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Editorial

Five Years Old and Growing

With this issue, *The Primary Care Companion to The Journal of Clinical Psychiatry* is 5 years old. I am delighted to assume the editorship. Through its first 4 volumes, J. Sloan Manning, M.D., has provided outstanding editorial leadership—leadership that has clearly demonstrated the importance of a journal that provides primary care clinicians and mental health professionals working with them an outlet for original research and guidance regarding the integration of mental health care with primary care. We anticipate Sloan's continuing work with the *Companion* as he enters a new phase of his career.

The need for the *Companion* is greater than ever. In recent years, several primary care journals have retrenched or gone out of business, and none address priorities at the intersection of psychiatric and primary care in the way the *Companion* does. Yet, the potential for real improvements in outcomes for our patients through the integration of psychiatric and primary care has never been greater.

As we increase our understanding of this nexus, it becomes abundantly clear that if primary care physicians do not provide this integration, they will not be able to adequately treat patients. For example, the World Health Organization forecasts that soon major depression will be the second most disabling illness worldwide.[1] The United States Preventive Services Task Force in mid-2002 recommended for the first time that primary care clinicians should initiate routine screening for depression and should activate their practices to support adherence to therapy for those depressed.[2] Several large practice groups have demonstrated major improvements in retention in care, adherence to treatment, and attainment of remission when such care is provided.[3] Key components of such care include not only screening and treatment initiation by the primary care clinician, but specific patient education, measurement and tracking of treatment response, and collaboration between primary care, case management, and psychiatric clinicians.[4]

Numerous studies demonstrate that depression is several times more common among those with chronic medical illnesses, and that depression not only contributes to the initial development of such disease, but also substantially increases the rate of complications and early mortality from them.[5] The Sertraline Antidepressant Heart Attack Randomized Trial (SADHART) has demonstrated the potential for safe treatment of depression immediately post–myocardial infarction and holds the promise that such treatment is among the most powerful interventions available to decrease cardiac mortality.[6] Similar National Institutes of Health–funded studies currently underway will likely demonstrate the same for diabetes. Thus, we are entering an era in which primary or specialty care of chronic disease that does not include integrated attention to depression will simply be substandard care.

More recently, we are recognizing that the anxiety disorders are chronic and devastating to our patients and that, even though treatable, as with depression, they are often neither recognized nor treated in primary care.[7] Our evolving understanding of the complex relationships between the anxiety and mood disorders and their substantial overlap will lead to new treatment and prevention opportunities. Both genetics and environmental factors have major influence. The frequent early-in-life development of social anxiety disorder, which places sufferers at increased risk of developing other anxiety disorders and depression during adolescence and early adulthood, is emerging as an important concept. Although not yet demonstrated by prospective data, the observation that early treatment of social anxiety and generalized anxiety disorders decreases the need for treatment of anxiety and depression later in life suggests the potential for prevention of not only the immediate school-related and other functional impairments of children and adolescents who suffer from anxiety, but additional psychiatric and chronic medical illness during their adulthood.

At the same time that our understanding of these disease relationships is emerging, so is our ability to effectively treat psychiatric disease in the primary care setting. With the release of the selective serotonin reuptake inhibitors, the practical ability of primary care physicians

to treat mood and anxiety disorders exploded. The past decade has led to our understanding not only of the breadth of efficacy of such medications, but of the importance of immediate and long-term side effects and of the potential for drug-drug interactions to limit the acceptability of such agents. More recent development of serotonin-norepinephrine reuptake inhibitors, atypical antipsychotics, mood stabilizers, and other novel agents is further increasing our treatment capacity. Currently there are over a dozen agents in phase 2 or 3 trials for depression and a similar number for the anxiety disorders. Potent agents also are under development that might revolutionize the treatment and prevention of substance abuse and other disorders presenting in primary care settings.

In addition, we are expanding our understanding of the limits of medication and the benefits of such psychotherapeutic approaches as monotherapies, adjunctive therapies, and follow-on therapies. The recent Institute of Medicine report, *Reducing Suicide: A National Imperative*,[8] has drawn attention to an important reality: depression and suicidality might not be synonymous, even though they are highly overlapping. Depression is present in over 90% of those who commit suicide, and the effective treatment of depression usually reduces the incidence of associated suicidality. However, even when remission is attained, if the patient's outlook on life remains one of "hopelessness," a significant risk for suicide might persist. Further, psychotherapies, particularly cognitive-behavioral therapy, can be effective treatments to intervene in this continued suicidality, through helping patients change their outlook and established means of relating to the world.[8]

The role of the *Companion* is to help primary care and psychiatric clinicians understand the interdisciplinary concerns of medicine and psychiatry, and to provide guidance in evolving treatment strategies that improves patient outcomes. To this end, we will continue to seek submission of original research and manuscripts that describe the experience of nonpsychiatrists who provide mental health services to their patients. Such original research is the bedrock upon which evidence-based improvements in practice will evolve. We also will publish manuscripts that help the clinician integrate such new knowledge into daily practice. These will include traditional reviews that synthesize the literature, as well as expert discussion in the style of grand rounds. We will continue the diary reports, which serve to provide insights into the commonality of our clinical experience across practice settings and specialties and convey at times invaluable clinical pearls. Not only through such articles in the core journal, but also through topic-related supplements, we will inform you, our readers, of advances in the recognition and treatment of psychiatric problems. America is a country of diversity, racial and cultural as well as economic. Primary care clinicians consequently must be prepared to respond to the needs of, and adapt their advice and treatment to, patients of all backgrounds. To this end, we anticipate starting a series of articles that guide such culturally responsive care.

For the *Companion* to continue to meet the needs of our readers, we must hear from you (e-mail us at primarycare@psychiatrist.com). What are your priorities? What would you like to see more of in the *Companion*? What should we change? As we continue to provide practical and current information on psychiatry and neurology, your input is essential.

Over the next decade, we anticipate that the *Companion* will expand to become the leading forum for clinical care at the junction of psychiatry and primary care. We look forward to the continuing opportunity to provide insights that will improve the ability of primary care clinicians and our psychiatric colleagues to better the lives of our patients and their families.

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