The Burden of Mood Disorders

THE OVERALL BURDEN OF MOOD DISORDERS—INDIVIDUAL, SOCIETAL, AND ECONOMIC—HAS BEEN increasing in recent decades. This is certainly the case for depression (see the special section beginning on page 67 of this issue). In Europe, the burden is greater than 10 years ago despite the availability of reasonably effective pharmacological and psychological interventions.* Yet the prevalence of mood disorders has remained steady at approximately 10% of the population.*‡ What explains the increased cost and societal burden of depression and bipolar disorders, and what can be done to improve the situation?

The major barrier to improving treatment in most countries has been limited financial and structural resources. A 2011 European Brain Council Report‡ revealed that unlike cardiac disease and diabetes, in which direct costs (diagnosis and treatment) typically account for over 50% of the total cost, mood disorders are dominated by indirect costs such as sick days, unemployment, long-term disability, and suicide attempts (direct costs account for about 23% of the total). A second factor, which is beyond the control of medical professionals, is the consequence of longer life spans. Living longer is associated with an increased probability of developing depression with a more malignant course due to, for example, vulnerability and risk factors that arise from other chronic conditions.*

There has also been a failure to generate the needed multidisciplinary models of disease intervention and effective mental health services. Mood disorders are highly complicated, with neurobiological, behavioral, and psychological etiologic pathways, and there is a range of complex treatment goals. Interventions also need to be tailored to address multiple factors, including the type of mood disorder, its severity, comorbid complications, and the patient’s preference for treatment. Current models of pharmacological or psychological interventions and even personalized medicine approaches fail to account for these issues sufficiently, in part because of a lack of knowledge regarding the neural underpinnings of the highly dynamic pathological pathways. Given that most patients are not recognized in a timely manner by physicians, never seen by a specialist, or not treated appropriately according to minimal guideline standards, the increase in the overall burden of mood disorders is not surprising.

Improved integrative models, based on research in the behavioral, social, and neurosciences, are urgently needed that better reflect the heterogeneity and complexity of mood disorders. The goal is to provide a range of effective interventions within a personalized perspective, taking into account the vulnerability and risk factors responsible for one’s clinical trajectory to illness, its duration, and remission, in addition to pharmacogenomic and other biomarker approaches. Early interventions based on personalized approaches have the most promise. Two-thirds of mood disorders start in late adolescence and early adulthood, predominantly as secondary conditions to other types of preexisting and untreated mental disorders, such as anxiety, attention deficit disorder, and addiction. These preceding disorders are powerful risk factors for the first onset of a mood disorder, and they can predict a malignant and chronic course as well as a poorer response to treatment. Early intervention targeted to such highly vulnerable patients can decrease not only the incidence of mood disorders but also the degree of disability and depression burden.§

Reducing the burdens of mood disorders requires major shifts in research, clinical practice, and public health by incorporating multidisciplinary models of intervention. The good news is that such changes are under way, as reflected, for example by the experts drafting Research Roadmaps (see www.roamer-mh.org) for the European Union.  

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Editor's Summary

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