On the (examination) couch: psychotherapy for depression in general practice

Psychotherapeutic treatments can be matched to individual patient requirements and delivered effectively in general practice.

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Depression, which is one of the most common problems encountered in general practice, tends to be a chronic, recurrent disorder. Research suggests that short term psychotherapies work as effectively as antidepressants in treating mild to moderate depression and can be delivered effectively in primary care settings.[1-4] When given an option, patients tend to prefer psychotherapy.[5] Yet a recent database review of Australian general practices showed that over 90% of patients diagnosed with depression are prescribed antidepressants, with few receiving a recognised depression-specific psychotherapy.[6]

What are the barriers to using psychotherapy in general practice? Obvious ones include time pressures and the lack of availability of accessible training and support. However, other factors also appear to be at work. A recent survey of 420 Australian GPs yielded some interesting results.[7] Non-pharmacological therapies (psychotherapies) were much more likely to be used by female GPs, GPs in urban areas and those who had undertaken additional mental health training. More generally, GPs who feel better able to distinguish between depression and unhappiness and who find treating patients with depression rewarding are more likely to initiate psychotherapeutic treatments.[8]

This article summarises psychotherapies that are available in general practice and makes some clinically informed suggestions about matching treatments to individual patients.

What is psychotherapy?

Psychotherapy has been defined as an interpersonal process designed to bring about modifications of feelings, cognitions, attitudes and behaviour that have proved troublesome to the person seeking help from a trained professional.[9] Michael Balint, the Hungarian-born British psychoanalyst, recognised that every doctor–patient encounter is inherently psychotherapeutic. Empathy, thoughtfulness, a positive regard for the patient and willingness to

IN SUMMARY

- **Patients prefer psychotherapy. It should be considered as a first line treatment in uncomplicated mild or moderate nonmelancholic depression.**
- **Supportive counselling, cognitive behavioural therapy (especially problem solving) and interpersonal psychotherapy have been shown to be effective in primary care settings.**
- **Short forms of interpersonal psychotherapy and cognitive behavioural therapy (four to six 30 minute sessions) have been developed for general practice.**
- **Add a first line antidepressant if no benefit after four to six sessions.**
- **Substance abuse, a personality disorder or acute intercurrent stressor should be excluded in patients who do not respond to psychotherapy.**
- **Specialist review is indicated for patients with suicidal ideation, mania or psychosis, and for patients with progressive or treatment-resistant depression.**

hear his or her story are the foundations of any good psychotherapeutic relationship.

How effective is it?

Research in psychotherapy is methodologically complex, and it is difficult to conduct studies of adequate power and duration because there is no incentive for large pharmaceutical companies to fund them. Nevertheless, the results of existing research are surprisingly consistent, showing that skillfully delivered, depression-specific psychotherapies are as effective as antidepressant medication for mild to moderate depression.[10] Overall, about 50% of patients receiving psychotherapy alone will achieve full remission of symptoms, but about half of these will develop recurrent symptoms after one year without some kind of maintenance treatment. These figures may sound disappointing, but they are very similar to those seen in longer term trials of antidepressants and reflect the fact that depression tends to be a recurrent or persisting disorder for many people.

What types of psychotherapy are available?

More than 400 schools of individual psychotherapy have been described, but it is helpful to think of them as occurring within three streams:

- **Counselling and supportive psychotherapies (sporting analogy: beach cricket).** Like beach cricket, counselling and supportive psychotherapies can begin spontaneously with a minimum of equipment. The primary requirements for both endeavours are goodwill, enthusiasm and a bit of space.
- **Structured psychotherapies (sporting analogy: one-day cricket).** These include cognitive behavioural therapy (CBT) and interpersonal therapy. Like one-day cricket, they are highly structured, time-limited and require the acquisition of specific skills and regular coaching.
- **Intensive psychotherapies (sporting analogy: test cricket).** These tend to be longer term therapies, and aim to achieve far-reaching changes in personality and attachment style. Like test cricket, they are redolent of a more sedate age: seemingly inconsistent with the pace of modern life, somewhat unfashionable, and having no guarantee of a positive outcome. They are full of arcane lore known only to initiates, and are really vocations to which a practitioner needs to devote the majority of a working lifetime.

A guide to selecting a psychotherapy is presented in the flowchart on page 28, and the key features of the types discussed in this article are summarised in the Table.

Counselling and supportive therapy

Most GPs engage in some form of counselling. Examples include encouraging patients to increase their physical activity and social contacts or to reduce drug and alcohol use, and educating them about sleep hygiene and problem solving strategies.[2,10] In this article, the terms counselling and supportive psychotherapy are used as near-synonyms, but they can be seen, respectively, as the directive (active) and supportive (containing) ends of nonspecific psychotherapy. Supportive therapy is best thought of as thoughtful and practical advice given to a person in emotional distress, with an additional 'halo' effect conferred by the patient's perception of the doctor as a respected and impartial source of help. In psychological jargon, supportive therapy 'emphasises the mobilisation of strengths to enhance self-esteem and utilise adaptive defences and positive coping skills'.[10,11]

These approaches have long been regarded with disdain by practitioners of more structured

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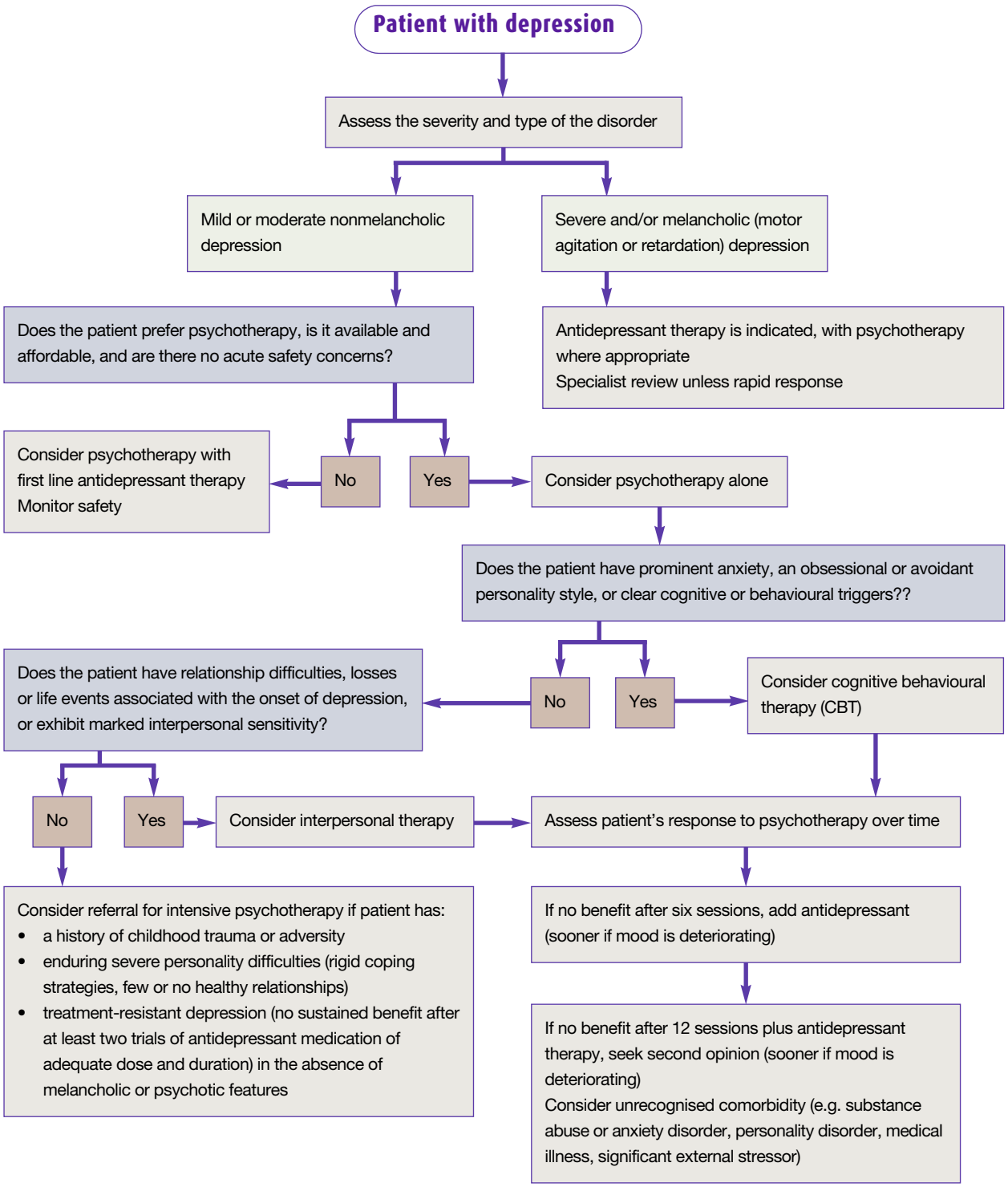
An approach to choosing a psychotherapy for depression



psychotherapies, but research has shown that many patients achieve significant improvements in depressive symptoms and interpersonal functioning. They may be particularly useful for people whose symptoms are related to an acute stressful event and for those with poor social functioning and limited insight that preclude more intensive therapies. In syndromal depression, however, studies suggest that benefits are modest and not sustained.[2,4]

Cognitive behavioural therapy

CBT, as the name suggests, is a synthesis of behavioural techniques such as operant conditioning, in which depression reinforcing habits are discouraged while more active and pro-social behaviour is encouraged, and cognitive theory, which assumes that unhelpful styles of thinking reinforce depression and require challenge. Common CBT strategies used in depression include identifying and challenging cognitive distortions, behavioural activation, structured problem solving and, where anxiety is also present, controlled breathing and progressive muscle relaxation. There is a strong evidence base for the effectiveness of well delivered cognitive behavioural interventions in depression of mild to moderate severity. A brief format (four to six sessions of 30 minutes) has been adapted for GPs by a group at the University of California, San Diego.[3]

A Cochrane review has shown specific evidence for the effectiveness of problem solving for treating depression in general practice.[12] This involves the patient formulating a problem in his or her life in clear and unambiguous terms (e.g. 'My husband is having an affair' or 'I hate my job') and then generating as many potential solutions as possible, no matter how outlandish or impractical they might seem. The patient and therapist then review the pros and cons of each suggested solution before deciding which one to implement. The outcome is reviewed and, if necessary, alternatives are generated.

Mindfulness-based cognitive therapy, which borrows a number of stress reduction techniques from meditation and Zen Buddhism, has received considerable publicity recently. It has shown benefit for stress management and as a specific treatment for depression in several small studies.[4,13] It may have specific utility in relapse prevention.

GPs interested in learning more about CBT can do so through the Better Outcomes in Mental Health initiative of beyondblue (www.beyondblue.org.au) or by contacting SPHERE, a national mental health project (www.spheregp.com.au). Excellent material is also available through the Black Dog Institute's GP workshops, part of the 1301MH initiative (accessed through www.racgp.org.au/mentalhealth), as well as the Mental Health Standards Collaboration (www. racgp.org.au). Individual or group supervision in CBT can be accessed through State or Territory branches of the Royal Australian and New Zealand College of Psychiatrists or the Australian Psychological Society.

Interpersonal therapy

Interpersonal therapy was initially developed as a time limited, weekly therapy for depression, relating patients' symptoms to difficulties in their relationships. It uses a more flexible approach than CBT and is more similar to psychodynamic psychotherapy than CBT.

In interpersonal therapy, depressive symptoms are related to one of four problem areas: grief and loss, role transitions, interpersonal disputes, and interpersonal sensitivity. After taking a careful history and establishing the diagnosis of depression, the therapist assists the patient in making an inventory of significant relationships. Several of these relationships are then discussed in detail, focusing particularly on areas of difficulty, differing expectations and indirect communication. Using a variety of techniques, including communication analysis and role play, possible solutions to interpersonal difficulties are explored. Interpersonal therapy borrows freely from other psychotherapies, but it focuses on current rather than past relationships and the therapist takes an active and directive stance. Further information can be found on the website of the International Society for Interpersonal Psychotherapy (see www.interpersonalpsychotherapy. org).

A brief form of interpersonal therapy (four to six sessions of 30 minutes), known as interpersonal counselling, has been developed, which is tailored for use in general practice.[14] GPs in New South Wales and Victoria who are interested in training and supervision in interpersonal counselling can contact Associate Professor Kay Wilhelm at the School of Psychiatry, University of New South Wales, Sydney, and Professor Fiona Judd at the School of Rural Health, Monash University, Melbourne, respectively.

Intensive psychotherapies

Intensive psychotherapies, which are also known as psychodynamic or insight-oriented psychotherapies, aim to alter fundamental aspects of personality structure. The patient is seen frequently (at least weekly) and usually for a prolonged period (for at least six months and sometimes several years), although short term dynamic therapies have been developed. Intensive psychotherapies often focus on trauma in early life, particularly attachment disruptions with caregivers. Conflicts are often acted out in the sessions, and the therapist's analysis of unconscious feelings evoked in both the patient and therapist (transference and counter-transference, respectively) is an important aspect of treatment.

The evidence for the cost effectiveness of these treatments in uncomplicated depression is limited, but it should be remembered that there are formidable barriers to conducting research in this area because of the many potential variables in patient, treatment and therapist and the difficulty in identifying the 'active' element of therapy. There is, however, accumulating

evidence that these approaches may be appropriate for patients with treatment-resistant depression, a comorbid personality disorder or a history of childhood trauma, for whom both pharmacological treatments and short term psychotherapies lead to little sustained benefit.[4] For such patients, referral to a psychodynamically-trained psychiatrist, GP or nonmedical therapist should be discussed for assessment of their suitability for intensive psychotherapy.

Summary

Patients consistently express a preference for psychotherapeutic treatment of mild to moderate depression over pharmacotherapy, but the pressures of time, cost and availability militate against this. Interested

Table. Psychotherapy: what to use, and for whom*

Patient profile	Duration	Requirements	Techniques	Goals
Counselling and supportive therapy				
Patients with depressive symptoms associated with an acute stressful event, poor social functioning or limited insight	4 to 16 sessions, weekly	Empathy, common sense, positive regard for the patient	Empathic reflection, concrete advice	Enhanced self-esteem, initiation of positive changes, emotional expression
Cognitive behavioural therapy (CBT)				
Patients with mild or moderate depression, especially if comorbid anxiety or obsessional traits are present	4 to 16 sessions, weekly	Additional training, supervision	Identification of core beliefs, behavioural activation, structured problem solving; controlled breathing and progressive muscle relaxation (for associated anxiety)	Correction of cognitive distortions and dysfunctional core beliefs, modification of 'depressogenic' behaviours
Interpersonal psychotherapy				
Patients with mild or moderate depression, especially those experiencing relationship difficulties, interpersonal conflict, grief and loss, role transitions or interpersonal sensitivity	4 to 16 sessions, weekly	Additional training, supervision	Relationship inventory, problem identification, communication analysis	Improved communication, adjusted interpersonal relationships
Intensive psychotherapy				
Patients with a personality disorder or history of childhood trauma or adversity, selected patients with treatment-resistant depression	Frequent sessions, at least weekly, over more than 16 weeks	Formal training, rigorous supervision and peer group review; possibly personal therapy	Exploration of early life trauma, analysis of defence styles, transference monitoring	Development of insight, adoption of mature defences, reduced self-defeating behaviours, achievement of acceptance

* Adapted from reference 15.

GPs can receive training and supervision in a depression-specific psychotherapy, or consider developing a referral network of practitioners. Counselling or supportive therapy may be helpful for patients with acute adjustment difficulties and for those who are unable to be engaged in more structured therapies. Cognitive behavioural techniques, especially problem solving, and interpersonal psychotherapy are effective in treating depression in general practice settings, but patients may require less frequent 'maintenance' sessions to achieve enduring benefits. Finally, in patients who do not respond to structured psychotherapy, consider addition of an antidepressant, exclusion of a comorbid disorder, review by a psychiatrist, and referral for intensive psychotherapy. MT

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Further reading

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