Loss of Meaning in the Era of *DSM* and Psychopharmacology

To the Editor: When addressing changes in symptom severity in patients with psychiatric disorders, it is important to consider psychosocial stressors before jumping to pharmaceutical interventions. Here, 2 cases are presented to illustrate this point.

Case 1. Ms A is a 54-year-old woman with a *DSM-5* diagnosis of recurrent major depressive disorder in remission on fluoxetine 20 mg daily. At a follow-up visit, she had symptoms of a relapse: more than 2 weeks of depressed mood, low energy, fatigue, reduced sense of joy, anxiety, poor concentration, insomnia, ruminations, and poor appetite. My initial knee-jerk response to this change was to increase the dose of her medication. However, through the interview, I learned that Ms A was off work due to a recent shoulder injury. She was very worried that she would not be able to support herself if she did not get paid during this period. This excessive worrying had led to worse mood, more anxiety, and other biological symptoms of a relapse. During the appointment, we called her company's human resources department. She learned that she would be paid during the time off due to her medical condition. I did not increase the dose of her medication, and she left the office in a better mood. At follow-up 2 weeks later, Ms A met *DSM*-5 criteria for remission.

Case 2. Mr B is a 24-year-old man who lost 2 of his childhood friends in a car accident while he was driving. He was devastated by the loss and met *DSM-5* criteria for severe posttraumatic stress disorder (PTSD) with frequent flashbacks and nightmares. He was going through a court proceeding, which could lead to years in prison if he was charged with vehicular manslaughter. Treatment with sertraline and cognitive-behavioral therapy reduced his symptoms to moderate PTSD (PTSD Checklist–Civilian version[1] [PCL-C] score = 49) prior to his court session. I saw him 2 days after the court session during which he was found not guilty of manslaughter and sentenced to 18 months of call probation. At this time, Mr B did not meet criteria for PTSD, and his symptoms were subclinical (PCL-C score = 22).

Neither of these patients requested documents supporting illness severity for the court or work, which rules out secondary gain. With a solely psychopharmacologic mindset, both of these patients would require medication dose increases (to address major depressive disorder relapse and to further improve PTSD). Current treatment guidelines' approach to patients is similar to the research they are based on: treat a constellation of symptoms for a designated time period regardless of psychosocial factors. However, patients similar to those presented here may have a better response to psychosocial intervention than medication dosage increase, which could explain moderate treatment response in clinical trials[2] based solely on symptoms and excusing etiology. The same applies to many cases of "treatment-resistant" conditions due to ongoing psychosocial stressors.

I believe it may be time to fine-tune our approach to mental illness in both research and clinical practice and explore nonbiological etiology more extensively. Decades ago, clinicians were inclined to find roots of all mental illness in childhood and neglected biological etiologies. I am afraid that in the current era, we may be focusing too much on medications in addressing mental illness to the point that we overlook the role of something as simple as clarifying worker compensation status for a patient with symptoms of a major depressive episode.

Reference

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