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'Anxiety and depression': document of 2022 Ministry of Health Consensus Conference. What is the purpose? The question is a good one and needs an answer

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ABSTRACT. – The document under discussion questions the entire scientific community and in particular those dedicated to the protection of physical and mental health. Which chosen method meets truly scientific criteria? What are the ethical and deontological implications? How much attention has been paid to the age of development, which is essential for the proper prevention and protection of future citizens? What understanding has been achieved regarding the pathological processes investigated? How effective is the tool defined as 'Consensus Conference' in informing and reaching out to citizens? The author carefully processes these aspects in the article and sends to the scientific community involved new questions that are indispensable for a lay approach (free of connotations and pre-judgments of specific psychological schools) but consistent with the scientific method, indispensable for the collective growth of knowledge. Her effort in commenting on this aspect aims not so much to point out what the author agrees with or disagrees with or to examine the merits of specific contents, but to point out crucial passages where the confusion between epistemological, theoretical, and technical levels generates slippage or the intertwining of levels risks distancing rather than bringing closer the goal that is proposed.

Key words: scientific method, evidence-based medicine, Consensus Conference, depression, anxiety, common mental disorders (CMD), deontology, epidemiology.

The document under discussion questions the entire scientific community and in particular those dedicated to the protection of physical and mental health. Does the Conference of experts meet scientific criteria? What are the ethical and deontological implications? What understanding has been achieved about the pathological processes investigated? How effective is it in informing citizens?

I have chosen to carefully examine these aspects in the article and formulate new questions by following a lay approach, devoid of connotations and

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pre-judgments of specific psychological theory, consistent with the scientific method, indispensable to the collective growth of knowledge.

My effort in commenting on it is to point out crucial passages in which confusion between epistemological, theoretical, and technical levels generates slippage and entanglements that risk distancing rather than bringing closer the proposed goal.

Robert Koch, a German physician, bacteriologist, and microbiologist, is considered together with his colleague-rival Louis Pasteur to be the founder of modern bacteriology and microbiology. He has been credited with the pithy comment, 'The question is too good to spoil it with an answer'. Perhaps uttered to avoid answering questions arising from the violent dispute over the theory of biogenesis formulated by Pasteur, as opposed to the one shared by the scientific community of the time, regarding spontaneous generation, to which Koch adhered and of which he was a staunch defender. I believe that every question is entitled to an answer and that more attention should be paid to the questions than to the answers. Knowing how to ask questions, as well as being a basic tool in our work, means having clarity about the premises with which one approaches a problem and what one wants to achieve. The history of Western science began by asking the question 'Why do apples fall?'. The answers that have been given have enabled us to understand what an apple is and the workings of the universe, all the way to black holes. Thanks to this question, we have been able to understand the general processes that link living beings and Nature. It is clear that I have no doubt that psychology is a fully-fledged part of the scientific disciplines and that it must therefore know and follow the epistemological, theoretical, methodological, and technical developments that accompany them. It also shares with them the ethical questions that new scientific discoveries entail. This implies that Psychology can be used to understand the functioning processes of the mind and psychic suffering or to control them. All of Science cannot avoid asking the question of which view of the human being it is serving. This is the observation on the basis of which I processed the Consensus text on Anxiety and Depression, the observation from which the questions and reflections I share below originated, to seek an answer to the question: what is the purpose?

Scientific method and precision of language: an inseparable couple

The first question that arose when reading the paper was stimulated by the title: Anxiety and Depression. Why the choice of such vague terms? Anxiety is a totally non-specific term, which does not define any 'object' of investigation. It is the equivalent of abdominal pain in medicine. It can only be described subjectively, and it is up to an external observer to decide whether to categorize it as normal (pertinent to the situation) or ab-normal (exaggerated, incongruent, irrational), and, in this case, which psychopathology it is

indicative of. Then the next question arises: according to which theory of mind and its diagnostic grid will the observer decide the cut-off? Using the DSM-5, now TR, or the ICD 11? Or the alternative but increasingly accredited HiTOP, the NIMH-Research Domain Criteria Initiative? It is striking that the document for the variegated anxiety chapter refers to criteria drawn up in the obsolete DSM IV and DSM IV-R.

Strangely enough, depression, a virtually more definite and definable picture, is mentioned second as if less relevant than anxiety. But at least one realized that the DSM-5 exists. In fact, the text refers several times to the term 'depressive symptoms', although one finds unipolar depression, bipolar depression, major depression, and suicide risk, all mentioned in the various sections in a sort of indistinct mish-mash. In any case, another question immediately arises. Why only depressive ones, since already on page 9 (Consensus ISS 1/2022) we read: 'Taken together, mental disorders account for the second highest burden of suffering and disability associated with all illnesses and account for 14% of all years lived with disability, with a worldwide prevalence of over 10%'. The drafters' group must have grasped the problem of the generic nature of the language, which they nevertheless decided not to take into account. In fact, in section 4.2 Topic B2 (ivi, p. 34) they report having come across 'symptoms that do not meet the criteria of any specific diagnosis', introduce the construct of 'sub-threshold' disorder, and 'It was unanimously agreed that it was opportune to address the broader issue of so-called 'common mental disorders' without confining oneself to the traditional diagnoses of anxiety and depressive disorders, given the existence of a pre-pathological band that nevertheless merits attention and intervention, and because of the tenuous borderline that separates those common mental disorders from pathology' (ivi, p. 51). But once again the attempt to resolve the problem of ambiguous language, prejudicial to the sharing of the cognitive process, finds an inadequate solution by inventing a new term: 'In the Final Report for the Jury, problems and disorders of anxiety and depression, the subject of this Consensus Conference, are referred to with more technical expressions of 'common mental disorders' (CMD) or 'common emotional disorders' (CED). The two expressions, referring to their high prevalence in the population, have essentially the same meaning and frequency of use. The former is probably used more by professionals, the latter less' (ivi, p. 21).

Considering the terms CMD and CED as more technical expressions is frankly perplexing. It can be inferred that the diagnostic criterion in fact coincides only with the statistical criterion, without raising the issue of how to define them. This brings us to the epistemological problem of the observed system/observer system relationship, to the irrepressible and inescapable circuit between the objective and the subjective in knowledge processes, especially with regard to the study of living beings. The choice of terms provides another interesting clue: mental disorders and emotional disorders are considered synonymous. Thus, the implicitly chosen but unstated theory of mind

begins to transpire. Are mental disorders of rational/cognitive control over emotional/instinctual aspects? Is what determines the cut-off a purely quantitative epidemiological survey? The need to categorize in order to bring order to what is being observed and to assign a name in order to be able to communicate is the hallmark of the scientific method. Counting what one observes, and explaining the processes that generate what one thinks one is observing, are two conceptually different operations.

Consensus Conference method

These clarifications are indispensable for analyzing the use of the Consensus Conference method to 'guide choices and strategies aimed at improving the quality of care for these mental disorders' (ivi, p. 9).

'It is not the task of this Consensus Conference to add to the chorus of complaints about the abstractness and artificiality of mental illness diagnostic systems. We merely observe that for most of the last century 'anxiety-depressive syndrome' and 'anxiety-depressive neurosis' have been the most frequent diagnoses of minor psychopathology' (ivi, p. 5). In the absence of 'pure cases' given that 'the clinical reality of anxiety and depression is crowded with important co-morbidities', one opts for yet another linguistic ratatouille: 'anxiety-depressive syndrome and neurosis'. The question then arises: would such a generic nature of diagnostic systems be tolerated in any other branch of organic medicine?

The question is pertinent because the Consensus method originated in 1977 when the US National Health Institute initiated the Consensus Development Program with the aim of providing independent, unbiased, and evidence-based assessments of complex medical issues. This was in order to rely on evidence-based medicine. Haynes *et al.*, 1997 defined it as 'an approach to clinical practice in which decisions result from the integration of the physician's experience and the conscientious, explicit, and judicious use of the best available scientific evidence, mediated by patient preferences'. In order to have independent and unbiased research available, the Cochrane Collaboration, an international, independent, non-profit group, was founded in 1993. Cochrane's efforts made it possible to monitor and recognize problems related to the interference of pharmaceutical industries, not only in terms of economic interests but also in terms of interference in academic and institutional dynamics. Those were the guidelines at least until September 2016, when on its official website Mark Wilson, CEO of Cochrane, announced that they had received 'a grant of $1.15 million from the Bill & Melinda Gates Foundation' and that they were 'delighted and honoured to receive the grant.' Could it be a mere coincidence that Peter Gøtzsche, one of the founders of Cochrane, who has published a large amount of research on the scientific reliability and over-diagnosis of ADHD, autism and depression even in childhood, has been discharged?

But let us keep to the purpose specified in appendix 1: ‘The primary aim of this Consensus Conference is not to promote psychological interventions tout court, but to promote effective interventions for anxiety and depression’. ‘A further aim is the dissemination, outside the narrow circle of specialists, of a wealth of information and indications coming from scientific bodies’ (Consensus ISS 1/2022, p. 55). ‘The purpose of this Consensus Conference is not to identify the best treatments for anxiety and depression... Nor is it to draw up guidelines or provide guidance for professionals, as there are institutionally mandated bodies for those purposes. Whom is the Consensus Conference aimed at? It intends to speak, first and foremost, to the millions of citizens who do not know about psychotherapy, healthcare, or mental illness, but who have experienced problems and/or disorders of anxiety or depression, either on their own or in their families. We think it is our duty to provide them with correct information’ (ivi, p. 56).

The aim is a worthy one, yet as I was reading the text, even as an insider, I was at a loss to understand the data provided. What one gets from this work is the impressive epidemiological incidence in contrast to the lack of awareness of those who, despite suffering from disorders, do not implement treatment behavior, thereby underestimating subclinical situations. It is not difficult to recognize the preventive medicine approach which is used in the fight against cancer, hypertension, overweight, *etc*.

At this point, we have another clue as to the purpose of the document: to alert and guide the perception of non-specialist (non-’psy’) citizens and health professionals regarding the identification of the *spectrum of anxiety and depressive disorders*, as they are subsequently labeled on page 66 of the document.

To adhere to a scientific methodological approach, one must take into account the margins of error that every data collection technique, statistical and otherwise, suffers from. In medicine, this is particularly relevant, both for a correct differential diagnosis and to avoid the phenomenon of overdiagnosis. The example of specific learning disorders (SLD) is significant. The first *Consensus Conference* dates back to 2006, the second to 2010, which resulted in the enactment of law 170/2010. Since that time, ministerial reports indicate an exponential increase in the percentage of SLD diagnoses: in 2010/2011, there were 0.9% (64,227) of students with a DSA diagnosis, ten years later, in 2020/2021, the percentage rises to 5.4% (326,548), with an increase of 408.4%, compared to a decrease over the same period of 8.9% of the student population in question (primary and secondary schools) (Gandolfi & Negri, 2023). In 2022, a new Consensus standardized and extended the diagnostic criteria to adults as well. Without questioning the further increase that clinical practice shows or considering research that indicates a different theoretical approach. What is the explanation for this?

Perhaps the scarce attention paid to data adjustment practices, which go under the name of trimming and cooking, is particularly dangerous in the biomedical and psychological fields. Practices geared towards choosing, from the

available data, those that best fit a predefined theory that enjoys consensus and is in agreement with hypothesized predictions. This prevents a theory from being updated because while the available data increases, it is not used to question the premises. If a theory does not question itself, it will only become a self-confirming explanation. A scientific approach to knowledge necessarily implies a dialectical relationship between consensus and divergent thinking.

These reflections, combined with the redundant abundance of statistical data, the ecumenical, unspecific, consensus recommendations of the experts, and the total absence of any explanatory hypothesis for the phenomenon, give rise to a further question or clue as to the purpose of the document in question: to formalize and legitimize the premise not explicitly stated by the drafters, but accepted by all. Mental illness exists objectively and is identifiable and treatable like any other organic disease affecting the human body. Given that the users of this document are not the insiders, left to their '*whining and contrived disputes*', but millions of citizens, we hypothesize that the aim is to orient their perception to accept this approach to mental distress and suffering as really and truly organic mental illnesses.

This would explain the idea that psychological distress problems can be treated with educational interventions, good exercise, or Omega 3. With 'self-help editorials available on the market... made freely available, one or more specially constructed e-books' or through the 'publication of freely usable self-assessment tools and real computerized and interactive intervention programs, through which users can gain awareness of their problems, assess their severity and build a guided self-treatment pathway'. Up to the 'possible use of somatic therapies, such as electroconvulsive therapy, transcranial stimulation, and nerve-vagal stimulation, to be implemented with caution where the previous therapies described above have not had the desired effects'.

What in the introduction appears to be an advertisement for psychotherapy in support of non-medicalization, turns out to be an insistent push for homologation: 'The variety of forms of psychotherapeutic intervention should be assessed in relation to the effectiveness of cognitive psychotherapy, the most scientifically studied'.

In the annexes, various techniques are mentioned that are disconnected from the frames of reference, but nothing that hints at a question about the complex processes underlying the behavior that is still defined as 'mental illness'. Like confusing the question of why apples fall with how many varieties of apples exist and how many are produced on the planet.

Mental health at the time of the pandemic

'The idea for this Consensus Conference arose at the conclusion of a conference held in Padua on 18-19 November 2016 with the title 'Psychological therapies for anxiety and depression: costs and benefits'.

All the epidemiological statistical data analyzed also refer to the pre-pandemic period. One cannot ignore that the specific laws enacted in 2020 have little to do with the protection of mental health but have produced huge rifts in the micro and macro social fabric. Not to mention the political upheavals at the national and international levels that saw the pandemic as the first test case for the use of health as an experiment in mass social control. There is no trace of the debate that intensely involved mental health workers. While timidly citing the bio-psycho-social model, the document omits an explicit position on the underlying question: whether COVID-19 is thought to have unleashed organic frailties in individuals, or whether the management of the pandemic actively produced situations that were detrimental to health, including the psychic health of citizens. Once again, the path of the indistinct was chosen. Everything was cleaned up, omitted, forgotten. But perhaps the aim was to confirm and pursue the Promethean nineteenth-century mirage of control over Nature, which finds renewed vigor in the mechanistic and transhumanist illusion of the man-machine.

If, as the conclusions state, the aim of the Consensus was to promote scientific research to promote mental health, I would say it has failed. The medical and psychological scientific community seems imprisoned in an eternal present incapable of self-critical, free, healthily divergent, and constructive thinking.

We behavioral scientists, traveling in convoy and chasing a mirage, remain trapped in a viscosity in which we have long been immersed. The COVID-19 pandemic: a missed opportunity.

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