The Bogus “Epidemic” of Mental Illness in the US

June 18, 2015 | Career [1]
By Ronald W. Pies, MD [2]

Critics of psychiatry claim there is an “epidemic” of mental illness in the US—and some argue this is a consequence of psychiatric treatment. But the best epidemiological evidence reveals no such epidemic in this country, rendering the iatrogenic “explanation” null and void.

COMMENTARY

Among psychiatry’s critics, the notion that there is an “epidemic” of mental illness in the US is one of the most enduring and widely held beliefs. More radical versions of the epidemic narrative implicate psychiatrists and psychiatric medication for the alleged proliferation of mental illness—a claim often tied in with the claim that psychiatry has “medicalized normality.” But what is the evidence for such an “epidemic” of mental illness in the first place? In discussing this question, it's important to distinguish actual increases in illness frequency from the issues of alleged “over-diagnosis” or “over-medication.” These are important clinical and societal concerns, but are beyond the scope of the present review.

What is an epidemic?

In medical terms, an “epidemic” usually refers to an infectious disease that has spread rapidly to many people—witness, for example, the recent Ebola epidemic. More broadly, an epidemic denotes any illness that appears with a frequency clearly in excess of what is normally expected. From the standpoint of medical epidemiology, the supposed “epidemic” of mental illness in this country is largely a myth. But as we will note later, our methods for tracking the occurrence of psychiatric disease over long stretches of time are very limited.

When we speak of an illness’s rate of occurrence, it’s important to understand 2 key terms: incidence and prevalence. Basically, “incidence” refers to the number of new cases of the illness within a specific period of time. “Prevalence” refers to the total number of persons sick with the illness during a particular period, regardless of when the illness began—so, prevalence includes both old and new cases of the illness. (The term, “lifetime prevalence” refers to the proportion of individuals in the population who have ever manifested a disorder, and who are alive at a particular time).

Now we are in a position to ask whether, over the past few decades, the incidence or prevalence of psychiatric illness has increased to the point of constituting an “epidemic.” At least with respect to the most serious psychiatric illnesses in adults, the answer is no. And recent data suggest this may also be the case in children and adolescents, though, again, our data base is far from ideal.
The Bogus “Epidemic” of Mental Illness in the US
Published on Physicians Practice (http://www.physicianspractice.com)

substantially interferes with or limits one or more major life activities.”\(^6\) Although MDD, bipolar disorder, and schizophrenia are commonly cited as prime examples of SMI, the NIMH definition could apply to PTSD, anorexia nervosa, or any other psychiatric disorder that fits the impairment criteria. While the federal definition of SMI is specific to adults, there is an analogous definition of “serious emotional disturbance” for children.

One method of comparing the occurrence of SMI now with that of years past is via the National Survey on Drug Use and Health (NSDUH)—an annual nationwide survey involving interviews with approximately 70,000 randomly selected individuals aged 12 and older. NSDUH data over the past decade show, overall, very little change in rates of SMI in this country.\(^7\)\(^\rightarrow\)\(^10\) For example, in 2013, there were an estimated 10.1 million adults aged 18 or older in the United States with SMI in the past year—representing 4.2% of the adult population.\(^9\) This compares with 5.0% in 2010 and 4.8% in 2009.\(^10\) And if we go back to the NSDUH data from 2002, we find that 8.3% of adults in the US were found to have SMI during the 12 months before being interviewed.\(^7\) So, if anything, it seems that SMI prevalence in this country has actually declined over the past decade or so. Going back farther, there is no reason to revise this conclusion. For example, using other national survey data, a group of technical experts estimated SMI in 1990 at about 5.4% of the adult population.\(^11\)\(^\rightarrow\)\(^\)\(^7\)\(^0\) Although their methods and data base differed from that of the NSDUH, their findings provide no evidence of worsening rates of SMI over the past 25 years—and certainly no evidence of an “epidemic” of the SMI that psychiatrists usually treat.

Specific psychiatric disorders

Rates of SMI as assessed by the NSDUH don’t yield incidence or prevalence rates for specific disorders, such as schizophrenia, bipolar disorder, or major depression. However, other sources of information suggest that incidence and prevalence of these conditions, worldwide, have remained fairly steady over the past 50 years.* For example, while rates of schizophrenia differ considerably from country to country, a 1997 review found that overall incidence rates appear relatively stable across countries and cultures, over at least the 50 years studied.\(^12\) Similarly, a recent study of the incidence of schizophrenia and other psychoses in England from 1950 to 2009 found essentially “. . . no evidence to support an overall change in the incidence of psychotic disorder over time . . .” although diagnostic shifts away from schizophrenia were reported.\(^13\) Neither of these studies points to rising occurrence rates of schizophrenia since the introduction of antipsychotic medication in the late 1950s and the 1960s—much less to an “epidemic” of schizophrenia or other psychoses. Of course, persons with schizophrenia will respond to antipsychotic medication in a variety of ways, and epidemiological data alone are not sufficient to guide individual treatment decisions.

With regard to MDD, data from the Baltimore Epidemiologic Catchment Area study “. . . do not suggest an epidemic of depression” in the period from 1981-2004, although there is evidence that the chronicity of depressive disorder is rising among women in late middle age.\(^14\) The period assessed (1981-2004) overlaps substantially with that of markedly increased antidepressant use in the US.\(^15\) If antidepressant treatment were truly “driving” an epidemic of major depression—or substantially worsening existing cases—we would expect to see this reflected in rising incidence and prevalence figures. But neither has been detected for the US population as a whole. Further confirmation of the “non-epidemic” of major depression is provided by 8-year NSDUH data.\(^16\) These show that the percentage of adults who had a major depressive episode in the past year remained stable between 2005 (6.6%) and 2013 (6.7%).

False indicators of disease occurrence

Some who argue that actual psychiatric illness is on the rise in the US point to increasing rates of psychiatric disability determinations—for example, increased numbers of those “disabled” by mental disorders who qualify for Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI). Thus, the journalist Robert Whitaker\(^\)\(^\) used such data to conclude that psychiatric disability rates are now around 6 times what they were in 1955. This is an interesting finding that bears further investigation. But SSDI determinations are in no sense a reliable measure of the actual incidence (new cases) or prevalence (total cases at a given time) of psychiatric disorders—or are they necessarily an indicator of psychiatric treatment success or failure. Disability determinations by the Social Security Administration are largely administrative hearings\(^17\)—not medical-psychiatric evaluations—and are subject to a myriad of confounding variables. The outcome may depend, for example, on how well-prepared the applicant is when presenting his or her “case” to the evaluator—who may or may not have medical or psychiatric expertise.\(^17\)

Observations
• Critics of psychiatry claim there is an “epidemic” of mental illness in the US—and some argue this is a consequence of psychiatric treatment. But the best epidemiologic evidence reveals no such epidemic in this country, rendering the iatrogenic “explanation” null and void.

• If antidepressant treatment were truly “driving” an epidemic of major depression—or substantially worsening existing cases—we would expect to see this reflected in rising incidence and prevalence figures. But neither has been detected for the US population as a whole.

• Rates of treatment (psychotherapy or medication) for a given disorder may be misleading with respect to actual prevalence of an illness.

Similarly, rising rates of medication prescription—although of potential concern from the clinical and societal standpoint—cannot serve as a reliable proxy for actual incidence or prevalence rates. Prescribing patterns may be subject to fluctuations owing, for example, to rates of direct-to-consumer advertising or to public and professional awareness of a particular condition. Neither can office-based rates of psychiatric diagnoses serve as reliable indices of illness incidence or prevalence, since clinicians differ widely in their application of DSM diagnostic criteria, which are often ignored. So, for example, office-based data showing markedly rising rates of bipolar disorder diagnosis in younger patients—certainly a matter of parental and medical concern—do not necessarily indicate an increase in actual cases of bipolar disorder in the younger population. For one thing, it is not clear how strictly formal criteria for bipolar disorder were applied by clinicians—so over-diagnosis could have occurred. Indeed, as NIMH Director, Thomas R. Insel, MD, observed, “We do not know how much of this increase reflects earlier under-diagnosis, current over-diagnosis, possibly a true increase in prevalence of [bipolar disorder], or some combination of these factors.”

Even rates of treatment (psychotherapy or medication) for a given disorder may be misleading with respect to actual prevalence of an illness, since psychiatric treatment availability is subject to socioeconomic variables, such as insurance coverage, proximity to mental health practitioners, and ethnic minority status.

In sum: although important for other reasons, none of these measures—disability rates, prescribing patterns, or rates of treatment—is a valid means of determining an illness’s incidence or prevalence. None is a “proxy,” or substitute, for applying consistent diagnostic criteria and/or using structured clinical interviews in comparable populations, over long periods of time.

**Serious mental illness in younger populations**

Thus far, we have reviewed data primarily derived from adult populations. But what about children and adolescents, in whom an “epidemic” of mental illness has been alleged? Recently, Olfson et al looked at rates of mental health impairment among young people who receive mental health care in the United States, focusing on the severity of mental health impairment. Data were derived from the household component of the 1996-2012 Medical Expenditure Panel Surveys conducted by the Agency for Healthcare Research and Quality, and the sample study (N = 53,62) included all persons 6 to 17 years of age. Mental health functioning was assessed with the use of the parent version of the Columbia Impairment Scale (CIS)—a 13-item measure of child and adolescent interpersonal relations, psychopathological symptoms, functioning in school, and use of leisure time. To the surprise of the authors, the percentage of young people with more severe mental health impairment (CIS score ≥16) declined from 12.8% in 1996-1998, to 11.9% in 2003-2005, to 10.7% in 2010-2012. Significant declines in the odds of more severe mental health impairment were observed among children, adolescents, male youths, female youths, and Hispanics.

Other data in younger psychiatric populations also undermine the “epidemic” narrative. For example, Costello and colleagues reviewed epidemiological studies of children born between 1965 and 1996. Meta-analysis was performed on all studies that used structured diagnostic interviews to make formal diagnoses of depression on representative population samples of participants. Twenty-six studies were identified, generating nearly 60,000 observations on children who had received at least one structured psychiatric interview. The authors concluded that, when concurrent assessment rather than retrospective recall is used, there is no evidence for an increased prevalence of child or adolescent depression over the past 30 years. Public perception of an “epidemic” may arise from heightened awareness of a disorder that was long under-diagnosed by clinicians.

Similarly, results from the National Comorbidity Survey Replication-Adolescent Supplement (NCS-A), which examined lifetime prevalence data of mental disorders in a nationally representative sample of US adolescents, found no evidence of substantially increased rates of major depression, compared with earlier NCS data. And, with respect to bipolar (BP) disorder, a recent
review\textsuperscript{26} concluded that “... there was no evidence of increasing prevalence of BP spectrum disorders over time ...” as ascertained by rigorous semi-structured interviews. This is in contrast to increased frequency of office-based BP diagnosis. While this disparity may indicate shortcomings in clinical assessment—eg, “... insufficiently stringent application of diagnostic criteria in clinical settings ...”\textsuperscript{26}—it does not point to an “epidemic” of actual bipolar disorder in younger populations. Furthermore, these same authors found that “... low rates of treatment of youth with BP suggest that withholding of BP diagnoses may also be common.”

**Conclusion**

The present review provides little support for the view that serious psychiatric disorders are on the rise, or that there is a “raging epidemic”\textsuperscript{1} of SMI in the US—either in adult or younger populations. On the contrary, rates of SMI appear to be either declining or fairly stable in this country. Relatively stable rates also apply with respect to the incidence and prevalence of, for example, major depression and schizophrenia. The incidence and prevalence of mental illness cannot be reliably inferred from changes in medication prescription rates, office-based diagnosis or treatment rates, or rates of putative “disability” attributed to mental illness. Only the uniform application of defined clinical criteria over long periods—or structured, clinical interviews—can yield reliable information on incidence and prevalence. There is no credible epidemiological evidence that psychotropic medication per se has led to rising rates of SMI, or increased rates of any specific psychiatric disorders in the general population.

Absent a demonstrable “epidemic” of mental illness in the US, the entirely speculative hypothesis that there is “a biological cause for the epidemic”\textsuperscript{2} is rendered nonsensical. Notwithstanding these conclusions, we need better prospective methods of tracking incidence and prevalence of psychiatric illness in this country. Ideally, assessments should be made contemporaneously with the index episode of illness, rather than inferred retrospectively. We also need to ensure that clinicians apply standard criteria for diagnosing psychiatric disorders—particularly in younger populations—and prescribe medication with care and vigilance. Equally urgent, we need to ensure that those with serious psychiatric illness have access to care and treatment by psychiatrists and other mental health professionals.\textsuperscript{21}

**Notes:**

* Rates of bipolar disorder vary considerably from country to country, and some evidence points to higher lifetime prevalence rates in the US than in several other countries. This “...may reflect methodologic differences in diagnostic procedures or assessment methods as well as true differences in disease prevalence.” (Merikangas KR, Jin R, He JP, et al. *Arch Gen Psychiatry*. 2011;68:241-251.)

† I have not dealt with ADHD in children because the criteria for this condition have changed significantly over the past 40 years, and estimates of prevalence depend crucially on how DSM criteria are applied by clinicians. The CDC reports that surveys asking parents whether their child received an ADHD diagnosis from a health care professional show that the percentage of children with an ADHD diagnosis increased from 7.8% in 2003 to 9.5% in 2007 and to 11.0% in 2011. But even assuming that the diagnoses provided by clinicians were valid, a roughly 3% increase spread over 8 years would not qualify as an “epidemic.” Commenting on these trends, the CDC notes: “It is not possible to tell whether this increase represents a change in the number of children who have ADHD, or a change in the number of children who were diagnosed. Perhaps relatedly, the number of FDA-approved ADHD medications increased noticeably since the 1990s, after the introduction of long-acting formulations.” (ADHD throughout the years. October 6, 2014. [http://www.cdc.gov/ncbddd/adhd/timeline.html](http://www.cdc.gov/ncbddd/adhd/timeline.html).)

**Acknowledgment:** I wish to thank Dr Kathleen R. Merikangas for providing important background reference material. The views represented here, however, are my own.

**Note to readers:** As with all of our blogs, the opinions expressed in this commentary are solely those of the author. Comments not followed by full names and academic titles will either be removed or heavily monitored. -Psychiatric Times

**Disclosures:**

Dr Pies is Editor in Chief Emeritus of Psychiatric Times, and a Professor in the psychiatry departments of SUNY Upstate Medical University, Syracuse, NY, and Tufts University School of Medicine, Boston. He is the author of The Judaic Foundations of Cognitive Behavioral Therapy; The Three-Petalled Rose; and Psychiatry on the Edge (*collected essays from Psychiatric Times/Nova Publishing*).
References:
bipolar disorder in youth. *Arch Gen Psychiatry.* 2007;64:1032-1039.


Links: