In a 1938 British Broadcasting Corporation audio interview, Sigmund Freud stated: “I started my professional activity as a neurologist trying to bring relief to my neurotic patients.” Freud never lost sight of the search for relief for his patients beyond the boundaries of psychology. A 1971 correspondence between Samuel Lipton and Anna Freud indicated that, in 1937, Freud and James Strachey opined that patients who do not respond to psychoanalysis presented obstacles “of a physiological and biological nature” and “thus in the main unsusceptible to psychological influences.” The existence of biological mental diseases compels the search for effective treatment and therapy. Biological psychiatry faces a chasm between descriptive psychiatric illness (ie, phenomenology) and the presence of reproducible, specific, documentable pathophysiology (ie, biomarkers).

Knowing how to listen and how to observe remains the art of medicine. This attentive process has been artificially sectioned into the patient’s history, symptoms, physical and mental status examination, and pertinent laboratory studies. Although the science of mood disorder has not reached Schildkraut’s challenge of “the direct demonstration of the biochemical abnormality in the naturally occurring illness,” the clinician is not excused from a duty to present courage and hope. In 1817, James Parkinson offered guidance to physicians as he argued his unproven theories of diagnostic specificity of “Shaking Palsy.” Parkinson saw a “duty” to provide opinion “even in the present state of immaturity and imperfection” [of medicine]. Parkinson was willing to “repine at no censure” if basic research would not confirm “conjectural suggestions.”

Medicine may always intertwine available science and art. The application of available science and art to treat mood disorders is the subject of two special issues of Psychiatric Annals about monoamine oxidase inhibitor (MAOI) therapy. These issues provide up-to-date information on a highly effective, yet underutilized, class of medicines for the treatment of depression and other disorders.

A favorable long-term prognosis for mood disorder requires a treatment goal of sustained remission. The myopic focus of many clinicians on possible adverse events of MAOIs has precluded the use of these agents for achieving remission in routine practice. Yet, at the same time, most treating clinicians regard MAOIs as “the final common arbiter” for patients with resistant depression in which prior therapies have failed. Treatment modalities for mood disorder require prudent risk/benefit analysis that weighs potential adverse events versus known adverse outcomes from inadequate or ineffective therapies.
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REFERENCES


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