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An Integrative Paradigm for Mental Health Care

Ideas and Methods Shaping the Future

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James H. Lake
Center for Integrative Medicine
University of Arizona College of Medicine
Tucson, AZ, USA

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The greater the ignorance the greater the dogmatism.

—Sir William Osler MD

Believe nothing, no matter where you read it, or who said it, no matter if I have said it, unless it agrees with your own reason and your own common sense.

—The Buddha

For Nicole

This book is dedicated to thousands of patients I have had the privilege to work with over my career. You have been my greatest teachers. May you find a path to relief from suffering. This book is also dedicated to young mental health professionals everywhere who are just starting their careers, already aware of the limitations of the orthodox view, and looking for a better way. You will be the architects of "new medicine." May your convictions remain strong and may your vision be clear.

Foreword

When it comes to mental health, modern medicine has painted itself into a rather awkward corner. It has done this by focusing so exclusively on the physical aspects of our mental and behavioral health issues that it has devalued and, in some cases, denied adequate treatment for humankind's emotional and social dimensions.

This devaluation of the mind and emotions has a number of unfortunate consequences. First, the treatment of mental illness itself is inadequate. A recent Harris Poll showed, for example, that depression and anxiety, which are some of the most prevalent conditions in the country, are rarely addressed in primary care—where they usually present (Devitt, 2018). Only a third of primary care providers have even discussed mental health issues with their patients. Therapeutic approaches that do not involve physical manipulation of the brain such as psychotherapy or cognitive behavioral therapy (CBT) are often restricted or even denied, whereas drug treatments will be paid for even beyond the period for which they have been shown to be effective. Proven self-care and complementary approaches are almost completely neglected. For example, the military patient population that I work with suffers from high rates of post-traumatic stress disorder (PTSD). But the only approved approaches for PTSD are medications and professionally supervised trauma exposure therapy. This is despite multiple non-drug and self-care approaches that have been shown to be effective in this condition, such as acupuncture and meditation (Engel et al., 2014; Hollifield, Sinclair-Lian, Warner, & Hammerschlag, 2007; Lake, 2015; Nidich et al., 2018).

A second consequence of this denial of the social and emotional dimensions of a human being is our failure to recognize the importance of mental treatments for physical conditions. Stress management training and support is not routinely provided for conditions such as cardiovascular disease, diabetes, chronic pain, or cancer even when they are known to be of value. In addition, the major impact of early childhood traumas and adverse experiences is largely neglected even when they perpetuate both physical and mental illness over decades of life.

A third consequence of our failure to recognize the importance of the social and emotional as well as the mental and spiritual dimensions of the human being is a

neglect of the behavioral and social determinants of health. Even if a patient does not have a diagnosable mental illness, behavioral components are a major aspect of their ability to get well and stay well. This neglect occurs even though the behavioral and social determinants contribute to 80% of population health and behavioral health embedded in primary care has been repeatedly proven to reduce costs, improve outcomes, and increase satisfaction with care (Jonas, 2018).

The public also suffers from these myths about mental health being derived only from the physical dimensions of a human being. Phrases such as "it's all in your head" or "my disease is real" result from a stigma around mental and emotional experiences as being "not real." This results in patients not seeking out mental health care even when it's available. Nearly 75% of depression is seen in primary care, for example, but often presents as another condition or is missed. Patients will refuse to go to a mental health clinic or see a psychiatrist because of this stigma or disbelief in the value and importance of treating their mind and emotions.

The fundamental neglect of the mental and emotional dimensions of a human being leads to multiple problems in our health care system including lack of access to mental health services, neglect of proven self-care, and non-pharmacological approaches to health, both mental and physical. These approaches become sidelined by using terms such as "complementary and alternative medicine (CAM)," meaning optional and on the sidelines, or "nothing but placebo," meaning "not real" when they are, in fact, at the core of healing.

Dr. James Lake is a psychiatrist who has for many decades been filling these gaps. And with this book, *An Integrative Paradigm for Mental Health Care: Ideas and Methods Shaping the Future*, he continues to do so in a most eloquent way. As one of the founders of the American Psychiatric Association's caucus on complementary and integrative medicine, Dr. Lake has influenced the professional dialogue on the importance of the social and emotional dimensions of human life for health and well-being. He has been a staff psychiatrist serving our veterans and so is well-versed on what happens on the front lines of health care when we either neglect or fail to provide whole-person mental health care.

This book starts where we all must if we are to provide solutions to the challenges just described. It first lays out the conceptual foundations and methods for a more integrative paradigm in mental health care. Once this is explained, it then proceeds to provide practical tools for addressing those challenges. It is grounded in science yet easily accessible. Based on years of practice and research, the writing is elegant, balanced, evidence-based, and easy to understand both for professionals and the public.

Readers should know, however, that before this book, Dr. Lake has written a most comprehensive and practical set of guides to mental health care for the public, thus opening access to effective integrative and self-care treatments for mental and emotional conditions globally. His writing is always grounded in good science and research providing readers with clear direction on what works and does not work.

It is my hope that this work will be read and used widely by patients, their caregivers, and providers. It is only by reclaiming care for the whole person—mind, body, and spirit—that medicine will save itself. Thank you Dr. Lake for holding a

vision of health care for whole persons in the form of integrative mental health care and for providing us with practical concepts and methods to help make it happen in everyday life.

Wayne B. Jonas
Samueli Integrative Health Programs
Alexandria, VA, USA
Office of Alternative Medicine,
National Institutes of Health
Bethesda, MD, USA

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Preface

Psychiatry as presently conceptualized and practiced fails to adequately address the core causes and meanings of mental illness. The reasons for this are complex and include the following:

- Current scientific theories do not adequately explain the causes of mental illness.
- Available mainstream treatments often fail to alleviate symptoms of mental illness.
- Academic and government institutions that promulgate psychiatry are, with few exceptions, conservative in ideology and resist new ideas.
- Postgraduate training programs in psychiatry are narrowly focused on psychopharmacology and do not cover non-pharmacologic interventions and non--allopathic models of mental illness causation.
- The pharmaceutical industry heavily influences ideology and clinical practices in academic institutions, the American Psychiatric Association (APA), and among psychiatrists broadly. As a result, non-pharmacologic interventions are marginalized in academic institutions, APA-sponsored conferences, and professional journals.

Although growing numbers of psychiatrists and other mental health care providers dispute the model and methods of contemporary psychiatry, our shared concerns have not resulted in a call to action within the APA, academia, or government agencies. A large grassroots movement has nevertheless emerged in industrialized countries in response to what is widely regarded as a growing crisis in mental health care. But there is a disconnect between a highly vocal popular movement to reform mental health care and psychiatrists in positions of leadership in the APA and academia that shape the policies and practices of psychiatry.

Proponents of the status quo argue that despite the inadequacies of psychiatry, the current dominant paradigm and mainstream practices are arguably better than the alternative: endorsement by Western medicine of novel theories and clinical practices that fall under the heading of complementary and alternative medicine (CAM). While it is true that many CAM modalities are not substantiated by

compelling research evidence, the same limitation applies to many conventional modalities including widely used psychotropic medications and psychotherapies. In fact, many CAM modalities have been investigated in sophisticated Western-style research studies and have been shown to be safe and effective treatments for specific psychiatric disorders. *The real bottleneck delaying progress in psychiatry toward a more eclectic, more effective paradigm is not the absence of evidence for CAM but strong negative biases in biomedical psychiatry against non-pharmacologic modalities based on an entrenched ideology that equates the practice of psychiatry to prescribing psychotropic medications.* Growing numbers of psychiatrists and other mental health professionals who find the status quo unacceptable are educating themselves about a variety of non-pharmacologic treatment choices and recommending these to their patients. However, mental health care practitioners who want to learn about CAM may encounter problems when trying to find reliable, up-to-date information on a particular modality. Finally, practitioners who know where to find reliable information may not have a systematic approach for developing a well-thought-out care plan addressing the unique symptoms, preferences, and circumstances of each patient.

The absence of a clinical methodology for integrating disparate Western medical and CAM modalities into a coherent whole is delaying progress in psychiatry toward a more effective, safer, and broader set of clinical practices. This book is offered as a conceptual framework for solving practical problems in integrative mental health care. It covers resources and methods that will help mental health practitioners find reliable information on CAM and know how to use it in day-to--day clinical encounters. The book is not a compendium of research findings on CAM though select CAM modalities are mentioned as examples. The reader seeking comprehensive reviews of research findings on CAM is referred to the appendix for valuable resources.

My principal goal in writing this book was to address the gap between what mental health care providers, patients, and the public *want* and what the conventional model of care and institutions that perpetuate the current dogma *permit. The book is not an attack on mainstream psychiatry nor is it intended as a wholesale endorsement of CAM. I've tried to chart a "middle way" between Western medicine and CAM keeping in mind advantages and limitations of different domains of medical knowledge and clinical practice.* I believe that a critique of mental health care as currently conceptualized and practiced is a legitimate and necessary prologue to *reconceptualizing* and *reinvigorating* this important domain of knowledge and praxis in light of promising new ideas and emerging research findings. I hope this book will provide a useful framework for dialog and debate on urgently needed changes in the way mental health providers practice, the way institutions and the academy interpret and use information, and, most of all, the way patients receive care.

I would not continue to do the hard work of psychiatry were I not optimistic about the future of my trade. I anticipate many exciting changes on the horizon and a brighter future for psychiatry for the benefit of all who suffer from mental illness. Collectively, these changes will become the *foundations for a new psychiatry*. In the coming decades—well before the end of the century—Western medicine will

undoubtedly evolve into a more complete paradigm that will embrace advanced technologies along with insights from the world's great healing traditions. Based on an analysis of current trends, I believe it is inevitable that advances in the basic sciences, artificial intelligence, and neurotechnologies will transform the clinical therapeutics and practice of psychiatry resulting in more effective, safer, and more compassionate "whole-person" mental health care.

Wayne Jonas, M.D., a pioneer in integrative medicine and former Director of the Office of Alternative Medicine, National Institutes of Health, graciously agreed to provide the foreword in which he makes an urgent call for renewed emphasis on the social, emotional, mental and spiritual dimensions of the human being.

The book is divided into two parts. Part I discusses the conceptual foundations of integrative mental health care. The first chapter reviews circumstances that have led to the current crisis in psychiatry in the USA and globally. Other chapters discuss philosophical problems, evolving paradigms and their impact on mental health care, and models of consciousness. Part II is on methodology and clinical applications. Topics covered include the evaluation and use of evidence in integrative mental health care, history-taking, assessment, formulation, and treatment planning. Chapter 9 discusses important clinical considerations when managing complex cases involving high comorbidity. The final chapter is an analysis of trends that are affecting mental health care and a forecast of where medicine and psychiatry are heading.

The book has three appendices. Appendix A provides a list of valuable online resources and books on integrative mental health care. Updates and links to important new web resources and books will be added on an ongoing basis. Appendix B contains blank evidence tables and algorithms that can be downloaded from a companion website created for this book www.IntegrativeMentalHealthPlan.com. Appendix C describes software that is being created by the author to assist practitioners in planning and implementing all phases of integrative mental health care. The software projects are based on the methodology developed in this book.

Tucson, AZ, USA James H. Lake

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Part I
Foundations

Chapter 1
Meeting the Challenges of Mental Illness Through Integrative Mental Health Care

"The person who takes medicine must recover twice, once from the disease and once from the medicine"

—Sir William Osler, MD

Contents

Limitations of Conventional Mental Health Care

Mental health care in its present form is at a critical juncture. Many individuals diagnosed with severe psychiatric disorders depend on medications to function and be productive members of society. However, after decades of research and billions of dollars of industry funding, the evidence supporting widely used pharmacologic treatments of major depressive disorder, bipolar disorder, schizophrenia, and other psychiatric disorders is not compelling (Denys & de Haan, 2008; Fournier et al., 2010; Hartling et al., 2012; Herrmann, Chau, Kircanski, & Lanctôt, 2011; Kelley, 2010; Kirsch et al., 2008; Stafford et al., 2015; Thase, 2007; Velligan et al., 2009). Determinations of the safety and efficacy of psychotropic medications are usually based on the results of short-term clinical trials lasting 6 weeks. The Food and Drug Administration (FDA) does not study the long-term efficacy and cost-effectiveness of psychotropic medications. Since many widely used psychotropic drugs are used for maintenance treatment, the effectiveness of these drugs in clinical

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practice is largely unknown. Poor treatment outcomes owing to limited efficacy of antidepressants, mood stabilizers, antipsychotics, and other psychotropic medications result in long-term impaired functioning, work absenteeism, and losses in productivity (Barbato, 1998; Barnes, Bloom, & Nahin, 2008; Beck et al., 2011; John M. Eisenberg Center for Clinical Decisions and Communications Science, 2016; Laxman, Lovibond, & Hassan, 2008). Medications are approved by the FDA for specific purposes and are also prescribed for the so-called "off-label" use. Drug manufacturers may not legally promote off-label uses of psychotropic drugs, but such usage is very common. No government agency is charged with evaluating off-label uses for FDA-approved medications. Many serotonin-selective reuptake inhibitors (SSRI) are used for off-label indications despite limited or no evidence supporting their effectiveness for these purposes (Frank, Conti, & Goldman, 2005).

In addition to concerns about efficacy, many psychotropic medications cause serious adverse effects, including weight gain, increased risk of diabetes and heart disease, neurologic disorders, and sudden cardiac death (Henderson, 2008). Metabolic syndrome associated with weight gain and increased risk of diabetes and coronary artery disease is a well-documented adverse effect of antipsychotics and other widely prescribed psychotropic agents.

Enormous psychological, social, and occupational costs are associated with depressed mood, which is the leading cause of disability in the USA for individuals aged 15–44 with annual losses in productivity in excess of $31 billion (Kessler, 2012). Suicide is one of the most common causes of preventable death among adolescents and young adults. Between 10 and 20 million depressed individuals attempt suicide every year, and approximately 1 million complete suicide. In 2016, the World Health Organization declared depression to be the leading cause of disability worldwide (Nguyen & Davis, 2017). On average, it takes almost 10 years to obtain treatment after symptoms of depressed mood begin, and more than two-thirds of depressed individuals never receive adequate care (Depression Fact Sheet, WHO, 2017).

More than 85% of the world's population lives in 153 low- and middle-income countries (Demyttenaere et al., 2004). Poverty is linked to a higher burden of mental illness, with variables such as education, food insecurity, housing, social class, socioeconomic status, and financial stress exhibiting a strong association (Lund et al., 2010). Most of these countries allocate scarce financial resources to mental health care needs and have grossly inadequate professional mental health services. In developed countries, elderly individuals, minorities, low-income groups, uninsured persons, and residents of rural areas are less likely to receive adequate mental health care, and most people with severe mental health problems receive either no treatment or inadequate treatment for their disorders (Mental Health Action Plan, WHO, 2013). A comprehensive survey of European Union member countries found that 38.2% (approximately 165 million people) met criteria for a psychiatric disorder, with fewer than one-third receiving any treatment at all (Wittchen et al., 2011). Disorders of the brain, including psychiatric disorders, were found to be the largest contributor to the all-cause morbidity burden as measured by disability-adjusted life years. Demographic changes have resulted in more people living longer with the

result that an increasing percent of the global population is inflicted with many chronic medical or psychiatric disorders (Mental Health Action Plan, WHO, 2013). The increase in life expectancy has led to increasing complexity and comorbidity of health-related problems in all world regions. It has been estimated that mental illness will *continue to be* the leading cause of mortality and morbidity globally (Mathers & Loncar, 2006).

In the USA the gap between mental health care needs and available resources is becoming ever wider in suburban, semirural, and rural areas. This is related to the fact that many psychiatrists are nearing the age of retirement. Combined with increasing vacancies in psychiatry residency training programs, the staffing pipeline for psychiatrists is shrinking (Hawryluk, 2016).

In response to shared global concerns over the crisis in mental health care, in 2012 the World Health Organization published "Mental Health Action Plan 2013–2020" (Mental Health Action Plan, WHO, 2013) and set forth four major objectives:

- More effective leadership and governance for mental health.
- The provision of comprehensive, integrated mental health and social care services in community-based settings.
- Implementation of strategies for promotion and prevention.
- Strengthened information systems, evidence, and research.

The Gap Between Conventional Mental Health Care and CAM

In many countries the principal role of psychiatrists and family physicians is to prescribe and "manage" medications addressing a range of medical and mental health problems. The majority of non-pharmacologic modalities are regarded as *complementary and alternative* (CAM) therapies and are frequently dismissed as invalid by allopathically trained physicians before an objective appraisal of research evidence is undertaken. In kind, many CAM practitioners actively discourage their patients to reject pharmaceuticals and other allopathic treatments and to accept *only* those treatments recommended by them. The situation becomes more complicated in mental health care because the majority of non-medically trained clinicians including psychologists, family therapists and social workers offer psychotherapy and advice on lifestyle while referring patients to psychiatrists for "medication management" consultations only when symptoms fail to respond to psychotherapy or lifestyle changes.

The current Western medical model of mental health care is limited in its capacity to alleviate the root causes of suffering because its theoretical foundations and clinical methods address only some of the complex causes and meanings of mental illness. This problem is directly related to incomplete understanding of the causes of mental illness which has led to unsubstantiated hypotheses and a multiplicity of

therapies that do not adequately explain or alleviate the root biological *causes* or social, psychological or spiritual *meanings* of symptoms (Wright & Potter, 2003). Among psychiatrists, the dominant view is an extension of contemporary allopathic medicine, which equates mental health problems to functional abnormalities at the level of discrete neurotransmitters. According to the dogma, successful "treatment" entails "correcting" a presumed neurochemical abnormality with the goal of restoring to normal a corresponding dysregulation in cognitive, emotional, or behavioral functioning.

While psychiatrists often use cognitive-behavioral approaches or "talk" therapies directed at changing maladaptive interpersonal dynamics, depth psychological approaches examining existential or spiritual themes are typically regarded as incidental to "more serious" psychotherapeutic or pharmacological treatments informed by the dominant allopathic paradigm. Agreeing on a "most relevant" theory or a "most appropriate" treatment is even more problematic for psychologists for whom numerous theories of symptom formation have yielded disparate and frequently contradictory explanations of the underlying meanings of psychopathology. Because of the multiplicity of theories and clinical practices that comprise psychology and psychiatry there is no theory-neutral method for evaluating the relative merits and weaknesses of disparate treatments. Subsequently, consensus is lacking on the "most appropriate" or "best" conceptual framework or practical clinical methods when approaching a specific mental health problem. In addressing this dilemma Wilber has systematically reviewed psychological theories of mind–body and has proposed guidelines for the creation of an "integral psychology" that takes into account core psychological and spiritual features of many leading theories of mind–body (Wilber, 2000). An important goal of Wilber's work is the elaboration of a series of integrative psychotherapeutic strategies that are ideally suited for specific symptoms of mind–body, psychological, or spiritual distress.

The divergent perspectives of mental health care providers reflect differences in training, financial interests, and values of conventionally trained physicians, psychotherapists, and CAM practitioners that may result in treatment delays, inappropriate or inadequate patient care, and poor outcomes. Increasing numbers of individuals who seek care for a mental health problem consult with more than one conventionally trained or CAM practitioner and receive widely differing treatment advice. While patients are actively seeking information and advice from a range of providers, limited or no dialog takes place between physicians and other conventionally trained mental health providers and CAM practitioners. This becomes problematic when patients receive contradictory advice resulting in misdiagnoses, *missed* diagnoses, delays in starting potentially beneficial treatment, or treatment combinations that are potentially unsafe. Many patients who do not benefit from a particular allopathic, CAM, or psychotherapy approach eventually seek other kinds of treatment. The process of moving from a conventionally trained provider to a CAM practitioner is frequently based on limited or unreliable information about the efficacy or safety of different treatment approaches.

Growing Acceptance of CAM by the Public, Patients, and Practitioners

Growing acceptance of CAM is the result of both scientific advances and social trends. Conventional allopathic medicine is being influenced by increasing openness in Western culture to non-Western healing traditions in the context of accumulating research evidence for many CAM modalities and growing demands for more personalized care from medical practitioners—often difficult to achieve during brief appointments in managed care settings. These issues have led increasing numbers of individuals who see conventionally trained practitioners to seek concurrent treatment from CAM practitioners, including Chinese medical practitioners, naturopathic doctors, herbalists, chiropractors, homeopathic physicians, energy healers and others (Barnes et al., 2008). Approximately 72 million US adults used CAM in 2002, representing about one in three adults (Tindle, Davis, Phillips, & Eisenberg, 2005). If prayer is included in this analysis almost two-thirds of US adults use CAM therapies (Barnes et al., 2008). A systematic review of 51 studies based on 49 surveys conducted in 15 countries showed that CAM therapies are widely used in all world regions (Harris, Cooper, Relton, & Thomas, 2012). 52% of adults in Australia, 38% of adults in the USA, and 41% of adults in the UK (Harris et al., 2012; Posadzki, Watson, Alotaibi, & Ernst, 2013) used at least one CAM modality during the previous 12-month period. CAM is also widely used in European Union countries however use rates are difficult to estimate because of the poor quality of many surveys (Eardley et al., 2012).

The limitations of conventional Western medical treatments have led to growing openness to CAM among conventionally trained medical practitioners and researchers (Kurtz et al., 2004; Shoaib & Khaliq 2017). Physicians' attitudes toward CAM are complex, vary between countries and world regions and are difficult to estimate. In the EU countries over 300,000 registered CAM providers including both non-medical and medical practitioners provide a variety of CAM services including acupuncture, herbal medicines, naturopathy and other modalities (von Ammon et al., 2012). A systematic review of surveys of UK physicians on CAM use found that 39% refer patients to CAM and 46% recommend CAM (Posadzki, Alotaibi, & Ernst, 2012). Many physicians are trained in one or more CAM approach and incorporate it in their medical practice however some physicians who use non-allopathic approaches have little or no formal training in CAM raising issues of medical ethics, professional competence and education requirements of physicians (Posadzki et al., 2012). In Australia a large percentage of MDs trained as general practitioners are knowledgeable in CAM and treat patients using a range of non-pharmacologic therapies (Pirotta et al., 2010). Physicians' attitudes toward CAM have been studied for over two decades. A comprehensive literature review of findings of 25 physician surveys conducted in the USA between 1982 and 1995 found that approximately half of US physicians believe that acupuncture, chiropractic and homeopathy rest on valid medical principles, and frequently refer patients to CAM practitioners for these therapies (Astin, Marie, Pelletier, Hansen, & Haskell, 1998).

The authors found that for medical and mental health problems 43% of conventionally trained physicians refer patients to acupuncturists; 40% refer to chiropractors; and 21% refer to massage therapists. Twenty-six percent of US doctors surveyed believed that homeopathy is beneficial and refer patients to homeopaths or prescribe homeopathic remedies themselves. In contrast to those findings, a small survey of a random sample of California physicians conducted several years afterward found that while most physicians were interested in learning more about CAM, the majority discouraged CAM use because they were not knowledgeable enough about the safety or efficacy of CAM (Milden & Stokols, 2004). The above trends suggest that allopathic medicine in industrialized countries is rapidly moving toward a more eclectic paradigm in response to shifting practice patterns among conventionally trained physicians and growing public interest in CAM.

Survey findings consistently show that individuals who report a mental health problem are significantly more likely to use CAM therapies compared to the general population (De Jonge et al., 2017; Unutzer et al., 2000; Unützer et al., 2002). Over 138,000 individuals (ages 18–100) in 25 countries who participated in 28 surveys administered by the World Health Organization were asked about contact with CAM providers during the previous year (De Jonge et al., 2017). Overall 3.6% of persons who reported any mental disorder consulted a CAM practitioner compared to 5% of individuals with a mental health problem who resided in high income countries. Individuals with more severe psychiatric disorders were more likely to consult a CAM practitioner. For example, 14% of those diagnosed with a severe mood disorder; 16% diagnosed with a severe anxiety disorder and over 22% of those diagnosed with a severe behavioral disorder consulted a CAM practitioner for advice. These findings are consistent with earlier population surveys showing that most individuals who have mental health problems use prescription psychotropic medications and CAM concurrently (Eisenberg et al., 1998; Unutzer et al., 2000) and individuals complaining of more severe symptoms are more likely to combine allopathic and CAM modalities (Kessler et al., 2001).

Large numbers of children and adolescents also use CAM to treat mental health problems. Findings of the 2007 National Health Interview Survey were analyzed for a sample of over 5000 youth aged 7–17 who reported ADHD, anxiety or depressed mood in the past 12 months (Kemper, Gardiner, & Birdee, 2013). Almost one third who reported a mental health problem used at least one CAM therapy compared to less than 12% of age-matched individuals with a mental health problem. Natural supplements and mind–body approaches were the most widely used CAM therapies. Youth who were more likely to use CAM came from higher socioeconomic backgrounds, had chronic health problems, were taking prescription medications, or could not afford professional counseling.

One-third of individuals who report a history of generalized anxiety, mood swings, or psychosis use CAM approaches to treat their symptoms (Unutzer et al., 2000). A national telephone survey of over 3000 women found that over half of women complaining of depressed mood used CAM to treat their symptoms (Wu et al., 2007). Factors associated with higher CAM use in this population included being single, working, having self-perceived poor health, preferring more “natural”

therapies, and previous disappointing or unpleasant experiences with conventional allopathic treatments.

In the USA the rate of CAM use to treat mental health concerns is much higher than the global average. The 2007 National Health Interview Survey found that 37% of US adults reported one or more neuropsychiatric symptoms and accounted for $14.8 billion in out-of-pocket expenditures on CAM services or treatments (Purohit et al., 2015). Individuals who reported one or more neuropsychiatric symptoms had a disproportionately higher demand for CAM compared to individuals who reported no mental health problems. Individuals with moderately severe mental health problems also use CAM modalities and use rates are related to ethnicity and other demographic factors. A data set analyzed from the 2012 National Health Interview Survey (NHIS) found that approximately 40% of US adults across all ethnic groups diagnosed with a moderately severe mental health problem used CAM during the previous 12-month period (Rhee, Evans, McAlpine, & Johnson, 2017). In contrast, only 32% of adults who reported no mental health problems used CAM. Differences in CAM use by ethnicity ranged from 24% of African-Americans compared to 45% of Asians and almost 50% of other ethnic groups. Being female, younger, having completed college, residing in the Western part of the USA, being employed, and having functional limitations were predictive of relatively greater CAM use.

Out-of-pocket expenditures on CAM are growing in parallel with increased CAM use. In 2007, the last year for which data are available, $13.9 billion in out-of-pocket expenditures for CAM services in the USA were made by roughly 30 million adults ages 18 and older (Davis & Weeks, 2012). Of these, roughly seven million adults (one quarter of those surveyed) accounted for 70% of total expenditures.

Conventional Mental Health Care Training Is Becoming More Eclectic

Training opportunities in conventional mental health care such as psychiatry residency training programs and MA or PhD psychology programs includes limited coverage of CAM. Similarly, most CAM training programs offer limited or no opportunities for learning about or training in Western medicine. An exception is naturopathic medicine which involves rigorous study of the same “basic sciences” required in allopathic medical education. After completing formal training, many family physicians and psychiatrists seek out continuing education and mentorship opportunities in areas such as mind–body medicine, including mindfulness-based stress reduction, pain medicine, palliative care, biofeedback, or hypnotherapy, while others procure training in acupuncture or the prescribing of nutraceuticals (i.e., purified pharmaceutical grade botanicals and other natural product supplements). Because of their eclectic focus it is likely that residency training programs in family medicine and psychiatry will increasingly emphasize integrative mental health care by including validated CAM approaches in their curricula.

Integrative Mental Health Care Offers Clinical and Cost Advantages over Conventional Care

Integrative health care has become the de facto standard of care in USA and other industrialized countries because of rapidly growing acceptance of CAM by conventionally trained physicians and the increasing use of CAM in the general public. In this context of increasing acceptance, CAM therapies and prescription medications are frequently used together despite the absence of evidence for the safety or efficacy of particular combinations. This is an important safety concern because of potentially adverse interactions that may result when natural product supplements are combined with pharmaceuticals. In fact, while some natural product supplements have beneficial synergistic effects when combined with a particular pharmaceutical there is limited or no evidence supporting safe effective combinations of the majority of natural products and pharmaceuticals. On a practical vein, while numerous CAM therapies are widely used in combination with prescription medications however few serious safety issues have been reported.

The perspective of integrative medicine is that combining select Western medical and CAM treatments on a case-by-case basis offers more advantages compared to any particular Western medical or CAM treatment or any single system of medicine. Representative approaches used in integrative mental health care include taking a natural product supplement or prescription medication concurrently with dietary changes, yoga or other mind–body practices, bright light therapy, exercise, music therapy, and the so-called "energy" therapies such as Reiki and Qigong.

Integrative mental health care is *not* a substitute for skillful psychotherapy. When a patient has the capacity for insight and is motivated to do psychological work that will help him or her resolve conflicts or adapt to stressful circumstances, psychotherapy should be offered together with appropriate CAM or allopathic interventions.

In both Western medicine and non-Western systems of medicine the conceptual framework used to interpret a mental health problem will lead to recommendations of particular treatments regarded as appropriate and beneficial. The same is true when helping a patient to work through dynamic issues in psychotherapy. In contrast to supportive therapy or cognitive-behavioral therapy (CBT), existential and transpersonal psychotherapies are based on a synthesis of Eastern and Western psychologies and permit insights into a broader range of psychodynamic issues compared to more conventional insight-oriented therapy (Walsh & Vaughan, 1993). These more "synthetic" approaches in psychotherapy are analogous to integrative mental health care in that they provide the patient with a broader range of interventions than are generally available through more conventional forms of psychotherapy, thus enhancing opportunities for beneficial insights and psychological or spiritual growth.

In addition to improving effectiveness of conventional Western medical treatments, integrative mental health care may result in significant cost savings. Findings from economic modeling research suggest that while incorporating CAM into treatment may initially be costly, downstream savings can be achieved when integrative

strategies yield positive long-term outcomes (Herman, Craig, & Caspi, 2005; Pelletier et al., 2010). Similarly, systematic reviews of economic modeling studies on comparative cost-effectiveness of allopathic versus CAM or integrative treatments of many health conditions (including mental illness) suggest that both CAM and integrative treatment are cost-effective, and in some cases, provide cost savings (Herman, Poindexter, Witt, & Eisenberg, 2012). Finally, higher up-front costs of integrative treatment may be potentially offset by improved work productivity and increased future Quality Adjusted Life Years (QALYs) (Herman et al., 2005).

Developing Clinical Guidelines for Integrative Mental Health Care

The implementation of CAM and integrative approaches in clinical settings is highly varied and idiosyncratic, reflecting differences in personal values and perspectives of practitioners, and disparate goals and priorities of training programs and clinics or hospitals where integrative approaches are employed. Results of a survey of integrative clinics and training programs suggest that integrative medicine is evolving into a coherent set of values and a consistent model of care delivery and clinical therapeutics, as evidenced by an increase in the peer-reviewed journal literature and a trend toward increasing numbers of affiliations between integrative centers and hospitals, health care systems, and medical and nursing schools (Horrigan, Lewis, Abrams, & Pechura, 2012). Integrative mental health care is a strongly collaborative enterprise that fosters cooperation among practitioners from disparate backgrounds and between patients and practitioners.

A 2012 survey of integrative centers found that integrative approaches are perceived as successful when used to treat both medical and mental health conditions (Horrigan et al., 2012). In all integrative care models, comprehensive clinical assessment of each patient was regarded as the crucial first step to ensure a valid diagnostic formulation. In all centers, surveyed treatment approaches were considered only after a thorough review of published research evidence supporting their use for a specific medical or psychiatric condition and taking account of risks of adverse effects, cost, and availability. It is important to note that over half of survey respondents reported that depression and anxiety were successfully treated at their clinics using integrative therapies.

Key Points

- Integrative mental health care incorporating validated CAM modalities into mainstream treatment is an emerging paradigm that may more adequately address mental illness than current models of care.
- High prevalence rates and unmet treatment needs of patients with depressed mood and other serious mental illnesses in all world regions underscore the inadequacies of currently available conventional allopathic treatments, complementary and alternative (CAM) therapies, and existing models of care.

- After decades of research and billions of dollars of industry funding, the evidence supporting widely used pharmacologic treatments of major depressive disorder, bipolar disorder, schizophrenia, and other psychiatric disorders is not compelling.
- Limited effectiveness, safety problems, and high costs of many psychotropic medications have resulted in an urgent mandate for safer, more effective, and more affordable treatments of mental illness.
- Complementary and alternative medicine (CAM) therapies are widely used to treat mental health problems however relatively few have been strongly validated by research findings.
- The current allopathic model of mental health care delivery is limited in its capacity to alleviate the root causes of suffering because its theoretical foundations and clinical methods address only some of the complex causes and meanings of mental illness.
- Conventional allopathic medicine is being influenced by increasing openness in Western culture to non-Western healing traditions in the context of accumulating research evidence for select CAM modalities and growing demands for more personalized care.
- Increasing numbers of individuals who see conventionally trained practitioners are seeking concurrent treatment by CAM practitioners.
- Individuals who report a mental health problem are significantly more likely to use CAM therapies compared to the general population, and individuals complaining of more severe symptoms are more likely to combine allopathic and CAM modalities.
- Training in conventional mental health care includes limited coverage of CAM while CAM training programs offer limited or no opportunities for learning about or training in allopathic medicine.
- CAM therapies and prescription medications are frequently combined despite the absence of evidence for the safety or efficacy of particular combinations resulting in treatment delays and potential safety concerns.
- The perspective of integrative medicine is that combining select allopathic and CAM treatments on a case-by-case basis offers more advantages compared to any particular allopathic or CAM modality or any single system of medicine.
- Integrative mental health care may result in significant cost savings.
- Implementation of CAM and integrative approaches in clinical settings is highly varied and idiosyncratic, reflecting differences in personal values and perspectives of practitioners, and disparate goals and priorities of training programs and clinics or hospitals where integrative approaches are employed.

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