The integration of PHC with behavioural sciences: talking treatments by GP's for emotional symptoms as alternative for pills

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Background

In primary care many patients present with emotional symptoms[i,ii,iii]. Sometimes patients have a depressive or anxiety disorder but more often the symptoms do not fulfil the criteria of a full-blown mental illness. Psychological distress is frequently presented through physical symptoms and persisting medically unexplained symptoms (MUS) are very common in general practice[iv]. In most cases watchful waiting is justified for some time, but if symptoms persist and the patient turns to the general practitioner (GP) for help, the question arises which of the available treatment options is best for that specific patient.

Medication could be an option. However, in General Practice the effectiveness, for instance of antidepressants for depression, is less than often believed, and for 'depressive symptoms' and in MUS and the milder end of the spectrum there is no indication to prescribe them at all[v].

Even if there is an indication, for instance a depression, many patients don't want medication. They often experience too many side effects, the medication has interactions with other medications or the patient has other diseases with contraindications for antidepressants. For these patients the various psychological treatments are an alternative as they can be as effective as medication.

But for many of these treatments a referral is needed. Furthermore, therapists are not always available or accessible for patients.

It would therefore be welcome if more GP's themselves could deliver effective 'talking treatments' for frequently presented symptoms and syndromes.

Brief Psychological treatments

In this context one of the options for patients presenting with more chronic MUS is reattribution, a Cognitive Behavioural (CB)-technique that can be used by GP's effectively as a first step of treatment[vi,vii][ref]. Another brief psychological treatment for GP's is Problem Solving Treatment (PST), also derived from CBT, which is effective for a variety of emotional pr psychosocial problems in primary care[viii,ix,x,]. It can be used as treatment for depression, but also as part of programmes for management of chronic illness[xi,xii,xiii,xiv] and as a preventive strategy[xv]. It can be delivered GP's, if they are motivated for psychological treatment and trained properly [ref].

Reattribution for MUS

The first step in MUS is to ensure the patient, who is worried and experiences symptoms he or she does not understand, feels understood. This can be achieved by taking a full history and carrying out a focussed physical examination. If nothing abnormal is found, the physician reassures the patient. Frequently, in addition to going through all normal test results, it is also necessary to explain how problems or unfavourable conditions in one s' life can lead to physical symptoms.

For more chronically somatising patients this explanation is not enough. In those cases the first step of the reattribution technique also contains negotiating and some further testing before moving on to the next step: changing/broadening the agenda. In this step a link is made between physical and psychological/emotional symptoms. To be able to do this effectively it is better not to talk about

(emotional) problems but about 'circumstances', or 'life-style matters' or 'what is going on in your life'. For patients who cannot see a link themselves it might help to try and find a link together. The patient is invited to keep a journal which should include data of 'when the symptoms are present' and 'what the patient was doing/thinking' as well as 'how he or she reacted to the symptoms' and is invited for a follow-up visit bringing the journal. GP and patient look at the journal together in order to find patterns and make the links needed to change the agenda together. If the patient accepts a link the GP explains how stress and tension lead to physical symptoms again. If this explanation is not reassuring enough it is important to then discuss how to move from there and negotiate further (psychological) treatment. The results of research about the effectiveness of reattribution alone are modest, but as first step to help patients accept further treatment it offers patient and GP support.
In MUS patients with practical every-day life problems PST could be one of the options for further treatment.

Problem Solving Treatment

This treatment is certainly an option in patients with mild to moderate depression.
The technique is used to (further) increase the patient's understanding of the link between their current symptoms and their everyday problems as an expected part of everyday living, and to show that effective resolution of such problems will help to improve how they are feeling. It is a brief psychological treatment consisting of 4 – 6 sessions of about 30 minutes each over a period of approximately 9 weeks total. For patients with a mild to moderate depressive disorder the treatment is as effective as antidepressants (and therefore a good alternative), and more effective than care as usual [7]. There is also evidence that PST is effective as part of various (self) management programmes for chronic illness for instance Diabetes and Rheumatoid arthritis, as prevention and for various other indications [8-13].
During every PST-session and at home between sessions a specific problem-solving procedure is used in an attempt to solve problems in a structured way[xvi].
The patient learns seven steps of problem solving, initially working together with the GP on one of his or her current problems, but gradually taking over control and doing the same thing on his own. The patient regains control and having a more positive experience regarding his or her own ability to solve problems is empowering.
There are 7 stages in problem solving treatment, with 7 clear steps for the patient

Problem Solving Treatment

1. Explanation and rationale
2. Problem definition
3. Establishing achievable goals
4. Generating solutions
5. Evaluation and choice of solution
6. Implementation
7. Evaluation

In stage one the therapist, in this case the general practitioner, makes an inventory of current symptoms and problems, makes sure the patient understands and accepts a link between the symptoms and these problems in every day life, and explains the treatment. When the patient is motivated for this treatment the steps the patient takes for every problem he or she wants to work on are: 1.making a clear problem definition of one specific and current problem, 2. setting achievable goals, 3. brainstorming about possible solutions, 4. weighing the pros and cons of every possible solution 5. to choose the best option to solve that problem with the least negative effects and 6. to make an implementation plan to ensure the chosen solution will be carried out. In the seventh step the results are evaluated, and the impact of the success on the patient's symptoms is discussed. At the end of 4-6 sessions many patients are able to cope better with their every-day problems and the treatment is ended.

The workshop and conclusions

During the workshop at the 4th National Family Medicine Days and 2nd European Systemic Family Conference participants practised part of the reattribution technique and 3 steps of problem solving treatment using a patient vignette.
This practice session was followed by a discussion between participants from various countries. Cultural differences were mentioned in patient expectations and attitudes towards psychological treatments and medications, but also in the possibility to take more than a few minutes and enough time to use these structured talking treatments with patients. Nevertheless participants agreed that these

talking treatments should be used more and these treatments could be an alternative.

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