Increasing sophistication of the pharmacotherapy of mood disorders

Russell T. Joffe, MD

Dean, New Jersey Medical School, Newark, NJ, and co-editor-in-chief, *Journal of Psychiatry & Neuroscience*

Mood disorders, both unipolar and bipolar, present a substantial therapeutic challenge to psychiatrists and primary care physicians alike. The last dozen years has seen a dramatic increase in the treatment options available for both diagnostic groups. A substantial number of new pharmacologic options are available for the treatment of both unipolar and bipolar disorder, and there are now supportive, rigorous controlled data to confirm the utility of various and specific psychotherapies, either alone or in combination with pharmacologic treatments. Twenty years ago, sequential monotherapy was regarded as the gold standard for treating both unipolar and bipolar disorder. There were few treatment options available for patients with unipolar illness beyond the original tricyclic antidepressants and the difficult to use, first-generation monoamine oxidase inhibitors, and lithium remained the gold standard for the treatment of bipolar disorder.

Since then, a whole range of new antidepressants has been developed, and greater emphasis has been placed on intermediate and long-term treatment. The recurrent and chronic nature of unipolar illness, with associated morbidity and mortality, is now recognized. Moreover, specific psychotherapies are seen to be effective in both the therapeutic and acute treatment of the disorder. As far as bipolar disorder is concerned, there are several therapeutic challenges for the treating physician. Very rarely do patients receive monotherapy; they invariably are taking 2 or more psychotropics with specific psychotherapeutic interventions introduced from time to time.

This treatment situation, analogous to that observed in other medical subspecialties where single agents, each yielding partial treatment responses, are combined to optimize therapeutic outcome, places several burdens on the treating physician. First, for the physician to make informed decisions to ensure both optimum outcome and minimal side effects, a thorough knowledge of the pharmacology of these various compounds is required. An understanding of the pharmacodynamic and pharmacokinetic properties and the interactions of various drugs is necessary to treat patients with both unipolar and bipolar mood disorder. In the past, the major concern was the use of first-generation monoamine oxidase inhibitors in combination with other agents. Now, a wide range of drug combinations must be considered. For example, the combination of a selective serotonin reuptake inhibitor and a tricyclic may be potentially harmful or, at best, inconvenient because of increased side effects if not taken properly. However, if used correctly, this combination may offer a therapeutic advantage to the treatment-resistant patient.

There is an argument to be made that, with the increased sophistication in the psychopharmacology of mood disorders, many patients, particularly those with bipolar disorder or treatment-refractory depression, should be treated in specialty clinics only. This, of course, is impractical because of the large number of such patients requiring treatment and the lack of tertiary facilities in small communities and underserviced areas. Therefore, there needs to be a concerted education effort, now more than ever, to ensure that all treating physicians, both primary care and specialists alike, are well versed in the psychopharmacology of the many agents used to treat unipolar and bipolar disorder.

Correspondence to: Dr. Russell T. Joffe, Dean, New Jersey Medical School, 185 South Orange Ave., University Heights, Newark NJ, USA 07103-2714; fax 973 972-7104; joffe@umdnj.edu

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