ANNALS OF CLINICAL PSYCHIATRY 2012;24(1):2-3

EDITORIAL

The Canadian Network for Mood and Anxiety Treatments (CANMAT) task force recommendations for the management of patients with mood disorders and comorbid conditions

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Results from epidemiological and clinical studies indicate that psychiatric and medical comorbidity occurs at a high rate among individuals with major depressive disorder (MDD) and bipolar disorder (BD). Comorbidity in mood disorders has diagnostic, prognostic, therapeutic, and conceptual implications. For example, comorbid substance use may obscure an underlying mood disorder, delay initiation of treatment, alter the determination of the most appropriate therapy, and challenge the clinician's development of an etiological understanding of the patient's condition. Moreover, an association between comorbid conditions and more complicated mood disorder presentations has been documented, with evidence of increased rates of chronicity, nonrecovery, suicidality, and premature mortality in comorbid patients. From a treatment perspective, the probability of achieving full recovery from an index affective episode is significantly decreased in the presence of comorbidity, and in many cases, treating a comorbid condition could inadvertently disrupt management of the mood disorder (eg, using antidepressants to treat an anxiety disorder in an adult with bipolar I disorder).

At the conceptual level, it has been discussed that comorbid conditions represent discrete entities comorbid with the mood disorder. The available evidence, however, may not support such an unambiguous assertion. For example, it has been hypothesized that a pathophysiological nexus may subserve some comorbid conditions in mood disorders (eg, activation of the hypothalamic-pituitary-adrenal axis in individuals who are overweight or obese and have a mood disorder). Moreover, what is labeled as "comorbid" may be a phenomenological variant of the mood disorder. For example, it is not uncommon for individuals who had attention-deficit/hyperactivity disorder (ADHD) as children to declare themselves as having BD as adults. In some instances, the ADHD phenotype is no longer apparent (ie, heterotypic continuity) while in others, the ADHD persists as a "comorbid" condition preceding BD onset. Taken together,

there is a clinical and research importance ascribed to comorbidity in mood disorders that is relevant to clinicians and researchers caring for individuals with mood disorders across the life span.

The upcoming release of DSM-5 will further the debate on the best classification system for comorbidity, with dimensional measures of anxiety and substance use given prominence in the mood disorders category. While highlighting the broad symptomatic expression of these conditions, further efforts are needed to determine the prognostic and treatment relevance of dimensional and categorical systems for comorbidity.

Clinicians often have stated that the primary use of clinical studies that do not represent patients commonly encountered in "real world settings" is a challenge to adopting these evidence-based treatment guidelines as part of a decision support approach to managing their patients. More specifically, efficacy studies, which are the foundation of evidence-based guidelines, often systematically exclude individuals on the basis of co-occurring psychiatric and medical conditions. It has been documented that perhaps <10% of individuals encountered in busy clinical settings would be eligible for enrollment in a standard, pharmacological efficacy trial.

Against this background, we thought it would be clinically useful to create Canadian Network for Mood and Anxiety Treatments Task Force recommendations that would inform treatment decisions in individuals with mood disorders and commonly encountered comorbid conditions. The process was consensus-based and pragmatic. We ranked the most often encountered psychiatric and medical disorders and decided that they would comprise our first endeavor on this topic. We agreed that providing recommendations on the management of anxiety disorders, substance use disorders, ADHD, metabolic and medical disorders, and personality disorders in individuals with mood disorders would be relevant to many patients encountered in clinical settings, with the limitation that not all possible comorbid conditions would be addressed. We endeavored to address less common conditions in a general paper on managing comorbid medical conditions. We believe that the hazards posed by metabolic problems in individuals with mood disorders warrants its own section.

Each section was led by a section head(s) who reached out to experts across Canada and internationally for contribution. The task for each working group was to review and synthesize the literature in a way that would be sufficiently comprehensive, convergent, and instructive. This balance is not always easy to achieve because there are relatively few studies of mood disorders that have primarily aimed to evaluate the effect of a pharmacological, psychosocial, and/or neuromodulatory intervention in comorbid mood disorder patients. We believe, however, that it is essential to assemble a series of recommendations with an aim to assist clinicians working with these patients, and to draw attention to the topic, which we hope will inspire further research. The recommendations are a synthesis of available evidence and expert opinion among our colleagues.

The framework for managing individuals with mood disorders is a chronic disease model. A component of this model is the use of decision support (eg, treatment guidelines). We hope that these Task Force recommendations provide clinically useful information for clinicians when selecting and sequencing therapies for mood disorder patients who present with comorbidity. Our recommendations are not intended to be prescriptive, and instead are to be used alongside other important clinical information as part of a personalized and measurement-based approach. Similar to all recommendations, ours are incomplete, lack sufficient information, and are guilty of short "shelf life." We intend to update our recommendations regularly and welcome feedback for the authors. We thank the contributors for their efforts and thoughtful insights on this project. We did not seek out commercial support for the creation of this Task Force, and would like to thank the *Annals of Clinical Psychiatry* for publishing this inaugural effort.