Editorial

Welcome! Why This Journal?

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Thank you for taking the time to read the inaugural issue of *The Primary Care Companion to The Journal of Clinical Psychiatry*. *The Primary Care Companion* is a publication that seeks to focus on primary care psychiatry and neurology in a way that is clinical in its orientation while maintaining standards of peer review that will make it a logical, attractive place to report on original research. We will strive to be eminently practical for clinicians and present current information on psychiatry and neurology in a logical and usable format. Those involved in academic and practice-based research will find a home for reports on deserving investigations that involve clinical practice or have the potential to be translated into patient care in a way that improves our understanding of illness and the quality of our practices. My own journey into practice and academic medicine underscores some of the intersecting issues that led to the creation of *The Primary Care Companion.*

My final year of family practice residency brought several poignant experiences in primary care psychiatry. One of my "problem" patients, a woman with dysthymia, was trying my patience. Anxious, somatic, relentless, she was making my life miserable with phone calls, emergency room visits, and office calls—even an admission for a chronic obstructive pulmonary disease exacerbation that was actually a panic attack. With her, it was always something, but never anything.

My residency had a very strong behavioral emphasis; I had wonderful attending physicians. I learned a great deal about family systems theory and psychodynamics. Dysthymia, according to everything I understood then, was a characterological illness . . . weak people making bad decisions and complaining about the consequences . . . no wonder the resulting depression was chronic.

One day in a fit of frustration, I gave the aforementioned dysthymic patient nortriptyline samples, with terse instructions to take 50 mg at night for 1 week, then increase the dose to 100 mg. She was to see me in 3 weeks; this just to get the visit to an endpoint.

Imagine my surprise when in 3 weeks she returned smiling, sleeping well, and in less somatic pain than she had experienced in 10 years. She eventually made a complete recovery. Stunned, I reconsidered the validity of my education and began to actively screen for and treat depressed patients. Initially, the experience was filled with scenarios and results like my first dysthymic patient, but as I identified and treated more patients, I quickly began to realize that a full response to antidepressant therapy was a coin flip in terms of predictiveness. Half of my depressed and anxious patients got excellent results, another fourth improved little or not at all. Most surprising, however, was the presence of a good 25% that responded erratically or at times got worse, particularly if I titrated the dosages of medication used! I certainly was not interested in complicating an illness, and there was nothing in standard texts or other materials on depression management that explained the phenomenon. Careful questioning for subtleties of vegetative and cognitive symptomatology made it apparent that complicated psychosocial contexts were not the sole culprit. Later, through the mentorship of 2 gifted psychiatrists, I learned that the cause of much of my confusion and poor management was the result of the effects of antidepressants on undiagnosed bipolar illness. This knowledge led to a deeper journey into psychopharmacology, clinical research, and many satisfying experiences treating complicated illness, while remaining a family physician at heart.

Where did my training fail me? Two weaknesses come to mind. My residency taught a biopsychosocial view of psychiatric illness that downplayed biological underpinnings in favor of systems theories and psychological constructs. As a result, psychopharmacology was relegated to second-line treatment for situations in which "superior" behavioral therapies were impractical. Second, since the complexity and heterogeneous nature of those biological realities have only recently come to light in the psychiatric literature, no consensus view embracing these data existed to be passed on to generalists. This was compounded by a training program that limited exposure to psychiatrists who practiced effective psychopharmacology in favor of interactions with nonphysicians whose philosophies neither stressed inherited biological vulnerability nor modeled such interventions. This view is still the predominant paradigm for psychiatric training in family medicine.

In time, my experience in private practice led to research questions and a desire to teach physicians in training some of the things that I have learned. I can testify to the fact that the paradigm can be changed. Generalist physician experts in primary care psychiatry are the natural role models for a fresh approach to practice and the development of new curricula. We have integrated these ideas in our department in part through the development of mood disorder clinics that function as teaching laboratories. In these clinics, family physician experts, nonphysician behaviorists, and resident physicians meet together with patients who are treatment resistant, present diagnostic dilemmas, or are in need of acute care. The result is a unique opportunity to model an advanced approach to the care of our patients and a rich experience where biopsychosocial contexts are assessed and used to design balanced treatments. Our residents learn about family systems theory, brief psychodynamic therapies, and how to use lithium and valproate. Our research has yielded fruit, but we have not always found existing primary care journals open to novelty, even when based on evidence from practice.

Many others have similar experiences. Not only did we find mind-body dualism impractical, we discovered that discarding the concept brought significant rewards. Some, like me, have returned to "clinical academics," hoping to become insiders with a chance to educate young physicians and translate newer concepts of illness and treatment into the language of practice. Not surprisingly, the experience of practice brings great power to education.

For all of these reasons, a new forum for dialog is vital. This editorial board pledges a journal that will always retain a clinical focus true to your practice experience. We will bring you information on new concepts in diagnosis and treatment that offer expertise within the reach of interested generalists. The *Companion* will be academically sound. We will welcome contributions from frontiering researchers. We believe in a balanced biopsychosocial view of illness. We will be multidisciplinary, inviting contributions from others who have insights to share regarding primary care psychiatry. The *Companion* is very interested in publishing reports on the integrated delivery of general and behavioral health care and would like to be an advocate for such approaches.

This inaugural issue is targeted to family physicians and internists identified as already providing an advanced level of psychiatric care. Your comments are appreciated. We are open to communication and invite your input; this journal is a work in progress.

Finally, I would like to thank those on the editorial board for participating in a new venture. Their commitment to the advancement of clinical science is also greatly appreciated.

Enjoy *The Primary Care Companion to The Journal of Clinical Psychiatry*.

—J.S.M.

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