An Integrated Approach to the Treatment of Mood Disorders

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This edition of CNS Spectrums is based on presentations at the Third Annual Georgetown University Department of Psychiatry Mood Disorders Symposium held October 18, 1997. The theme of the conference each year is the biopsychosocial model of psychiatric disease as applied to mood disorders. The driving force for the conference is the appreciation that these illnesses, although medical in nature, occur in a social, psychological, and societal context. This model was developed by Adolph Meyer, MD, while he was the director of the Henry Phipps Psychiatric Clinic at Johns Hopkins University in Baltimore, Md. Dr. Meyer rejected Cartesian mind-body dualism and regarded each patient as a biological entity who reacts to unique social, psychological, and biological influences.

The biopsychosocial model, once prominent in American psychiatry, has been supplanted, first by the psychoanalytic model, and more recently by the biological model. The current explosion of biological data about the brain has dazzled many of us. What should not be forgotten is the fact that we are making great strides on the psychosocial fronts as well. Our technological advances should not blind us to the truths and values of the humanistic psychosocial world. It has been said that great advances in human knowledge are often associated with the loss of knowledge. The conference and this edition of CNS Spectrums are part of an effort to integrate existing knowledge rather than to extend one area at the expense of another.

Unfortunately, there are considerable forces at play that run contrary to this approach. Among these are professional competition, the managed care movement, and the universality of denial with regard to mental illness. Psychiatrists seem to be on the verge of giving up on psychotherapy despite clear evidence supporting its efficacy. Psychologists cry foul, attack the scientific basis for clinical drug trials, and are conflicted about making psychopharmacological referrals. Managed care companies, hoping to reduce their mental health care costs, limit access to both psychopharmacologists and psychotherapists and encourage fragmentation of treatment.

Finally, there is the issue of denial of illness. If one can disregard an illness or a component of an illness, one can make it more controllable, or at least, less threatening. This strategy, when applied to psychiatric disorders, backfires. Patients, often ready to deny illness, may delay seeking treatment, be noncompliant with treatment recommendations, or agree to health care plans that offer inadequate benefits—all with disastrous results. Denial may also take the form of oversimplification. I am reminded of a patient who once consulted me for a problem she described as a "lithium deficiency"—a mere chemical imbalance. She was hoping that the solution to her problem was as simple as taking her car in for an oil change. An equally dangerous notion is that disease states occur primarily in response to life traumas and, therefore, are amenable to psychosocial treatments alone. Treatment should involve helping patients to see their illness realistically, not to support or encourage denial. Clinicians, insurance companies, managed care companies, and families should not collude with patients’ built-in tendency to deny the reality of these illnesses.

At the conclusion of the conference, many of the participants commented upon the synergy amongst the presenters. I hope that in reading this edition of CNS Spectrums, the reader will experience a similar feeling. In these articles, I believe there is a simultaneous appreciation of the gravity of the problem, an optimism about potentialities, and a sense of camaraderie about the goal.

I hope that you enjoy this issue of CNS Spectrums and I thank the editor, Eric Hollander, MD, for inviting us to participate.