Introduction

Depression and Anxiety: New Tools for Diagnosis and Treatment

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This special symposium brings together 7 experienced researchers who have devoted their careers to improving the recognition and treatment of mental illness in both primary care and mental health systems. Methods to improve recognition of anxiety, depression, somatization, and suicidal behavior will be described as well as the development of evidence-based treatment guidelines and exciting, pharmacologic treatment advances.

Dr. Hirschfeld's article helps frame the other presentations in this supplement in an historical context. Dr. Hirschfeld describes the fundamental developments in the evolution of American medicine in the 20th century and how the treatment of mental illness fits into this framework. Two new developments, including the advent of serotonin reuptake inhibitors and the emergence of managed care, are described as having major potential impacts on the treatment of mental illness. Dr. Hirschfeld poignantly describes the gap between the fact that effective treatments have been developed in the last 2 decades but few patients are receiving them, especially in the primary care setting.

The article by Dr. Panzarino emphasizes that major depression is one of the most common illnesses primary care physicians treat but that it frequently goes undiagnosed. Depression is associated with increased medical costs due to increased visits for unexplained medical symptoms such as fatigue and headache and more functional impairment than seen with most chronic medical illnesses. Moreover, when depression is comorbid with chronic medical illness, it is associated not only with additive functional impairment but also with increased mortality.

Dr. Schwenk and colleagues describe findings from the decade of research in the Michigan Depression Project which show that (1) significant demographic and clinical differences exist between depressed patients presenting in primary care versus psychiatric practices; (2) detection rates of major depression in primary care are actually much higher than in the past, especially when significant functional impairment is present; (3) severe life events and medical comorbidity are more likely to be present in primary care patients with depression, making diagnosis more complex; and (4) primary care physicians, by nature of their longstanding relationships with patients, appear to employ historical cues in assigning the diagnosis of depression.

Dr. Walker and I emphasize that 50% to 70% of patients with DSM-IV psychiatric disorders present to primary care physicians with medically unexplained symptoms such as fatigue or headache. Patients with psychiatric disorder who present with medically unexplained symptoms or amplification of symptoms of chronic medical illness are most likely to have their psychiatric disorder misdiagnosed. Patients with medically unexplained symptoms and those with comorbid psychiatric and chronic medical illness frequently receive multiple medical workups resulting in high medical costs. We describe several screening

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scales that have high sensitivity and specificity in identifying patients who are somatizers or meet DSM-IV criteria for hypochondriasis.

Dr. John Rush, the chairman of the multidisciplinary panel of experts that developed the Agency for Health Care Policy and Research (AHCPR) Depression Guidelines in Primary Care, along with his colleagues discuss the rationale for and critical issues in the development of evidence-based medication algorithms and the timely use of symptom measures to ensure proper implementation of guidelines. They also review the important health policy and educational issues that have to be addressed for the 3 stakeholders involved in the implementation of guidelines—the patients and their families, clinicians, and health care administrators. They address the fact that excellent consensus guidelines and algorithms based on available reviews of evidence are the first important step in improving the quality of care, but we are still struggling with how to *implement* these steps, especially in an environment of health care budget cuts.

Dr. Shea describes the development of a unique interview method for primary care physicians and mental health professionals to evaluate a patient with suicidal ideation, plan, or attempt. The Chronological Assessment of Suicide Events (CASE Approach) helps the clinician to uncover critical data in 4 overlapping time frames: (1) presenting suicidal ideation/behavior, (2) recent suicidal ideation/behaviors, (3) past suicidal ideation and behaviors, and (4) immediate suicidal ideation. Prior studies have shown that at least half of the patients who attempted suicide had visited a primary care physician within the previous 2 months. This innovative method to teach interview techniques with suicidal patients has the potential to increase the primary care and mental health clinicians' ability to accurately diagnose the potential lethality of suicidal ideation and plan.

Dr. Sheehan and colleagues describe the development of a short structured diagnostic interview—the Mini-International Neuropsychiatric Interview (MINI)—that was developed jointly by clinicians in the United States and Europe to identify DSM-IV and ICD-10 psychiatric disorders. The interview takes approximately 15 minutes and has been validated in relation to the Structured Clinical Interview for DSM-III-R, Patient Version (SCID-P), the Composite International Diagnostic Interview (CIDI), and expert professional opinion. It can be used as a structured interview for multicenter trials, epidemiologic studies, and outcomes tracking in nonresearch settings.

Dr. DeVane reviews the pharmacologic characteristics and the pharmacokinetic and pharmacodynamic similarities and differences in the 4 serotonin reuptake inhibitors as well as the newer agents such as nefazodone, venlafaxine, and mirtazapine. Two agents that are likely to be released in the next year, i.e., citalopram and reboxetine, are also reviewed in depth. The therapeutic and side effects of these agents are compared and contrasted.