Cognitive behavioural therapy in primary care: what are the possibilities?

In San Francisco, cognitive behavioural group therapy (CBT) for depression was administered using a specifically adapted manual by a primary care physician (PCP) facilitator with non-physician co-facilitators in two groups of patients aged 55–84. **Drs Liana Lianov** and **David C Mohr** with **Leilani Feliciano** discuss how this pilot study suggests the potential efficacy and user-friendliness of PCP-administered CBT in geriatric groups.

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Over half of all individuals with depression are treated in the primary care setting[1], yet only six to 20 per cent of these patients ever see a mental health professional. In addition, one-quarter of people with major depressive disorder never receive any treatment[2].

Outcomes with pharmacotherapy in primary care are poor, with most patients showing little improvement over one to two years[3]. One possible contributor to these poor outcomes is that approximately two-thirds of depressed primary care patients prefer psychotherapy or counselling over antidepressant medication[4]. Yet only about 20 per cent ever follow-up on referrals to mental health specialists[5].

A recent study also showed that older primary care patients express greater satisfaction and adherence to treatment in an integrated system of behavioural healthcare in their primary care settings compared with specialty referral[6]. However, many efforts to improve screening and treatment of depression by primary care providers have not resulted in significant changes in care.

The provision of group counselling by primary care physicians might overcome several barriers to care that contribute to poor outcomes for depression in the elderly. Traditionally, psychotherapy has been provided by specialists with considerable training. However, the increasing availability of structured standardised treatments such as cognitive behavioural therapies (CBT), could allow other medical personnel — for example, primary care physicians — to provide treatment for depression.

CBT is a form of psychotherapy that helps patients recognise how their negative and irrational thoughts and beliefs can affect their mood and how certain behaviors — such as social isolation — can lead to symptoms of depression. CBT also assists patients in adjusting their self-defeating thoughts and beliefs to ones that are more rational and realistic and to increase pleasant activities in order to improve mood.

A recent study has shown the cost-effectiveness of enhancing primary care depression management[7], motivational interviewing and problem solving by GPs[8]. Therefore, a psychosocial intervention to be administered in primary care settings to elderly patients for the treatment of depression would be useful, especially as survey evidence indicates that older people report cognitive maladaptive strategies that may respond to CBT[9]. This study is the first, to the best of our knowledge, to examine a primary care physician administered psychosocial intervention aimed at treating depression. Some other studies have successfully used physician psychiatrists or researchers to run such groups[10].

Methods

Recruitment and study sample

Patients were recruited via referral by providers in primary care, specialty care and mental health clinics at the San Francisco Veterans Affairs Medical Center and the Langley Porter Psychiatric Institute (San Francisco, California, USA). Investigators sent written information to providers describing the study and the inclusion criteria along with informational flyers about the study to be distributed to patients. Patients eligible for the study met the following criteria:

- diagnosis of major depressive disorder, adjustment disorder with depressed mood or dysthymia (as noted in the medical record by the primary care physician or psychiatrist according to DSM IV (Diagnostic and Statistical Manual of Mental Disorders) criteria);
- Beck Depression Inventory II (BDII)[11] score of 12 or more;
- interest in psycho-educational approach;
- ability to speak and read English;
- age 55 years or older; and
- ability to give informed consent.

Clients taking antidepressants and/or going to other psychotherapy were included. Exclusion criteria were:

- cognitive decline, dementias or other serious psychiatric pathology (including psychosis and thought and bipolar disorders), or current alcohol or substance abuse;
- current exacerbation of a medical condition that required surgery, other hospitalisation or frequent treatment (such as radiation or chemotherapy);
- suicidal intent with a specific plan;
- severe, uncorrected vision or hearing loss; and
- serious difficulties in reading or writing.

Treatment

Each group participant met with one of the investigators before entering treatment. At the pre-treatment visit an initial history was obtained, the study was explained and patients were asked to sign a consent form and complete a BDI II.

The treatment consisted of a 90-minute group session once a week over the course of 12 weeks using the CBT manual by Aréan[12], which was modified to include two sessions that emphasised motivational interviewing constructs[13-16]. Each session material from the previous week was reviewed; participants reported on their success in implementing a CBT technique during the week, and a new topic was introduced. The topics covered included:

- barriers and facilitators to making changes;
- thought errors;
- rational dispute of erroneous thoughts;
- the action/behaviour/consequence/dispute method;
- goal setting;
- scheduling pleasant activities; and
- building support networks and relationships.

The lead group facilitator was a primary care physician with a social worker as co-facilitator in the first group and a psychology pre-doctoral student as co-facilitator in the second group. They were trained by a mental health social worker and a psychologist. Training included self-study of the manual and a single one-hour discussion of the materials and group process.

Assessment

The primary outcome was the BDI II administered at pre-treatment and at the end of the 12th session. The pre-post difference in the results was analysed by a dependent t-test. In addition, qualitative data were collected through an 'exit interview' conducted by a pre-doctoral student not involved in the study. This interview evaluated ease of utilisation of materials by group members. Group facilitators provided written feedback about the ease of implementing these materials.

Results

Of the 18 patients completing the baseline, nine were female and nine were male, with a mean age of 67.6; one was of Hispanic origin, two were African-American and 15 were Caucasian. Ten were veterans and eight were not. Two patients dropped out after initiating treatment: one after three sessions due to inpatient psychiatric hospitalisation and one after eight sessions due to prolonged medical illness. One patient's scores were not included in the analysis because of multiple blank items on the BDI II. Thus, outcomes were available for 13 patients, seven female and six male (mean age 68, range from 55 to 84).

Patients completing therapy showed a significant reduction in the mean BDI II, from 22.46 (SD=7.09) at baseline to 16.46 (SD=11.40) post-treatment ($p < 0.05$). These results are

Key points

- A possible contributing factor for poor outcomes of depression in the elderly may be a preference for counselling over antidepressant medications.
- Elderly patients often do not follow-up on referrals to mental health specialists.
- A CBT manual for depression in the elderly was modified to accentuate motivational interviewing constructs.
- A primary care provider received a one-hour training session on the use of this manualised therapy and was lead facilitator for two groups of elderly patients with depression.
- BDI II scores decreased by 26.7 per cent after 12 weeks of a single 90-minute session per week.
- Group CBT may be a user-friendly and effective method for primary care physicians to treat elderly patients.
- Future studies are needed to evaluate the use of primary care support staff to conduct group therapy in primary care settings.

clinically significant, representing a decrease in severity of depression from moderate to mild. Exit interviews of participants revealed that most felt the modified CBT materials were easy to understand and plan to refer to the manual after therapy.

Most participants would have preferred a greater number of sessions, with some requesting additional topics they felt were important to a geriatric group such as spirituality, bereavement, chronic pain, death and dying. Group facilitators noted that materials were easy to use.

Discussion

This initial study suggests group CBT interventions using a structured manual conducted by a primary care provider with minimal training may be both feasible and effective in reducing depression in an elderly population. Care improvement requires innovative approaches such as this one to translate evidence-based interventions into mainstream treatment of older adults. Several factors should be considered in interpreting these preliminary data. The sample size was small and the results may not be widely generalisable. The absence of a control group also means that we cannot rule out the possibility that these improvements are not due to the treatment itself, but rather to some other factor, such as being in a research study.

Nevertheless, these findings provide a foundation for future research to develop and evaluate group interventions for depression that can be administered by providers in primary care practices. Future research will need to include larger, more representative samples in controlled trial designs. To improve the application in busy primary care practices, future studies need also to evaluate the use of support staff as group facilitators.

Conflict of interest: none declared.

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