EDITORIAL

A Turning Point in Psychiatry

Targeting rapid symptom relief may be in psychiatric nursing's future.

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Over the past several decades, the apparent rise in mental illness, especially in our young people, has become one of the defining public health concerns of modern life. Whether viewed through global prevalence estimates, disability metrics, or day-to-day clinical demand for unavailable psychiatric beds, mental disorders now represent an enormous share of human suffering and health system strain. The reasons are not simple: part of what looks like an "increase" reflects better recognition, reduced stigma, and expanded screening, while part reflects real changes in risk exposure via social isolation, economic insecurity, substance use patterns, and chronic stress. Regardless of the mix of causes, the practical reality is the same—more people are seeking help and many are not getting well with the tools we have.

Global snapshots help illustrate the scale of the problem. The World Health Organization (WHO) estimates that in 2021, nearly one in seven people worldwide, about 1.1 billion individuals, were living with a mental disorder, the most common being anxiety and depressive disorders. The WHO notes that mental disorders account for a substantial portion of global disability, affecting education, employment, relationships, and physical health over a lifetime. A large-scale epidemiologic synthesis published in the February 2022 *Lancet* reinforces that the *overall* burden of mental disorders has not meaningfully decreased since 1990.

At the same time, "increase" can mean multiple things. Certainly, the number of people affected grows as populations grow and age. Screening strategies have expanded and are more widely used in primary care, schools, and workplaces. Public awareness campaigns and social media access have lowered barriers to naming distress and seeking treatment. Those shifts are, in many ways, progress. But the trend also highlights a deeper problem: despite decades of research and billions in spending, many patients cycle through treatments with limited relief.

That frustration is closely linked to a second observation: the core treatment paradigm for common mental illnesses has changed surprisingly little in roughly 40 years. In depression, for example, most medications prescribed today still descend from the monoamine depletion paradigm—where deficiencies in monoamine neurotransmitters (serotonin, norepinephrine, dopamine) are considered the causal feature of severe depression. Miller and Porter's historical review of antidepressant development (*Experimental and Clinical Psychopharmacol*ogy, 2015) notes that these drugs have primarily targeted monoamine systems, with the rise of selective serotonin reuptake inhibitors (SSRIs)/serotonin–norepinephrine reuptake inhibitors (SNRIs) reinforcing the "monoamine hypothesis." The approval of fluoxetine (Prozac) by the Food and Drug Administration (FDA) is often treated as a watershed moment. Many subsequent "new" antidepressants have been variations on reuptake inhibition or closely related mechanisms.

The same pattern can be seen in psychotherapy. Cognitive behavioral therapy, one of the most widely used evidence-based psychotherapies for depression and anxiety, was developed in the 1960s and remains a mainstay of treatment. Similarly, electroconvulsive therapy, still among the most effective options for severe or treatment-resistant depression, has been used since 1938, with modern practice improving safety, anesthesia, dosing, and stigma management rather than replacing the core method.

None of this means "nothing has improved." We have better adverse-effect management, broader access to therapy modalities (including telehealth), more structured measurement-based care, and newer neuromodulation options (for example, transcranial magnetic stimulation). But for many patients, the lived experience of treatment remains imperfect; relapse is common, and significant subgroups are "treatment resistant."

This is why the emergence of novel, rapid-acting treatments has drawn intense interest, especially ketamine-based therapies. Unlike traditional antidepressants that primarily target monoamines, ketamine and its derivatives act on glutamatergic pathways and can produce antidepressant effects within hours to days for some patients. In the United States, intranasal esketamine (Spravato) received FDA approval in 2019 for adults with treatment-resistant depression, representing a major mechanism shift compared with decades of monoamine-centered pharmacology. Regulatory attention has also underscored an important distinction for nurses: while esketamine is FDA approved for specific depressive indications, ketamine itself (as used in many private clinics, sometimes compounded or delivered in nonstandard formulations) is not FDA approved for psychiatric disorders and carries safety and oversight concerns.

In this issue, Braun and Colbert provide an update on the use of both esketamine and ketamine in mental health settings for individuals with treatment-resistant depression. Although the latter is not currently FDA approved, it has widespread support as a treatment, including from the American Psychiatric Nurses Association.

The promise of ketamine therapy is not that it will "replace" everything else, but that it may signal a broader turning point: psychiatry moving beyond slow-onset, monoamine-focused treatments toward interventions that target rapid symptom relief. If that trajectory continues—paired with careful monitoring by nurses, equitable access, and long-term outcome data—ketamine-derived treatments may be early indicators of psychiatric nursing's future: faster-acting therapies, more personalized care, and a psychiatric toolbox that finally looks meaningfully different from what clinicians have relied on for much of the last four decades. ▼

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