A new era and a new paradox for mental health

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As we see the end of the COVID-19 era through a collective windshield, there is hope and optimism at the exit ramps ahead of us. This unforeseen era has brought not only unprecedented change to the practice of medicine, but also a resurgent focus on the impact of medical care. The rapid adoption of telemedicine, the medical heroism lauded in the press during the early days of the pandemic, and the subsequent psychosocial impact of quarantines and lockdowns have brought increased attention to our citizens' mental health, and not just during a crisis, but in a more holistic sense.

In fact, with the most recent annual Presidential State of the Union Address, mental health has finally received an invitation to the national agenda. This is an admirable achievement, a nod from Uncle Sam that says, "Here's your seat at the table." Now that we have earned this seat, have we improved our understanding of mental illness, treatment options, and our access to them? Or have we lost sight of our real challenges? Shouldn't achieving national prominence have resulted in newfound treatments and strategies to increase access and understanding?

Instead, we are still touting the same (although perhaps nuanced) monoamine hypothesis underlying most of our conditions, as we have for decades. Vast areas of the country are out of reach of a local psychiatrist. Our treatments, largely centered on medications, though hopeful and promising at times, would fall short of the hurdle to become mainstay treatments in other medical specialties. Of course, the counterpoints are obvious: there are novel treatments (eg, ketamine, transcranial magnetic stimulation) and new understandings of glutamate and gamma aminobutyric acid systems in mood regulation and addiction. We also can use telemedicine to improve access to psychiatric care in underserved areas. But the overarching truth remains: an understanding of psychiatric illnesses, specifically the pathophysiology underlying those conditions, remains elusive or partially understood. Until we have a pathophysiology to treat, we can only continue to describe phenomenology and treat symptomatology.

Since we are treating symptoms, we must rely on verbal descriptions of psychiatric conditions. Descriptions and discussions of mental illness have pervaded the airwaves and media. It is not uncommon or unusual to hear people talk about depression, anxiety, insomnia, addiction, or even psychosis in a very normal, unjarring way. These words, which represent severe medical conditions, have now become part of the national nosology and colloquial description of individuals' day-to-day lives. Have we stripped the severity and seriousness of our conditions from their descriptors in order to increase awareness and make mental health care a more "normal" part of health care?

continued

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We see it in clinics, the media, our schools, and our workplaces. Children and teens are talking about social anxiety because they feel a bit nervous on stage as their part in a school play begins. Teens are asking for extra time on a difficult test in a challenging class that is supposed to be strenuous. Employees are asking for mental health leave when a demanding new boss arrives on the scene.

Has our own campaign to increase awareness and destigmatize mental illness caused it to become diluted? Have we raised awareness by diluting its severity and seriousness, by making our nosology equivalent to everyday stressors? Was this a marketing strategy, a failure of our own nosology, or an inadvertent fallout of a decades-long campaign to raise mental health awareness?

Until we have clear, delineated pathophysiology to treat, we will remain wed to our descriptive nosology. This nosology is flawed, at times ambiguous and overlapping, and now has become diluted to be more palatable to a national and consumer audience.

So yes, let's grab a chair at the national table, but let's make sure we're not just chair-warmers. It's time we redouble our focus on unraveling the pathophysiology of psychiatric illnesses, and to focus on a new scientific nosology, as opposed to our current, almost colloquial and now diluted descriptors that may raise awareness but do little to advance a real understanding of mental illness. A more holistic understanding of the pathophysiology of psychiatric disorders may provide us with a more scientific nosology. Ultimately, we can hope for more effective, and perhaps even curative treatments. That, my colleagues, is what will give us not just a seat at the table, but maybe even a table of our own.

Clinical Point

It's time we redouble our focus on unraveling the pathophysiology of psychiatric illnesses