – have been a subject of pondering by different actors in the fields of health and social sciences. Furnished with the supposed objective neutrality to standardize categories and nomenclatures and gather statistical data on the mental health of the global population, the manuals become increasingly extensive, adding, in each edition, new pathological categories of behavior. For editing teams, it becomes relevant to declare their productions as atheoretical, neutral, and aligned with evidence-based medicine amidst the controversies and theoretical debates arising with each new edition. Today, the production of these manuals is questioned as

to their biological and reductionist character, moving away from the individuality of the subjects to whom they should be applied[9].

Current classification systems, guided by biomedical psychiatry, try to support theories on mental disorders by researching their etiology in organic based alterations, but still without being able to confirm specific anatomopathological or genetic substrates as the etiological cause of each disorder. Thus, the classification systems remain mostly grounded on the observable behaviors of patients, which serve as operational criteria for diagnosis in separated categories, leaving aside the phenomena as they are experienced by people[10].

Where there is an effort for the universalization and transculturality of psychodiagnostics categories, there is also a call for the abandonment of the exclusively biological model to make room for cultural elaboration over the expressions of psychic suffering[11]. Kleinman[12] adopts the expression social suffering to name the effects that social forces can inflict on the vital experience, considering that human suffering is essentially a social experience at the same time individual and collective. From this perspective, pain and anguish are not only medical or psychological conditions, but profound social experiences, reflecting structural and cultural inequalities[12].

However, neuroscience and behavioral perspectives still receive a lot of investment in the biomedical field in a search for neuronal and genetic biologic markers that justify symptoms and psychiatric conditions. Depression is a central example of the importance of caution with these initiatives, leading to an exponential increase in the pharmacological approach to treatment and significant economic costs to health systems. Characterizing depression as a mood disorder and considering it as one of the greatest current burdens on global health affecting the psychosocial functioning and quality of life of those who are affected by it[13], WHO considers depression as a highly prevalent mental disorder that affects more than 264 million people worldwide, being the main cause of disability and contributing significantly to the global burden of disease, possibly leading to suicide in severe cases[14].

Contrary to the alert promoted by WHO, there is a significant theoretical-scientific production that indicates an inverse trend: that there is an established global propensity to medicalize human suffering based on the experience understood as depression, characterizing a situation of overdiagnosis that leads to adverse consequences for health service users. Two hypotheses are raised by Wakefield and Demazeux[15] to explain the epidemic character reached by depression: a) there is a real increase in global depression due to changes in behavior and environmental factors; or b) data regarding the increase in depression are, to a certain extent, artificial, due to the lack of a clear delineation between depression and forms of suffering. Commonly associated with states of sadness, mourning, discouragement, and hopelessness, depression has become the most adopted psychiatric diagnosis by physicians when confronted with experiences of suffering. The expansion of the diagnosis ends up blurring the traditional boundary between the condition of normal unhappiness or sadness and the pathological condition that receives the diagnostic formulation of depression, leading to the medicalization of everyday life emotions[16].

A reference author on the subject, Conrad defines the phenomenon of medicalization as "the process in which non-medical problems are defined and treated as medical problems, usually in terms of diseases and disorders"[17](18). The author understands that among the medicalization engines are science, medicine, commerce, biotechnology and culture, currently being mainly regulated not by representatives of medicine, but by commercial and market interests of the pharmaceutical industry and its initiatives. As to Conrad[17], medicalization, as a problem much discussed through a critical look at the social transformations created by the medical jurisdiction expansion, focuses more on the feasibility of medicalizing

designations about a phenomenon than on the validity of the diagnosis itself.

Promoted through the definition of a problem as a medical one, the use of medical terms and interventions, and the adoption of a structure also belonging to the medical field around a phenomenon, medicalization creates a process that concerns the treatment of an entity as an object of medicine. Thus, the term medicalization considers the transformation of everyday issues into pathologies, redrawing the limits of what is considered socially acceptable or healthy, and tending to direct the source of the problem to individual factors, furthering individualized interventions rather than collective or social solutions. As medicalization is bidirectional, a process of de-medicalization can occur when an issue is no longer defined in medical terms – and, thus, medical treatments become inappropriate, as were the classic cases of masturbation and homosexuality[17].

Zorzanelli and team[18] ponder that the medicalization concept should be thought of by means of its different degrees, always varying according to each specific case and existing social contexts, making some behaviors more prone to medicalization than others. Among the factors influencing the process are the greater or lesser support of the medical profession, the availability of interventions and treatments, the action of pharmaceutical industry, the existence of associative movements of users, and the influence of the media and politics[18].

This essay seeks to discuss, in the format of a theoretical-critical reflection and upon the scientific literature that supports the critical view on the issue, the vectors that compete in the design of the process of medicalization of depression, how the diagnosed individual can become decentralized from their experience and how the processes of diagnosis formulation and clinical intervention are influenced by theoretical, economic, social, political and circumstantial actors.

To call attention to limitations of initiatives applied in the processes of diagnosis and treatment of depression upon scientific literature does not mean a denial of drug treatments, medical advances or even the experience of suffering linked to the phenomenon called depression. Discussing the hegemony of the biomedical model and the political and economic interests of those who further it differs from an anti-science or denialist stance. It is an ethical and methodological concern that also adopts scientific language for its formulation in defense of critical science and good clinical practice, centered on the existential experience of the individual.

The overdiagnosis of depression

The concept of psychiatrization of everyday life was articulated by means of the emergence of tensions in the field of mental health as for the relevance of sociocultural aspects for the understanding of the subjective experience and its consequent suffering. Considering depression as a phenomenon subject to psychiatric perspective can lead to a search for drug treatment and medical interventions in which other social, economic, political and cultural agents act, overtreatment becomes a relevant concept in the debate on initiatives adequate to understand depression[19]. Main difficulties in the field of depression diagnosis and treatment are: 1) the scope and discrepancy with which the diagnosis is applied for different conditions; 2) the uncertainty regarding the functioning of antidepressants and the asymmetry among various drugs on the market; 3) the methodological indeterminacy of personalized medicine for the understanding of depressive episodes in their particularities; 4) the lack of evidence and definition as to the etiology and genetic markers of depression; and 5) the chronic aspect of treatment-resistant depression[20].

The process of medical assignment of a diagnosis consists of a step that traditionally initiates and assists treatment. Its use, when

applied to conditions not harmful to the individual – tends to overvalue the presence of mild symptoms commonly associated with some diagnostic category –, is known as overdiagnosis, subjecting the patient to initiatives such as invasive tests and the use of drugs[21]. In the field of mental health, overdiagnosis appears in cases in which an identified uneasiness may come from life experiences that would not require medical or drug intervention. When those sensations appear as result of events in human experience and are transformed into disease and medicalized, a process of overdiagnosis is identified[22]. Therefore, overdiagnosis can be defined as the diagnosis of a condition that, when not recognized, would not produce symptoms or harm to the patient during their lifetime, being considered as a phenomenon derived from the method applied to the screening and tracking process[23]. It is caused by two main phenomena: over-detection – characterized by the identification of abnormalities that will not cause future harm or that resolve on their own – and over-definition – defined by lowering thresholds for risk factors or expanding diagnostic definitions, including patients with mild or ambiguous symptoms. Overdiagnosis differs from false-positive results – positive results that, after verification, prove erroneous –, from cross-sectional phenomena, such as overtreatment and over-testing, and from diagnostic error, in which a diagnosis is attributed to a condition based on symptoms that belong to another condition[24].

Vilhelmsson[25] comments that medical consultations usually adopt diagnostic manuals and fast tests, used as a quick way to judge a person's health status in a health system that allows and encourages doctors to choose a diagnosis without an in-depth investigation of the whole situation involving the individual. In this same context, physicians are more likely to recommend drug therapy, even when there is no scientific evidence that the use of drugs would be a better treatment to other alternatives. The author advocates that preventive action of medicine focuses exclusively on the health of the individual, removing him from a contextual understanding in a way that individualizes social crises[25]. At times when a diagnosis allows the individual to validate their perception of their own symptoms, their experience is given a name and, at the same time, the pathologization of occasional daily experience is created.

Vilhelmsson[25(2)] understands that a powerful stimulus to the expanded diagnostic formulation and overtreatment of depression comes from the phenomenon known as disease mongering, the process in which "a health condition is promoted as a major public health problem so to generate a treatment market, usually without the public's knowledge", revealing the existence of financial partnerships between the pharmaceutical industry and the physicians responsible for formulating the guidelines for other medical conditions.

Nogueira[26] evidences the influence of the historical perception of diseases as the opposite of health – such as states of illness, confusion and disorder –, an inheritance of the medical theory of body functions on current care practices. Psychiatry becomes more interested in diagnostic manuals as tools for identifying, diagnosing, and treating, and less in their use as mediators of understanding the patient's experience of their own condition. Depression, in turn, is no longer perceived as an existential condition that compromises quality of life, in a way to express internal conflicts of the human experience of life, but rather as a list of factors related to the condition of productivity and interaction of the individual with society, with an evaluation being made from cognitive criteria predefined by public health agencies[26].

The field of nosology is responsible for anchoring diagnostic categories upon scientific data, evaluating their construct validity. Most data are currently collected by means of self-report questionnaires, requiring external validation because they are heavily influenced by subjective bias. This interpretative abstraction

contained in data evaluation is guided by the concept of normality, an abstraction that conceives a possible state in which there is no current pathology, that is, a state of complete well-being: for example, the unattainable character of that state allows the diagnosis of conditions subclinical to depression in situations of great sadness[27]. Epidemiological statistics are important as support for defense arguments before public policy makers, research funders, pharmaceutical companies, and campaigns aimed at the public. From the moment data are, in fact, representative of the information collected, the choice of how to present, to measure and to analyze them is as important as data themselves, both for the politicization of a theme and for its depoliticization and distancing from the social context[28].

Among the tools easing overdiagnosis, technological developments in diagnostics by imaging or biomarkers can be considered, as well as the change in thresholds for diagnosis and treatment of conditions, allowing the medicalization of a greater number of people. There is a complex relation between overdiagnosis and overtreatment, in which one usually leads to the other: for the creation of a care plan, individual risks and prognosis, benefit and harm calculations, and personal values and preferences should be considered as inherent to the decision-making process. To avoid them, some measures can be taken preventively, such as better stratification of people according to the severity of the suffering experienced; the understanding that the pathological state is measured on a continuous scale, not merely as a dichotomy between the absence or presence of a diagnosis; a diagnosis formulated in spectrum for the best assessment of risks and benefits of each case; and the composition of panels for the creation of manuals and guidelines free of conflicts of interest[29].

Studies indicate that the use of psychometric scales to assess depression symptoms has generated diagnosis and treatment in cases of suffering that would rather be transitory and self-limiting, not requiring any intervention[30]. These structured scales are useful to corroborate or not the diagnostic criteria for depression expressed by diagnostic manuals. In this way, each patient's diagnosis consists of a checklist. As Nogueira[26] underlines, the psychiatrist's objective is no longer to understand what is happening to the person being treated, but to arrive at a prompt diagnosis. The checklist character of this process refers to a technical system of inputs and outputs, which could possibly be applied to itself by the patient by means of a computer[26].

Context and consequences of depression overdiagnosis

There continues to exist substantial discrepancy in the scientific community about genetic and environmental factors involved in the etiology of depression. Adequate treatment is also still under discussion, in light of the biomedical and pharmacological aspects that involve its treatment, prescription and side effects[20]. Despite the exponential growth of diagnosis cases, WHO underlines the continued existence of a global gap in depression treatment, claiming that a significant portion of the population has an undetected depression[31]. However, theorists and specialists have questioned the formulation of that diagnosis, its severity spectrum, the multifactorial character of its causes, and the best available treatment options. Such considerations indicate that everyday feelings such as sadness, discouragement and hopelessness may represent a reaction to specific stressors, being inappropriate to label them as diseases. The psychopathologization of these routine phenomena generates an increase in demand for health systems and the consequent medicalization of social problems, leaving aside the psychosocial aspects in their genesis[32].

The technological revolution brought interest in the field of mental health in the search for genetic and later neuroscientific

explanations: the initial hypothesis arising from research build the idea of a genetic identity that determined the individual, yielding a belief that reduced causal explanations to the individual genetic load and creating the genetic essentialism by means of its practices and techniques. The "cerebralization of psychological suffering", as the authors Vidal and Ortega[11(182)] name it, localizes psychological suffering as essentially cerebral from an epistemological hierarchy: neuroimaging techniques, for example, when adapted to mental health care, can be identified as strategies for reductionism of a clinical analysis when not accompanied by an integral assessment of the individual. This explanatory initiative furthers the appeal to individual responsibility and its organic composition in suffering stances that could otherwise be conceived as existential suffering. Such conceptions can both exert social consequences in the generation of stereotypes, stigmas and group exclusion, as scientific consequences, through the exclusive emphasis on initiatives to search for biochemical markers. Carried out by this logic, the chemical imbalance hypothesis is the best known among modern neurobiological justifications for depression explanation, making it capable of being treated by drug intervention to recover balancing[11].

Despite the great cerebral complexity of its neural and synaptic structures, the chemical imbalance hypothesis proposes a simple justification for the phenomenon called depression when it states that serotonergic neurons are releasing little serotonin in the synaptic cleft, leaving it underactive. The arrival of Prozac®, an antidepressant composed of fluoxetine that impose fewer side effects than the others available on the market, became a revolutionary phenomenon among psychiatric drugs in the 1980s and 1990s, allowing the normalization of medications use in search for solutions to everyday emotional issues, in addition to the increase in cases of self-diagnosis by persons that requested medication from their physicians so to control their emotions and improve their productivity[33]. Broadly applied today, this theory has exerted great influence over decades, also in the formulation of guidelines for treatment of depression as in the popular imagination, which greatly associates depression with brain dysfunction.

However, to date, there is no accumulated scientific evidence strong enough to support that thesis as most studies do not find correlations between low serotonin or any other biochemical basis or the presence of biomarkers for the phenomenon of depression[34]. Thus, since antidepressants do not act on the serotonin imbalance for the treatment of depression – because the imbalance does not occur – their effect also becomes indeterminate. Even in cases of improvement in the clinical condition of patients who used antidepressant medication, it is not possible to affirm how its components act and what provided the change in the emotional state. Therefore, it cannot be understood as a direct solution to that specific suffering.

According to Frances[35], a participant in the process of elaborating diagnostic manuals, one of the causes responsible for the diagnostic explosion of depression is the constant expansion of the boundaries of psychiatry, which has been incorporating many diagnoses that are nothing more than variants of the so-called normal behavior. Due to that, pharmaceutical companies develop campaigns to promote the cure of the population's problems by means of pills consumption[36]. Whitaker[33] gives thought to the current moment of drastic expansion of psychopathological categories and the indiscriminate prescription of psychotropic drugs as an epidemic of psychiatric diagnoses and drugs. Despite signs of chemical dependence, changing in the functioning of neurotransmitters and gradual loss of efficacy in patients who use antidepressants, these are often prescribed in increasing doses[33].

The decision to prescribe antidepressants involves three central issues: the efficacy of antidepressants adoption for treatment; the risk of their side effects; and the severity of

withdrawal syndrome after discontinuation. Regarding its efficacy, the benefit of antidepressant medication, when compared to placebos, seems to increase following the severity of the symptoms observed, and may be minimal or non-existent in patients showing mild and moderate symptoms, seriously impacting the selection of patients to receive the prescriptions[37].

During the ongoing use of selective serotonin reuptake inhibitor antidepressants, the most problematic side effects seem to be gastrointestinal ones, weight gain, sleep disturbances, and sexual dysfunctions, the latter of which may persist even after discontinuation of use[38]. Upon discontinuation, a withdrawal syndrome may occur comprised of physical and psychological manifestations, such as fatigue, insomnia, anxiety, agitation, visual disorders, among others. The syndrome typically occurs within a few days after discontinuation and may last a few weeks, but it may also show variations such as a later onset or longer persistence[39].

As for the same subject, Davies and Read[40] developed a systematic review of the literature to assess the incidence, severity, and duration of antidepressant withdrawal reactions. Results indicated that more than half (56%) of people who tried to stop antidepressants experienced side effects; among them, 46% qualified as severe. It is not uncommon that withdrawal effects persist for weeks or months. According to the authors, existing clinical guidelines underestimate the severity and duration of antidepressant withdrawal symptoms, carrying significant clinical implications[40].

One of the factors that may be inducing the increase in the diagnosis of depression and the consequent overtreatment would be the great demand of users serviced by Primary Health Care (APS)[41]. Matta and team[42] advocate that the context of care by APS can favor, undesirably, the process of life medicalization, leaving it to those involved to permanently reassess the nature of what is demanded and what is offered. Precisely because it is the most extensive instance of contact and interface between populations and health services, APS offers opportunities both to provide a barrier against excessive medicalization and to be the gateway to large-scale medicalization itself[42].

Mark Fisher[43], an English philosopher and professor, emphasizes the importance of politicizing the growing incidence of psychological distress categorized in terms of mental disorders in contemporary societies. Rather than individualizing the responsibility for self-care in situations of adversity, it is essential to question how such number of people experiencing severe suffering in society became acceptable and what is the inherently dysfunctional role of existing socioeconomic systems[43]. Once doubts regarding diagnostic accuracy and pharmacological efficacy have been suspended, it seems insufficient to limit to the adding context merely as a risk or protective factor for a more comprehensive understanding of the social, economic, and political influence on the increase in depression diagnoses. There are more and less forceful views of the so-called neoliberal models and capitalism, some accusing them of creating loneliness, poverty, deprivation and misery, and others that search for factors or aggravating circumstances in this model that can induce suffering[28].

In the current context, public policies sparsely address the suffering resulting from issues regarding mental health and its multicausality. It is essential to intensify intersectoral actions for the development of initiatives that, in addition to the health sector, mitigate structural inequalities in society and implement specific protection guidelines for groups in situations of social vulnerability.

Conclusions

The care proposal offered by the health field carries the dispute between universalist and individualist models grounded on values that, on the one hand, advocate the universalization possibility of concepts and phenomena, seeing that humanity shares fundamental elements

for the understanding of individual experience; and, on the other hand, what happens at the individual level is managed by aspects of personal structure, such as the organic or genetic functioning of the individual and inherent characteristics. Both views fail to value the perception of an individual placed in a cultural, political, economic and social context, the influence exerted on their experience, and the way the individual deals with daily life.

An experience of suffering cannot be reduced to a neurochemical explanation of the brain and contain a whole and understandable explanation of the individual experiential situation. The relief of mental suffering carries a great existential and contextual component, linked to components of the biopsychosocial understanding of the human experience in society. To ignore the psychosocial factor to the detriment of the biological factor or vice versa is to fall into a dualistic perspective that distances the understanding of so-called 'physical' aspects from 'mental' ones. When care is concerned, historical localization is essential to understand how the symptoms or illness occurred, which elements of culture, sociability and symbolization affect the relation with that suffering. From the identification of depression overdiagnosis, some aspects are solidified for the global understanding of the phenomenon in gradual recognition as for the emerging logic of criticism of existential suffering medicalization.

As to the available scientific literature, among the factors that facilitate depression overdiagnosis are included APS overloaded services and the increasingly expanded boundaries of the pattern conceived by diagnostic manuals. The corollary of that situation is the exponential growth of prescriptions for antidepressant medication. It is WHO responsibility to think about the alternative possibility that the detected increase in prevalence be to some extent artificial and to propose a model of care that encompasses different expressions of existential suffering, and that it be not grounded on the consumption of medication as the main solution.

Another key issue as for the contextual understanding of overdiagnosis is the disagreement of the scientific community regarding the causal origin of depression and the possibility of a neurophysiological explanation that accompanies it. Genetic factors and neurological functioning are still researched for psychiatric conditions while the main treatment, in the case of depression, is entirely based on an exclusively physiological hypothesis of brain chemical imbalance that has not accumulated significant evidence despite decades of research. The 'cerebralization' of suffering locates uneasiness as fundamentally biological, justifying the medicalization of emotional and contextual everyday issues for its most varied populations and global cultures. Depression has been popularized worldwide by Western medicine as an expression of sadness, tiredness, discouragement, and the culture of productivity and exhausting work causes more stress to populations already emotionally overloaded and economically vulnerable. Cases of depression self-diagnosis increase, causing patients to arrive at health services requesting antidepressants even before evaluation by a health professional.

Amid the tension between the neurochemical model and the contextual model, especially in the light of publications that emphasize the need to discard the hypothesis of chemical imbalance in view of its lack of scientific evidence, new scientific guidelines should problematize the extensive and growing use of psychotropic drugs for depression treatment in health systems. The medicalization of life suffering, in the specific case of depression, represents an obstacle to the progress of the understanding of contemporary uneasiness, simplifying the conception of the individual by means of a reductionist biological explanation. Thus, there is a need to always emphasize the contextual factors of the economic, political, social and cultural systems of societies with such plural cultures, characterized by technological processes and complex social problems.

Collaborators

Degrave A (0000-0001-5941-3836)* was responsible for data conception, collection, analysis and interpretation; and writing and approval of the final version of the manuscript. Silva PRF (0000-0003-0811-4080)* was responsible for the conception of the work; critical review of the intellectual content; and approval of the final version of the manuscript. ■

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