# Introduction

# Optimizing Outcomes of Treating Depression: Meeting Patient Expectations

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Over the past decade, numerous epidemiologic studies have revealed the high prevalence of depressive disorders and elucidated the magnitude of the individual suffering and societal burden associated with depression.[1,2] Based on data from the Global Burden of Disease Study, depression is projected to be the second leading cause of disability among all medical conditions investigated by the year 2020.[3] This finding comes at a time when several treatment options for depressive disorders have been proved efficacious and safe in at least reducing the impairment and disability associated with depression, yet numerous studies reveal the troubling finding that more than 50% of all depressive episodes remain untreated.[1,4] While this deficit may be partly attributable to depressed patients' lack of health care seeking, unsatisfactory illness recognition, diagnostic imprecision, and inadequate knowledge of treatment options by primary health care providers and specialists are likewise main contributors to the undertreatment of depression. In addition, there is evidence that among patients receiving treatment, the therapeutic regimen may be suboptimal in terms of type, dosage, and length of treatment.

The articles in this supplement address issues relevant to current trends in the clinical management of depression, highlighting a critical strategy in optimizing the treatment of depression, i.e., setting the treatment goal toward the attainment of remission rather than simply an attainment of symptomatic improvement.

In our article, my colleagues and I present an overview of relevant epidemiologic issues in depression, focusing on the size and breadth of the problem as well as raising critical issues from a needs evaluation and health care policy perspective. The current weaknesses of community and primary care sectors in the management of this mood disorder are elaborated. A case is made for optimizing the role of primary care physicians as gatekeepers and health care system conduits. Primary care physicians have the potential to detect and treat depressive symptoms at an early stage of patient access to care; they can also channel patients with more severe cases of depression to a mental health specialist.

The other 3 articles feature several recent clinical approaches to optimizing the treatment of depression. David Bakish, M.D., elaborates on the current goal of treating depression toward achieving remission rather than limiting expectations to a treatment response. There is ample evidence that patients who respond to treatment might still have subthreshold symptoms that could prolong functional impairment and increase the likelihood of relapse. Current and future strategies for the attainment and maintenance of remission, a focal point and challenge for the treating physician, are discussed in this article.

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Ian Nicol Ferrier, M.D., characterizes the pharmacologic properties of antidepressants, such as selectivity, potency, synaptic effects, and dose-response relationship, that enhance therapeutic efficacy. He comes to the conclusion that there are clinical advantages of antidepressants with a dual mechanism of action (i.e., engaging serotonergic and noradrenergic systems) over agents with a single mechanism of action, particularly in regard to the facilitation of remission.

Jeffrey E. Kelsey, M.D., Ph.D., provides a broad clinician perspective on approaches to achieving and maintaining remission. In light of a paucity of long-term efficacy studies in depression, he emphasizes that the long-term management of depressed patients, with remission as the ultimate goal, frequently requires the consideration of a full spectrum of therapeutic options including psychotherapy, pharmacotherapy, and/or a combined regimen. The choice of the most promising therapeutic approach should be based on aspects of the patient's background such as age, assumed disease pathogenesis, current health status, and medical and psychiatric history as well as past and current comorbidities. Dr. Kelsey highlights the need for increased attention to relapse or recurrence prevention, a strategy that is consistent with setting treatment goals toward remission.

Shelia S. Singleton provides a patient's perspective on depression and its dramatic impact on social functioning, the life course, and the social network. Her article underscores the importance of a stable and positive patient-doctor relationship that should complement the pragmatic diagnostic and treatment approaches.

The current and projected socioeconomic impact of depression should forcefully trigger clinicians to reevaluate current diagnostic and treatment practices, modify the practices to improve outcomes, and aim for more than just response and improvement. A more aggressive treatment approach is necessary because a partial response to treatment with persistent residual psychopathology is a powerful risk factor for relapse that, ultimately, leads to an unfavorable prognosis. Beyond the need for patient educational initiatives to improve health care–seeking behavior, patient access to care should be enhanced, particularly by improving the recognition and diagnostic skills of primary care doctors, who are frequently the clinical gatekeepers in most industrialized countries. It is noteworthy that excessive diagnostic sophistication may actually be a significant "barrier" for improved care because a tentative primary care diagnosis of "probable depression" alone increases the likelihood of receiving proper psychiatric care.[5] Given the available arsenal of treatment options, the ideal treatment goal should be remission, because the attainment of this asymptomatic state considerably improves the long-term prognosis of the patient, subsequently easing the socioeconomic burden of depression.



## REFERENCES

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