

Should general practitioners refer patients with major depression to counsellors? A review of current published evidence

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SUMMARY

Major depression can be treated effectively with antidepressants. However, in the United Kingdom, patients with depression are often referred to counsellors, and surveys indicate that public opinion favours this approach. We carried out a literature review to determine the evidence for the effectiveness of counselling for depression in primary care. Because no studies were identified in which counselling had been evaluated specifically in relation to treating depression, we examined indirect evidence from studies evaluating the overall effectiveness of generic counselling in primary care, and studies evaluating the effectiveness of psychological treatments, other than counselling, for depression. Methodological problems influencing the interpretation of such studies are discussed. We conclude that, while specific psychological treatments have been shown to have equivalent effectiveness as antidepressants, there is currently insufficient evidence to recommend that generic counselling should be used alone in the treatment of patients with major depression.

Keywords: depression; antidepressants; counselling; general practice.

Introduction

DEPRESSIVE disorders are common and disabling.¹ Early detection and appropriate management may reduce the severity, alleviate distress, and possibly reduce the risk of recurrence or chronicity.^{2,3} General practitioners (GPs) play a key role in this process since 90% of depression is managed in primary care.⁴

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There is clear evidence that antidepressants are both effective and relatively safe in the treatment of major depressive disorders.⁵ However, public opinion is largely negative concerning their use: a recent survey of public attitudes following the national Defeat Depression Campaign (1992-96) found that, of approximately 2000 people interviewed, 74% believed antidepressants to be addictive, and only 60% believed them to be an effective treatment for depression.⁶ Only 24% believed that people with depression should be offered antidepressant treatment. Professional attitudes to antidepressants also appear to differ: there is wide variation in prescribing rates between GPs,⁷ and patients are frequently prescribed courses at subtherapeutic dosages or for insufficient duration.^{8,9}

By contrast, public opinion strongly favours the use of psychological treatments for depression. The Defeat Depression survey found that 86% of responders believed 'counselling' to be an effective intervention for depression, and 90% agreed that people with depression should be offered it.⁶ 'Counselling', although poorly defined, is one of the most widely available forms of psychological therapy within general practice, having developed over the past 20 years. Over one-third of GPs have direct access to counselling services, most of which are provided by specific 'counsellors' as distinct from other health professionals employing such techniques.¹⁰⁻¹² Although counsellors deal with a range of conditions, surveys have demonstrated that between 20% and 74% of their workload consists of patients with depression.^{11,13-16} It therefore appears that GPs consider counselling to be an appropriate form of management for depressive illness, and that this view concurs with public opinion.

We carried out a literature search to identify published evidence for the effectiveness of counselling in treating major depression. In particular we aimed to seek evidence for the relative effectiveness of counselling in relation to the current recommended 'gold standard' of antidepressant therapy.

Method

We searched MEDLINE and EMBASE electronic databases covering the period 1980-98. We also searched the Cochrane Library and hand-searched index lists of identified sources. Our strategy was intended to identify references to trials of psychological treatments for major depression for adults in primary care, and incorporated the following thesaurus terms: 'primary care', 'family practice', 'general practice', 'depressive disorders', 'unipolar depression', and 'depression'. Terms used to specify broad categories of psychological treatments were as follows: 'counselling', 'counseling', 'psychotherapy', and 'psychology — clinical'.

We selected randomized controlled trials performed in United Kingdom (UK) general practice in which a psychological treatment was compared with either another active intervention or with 'usual treatment'. We excluded studies of postnatal depression, depression in the elderly, co-morbid depressive disorders, psychotic depression, or bipolar affective disorders. Where appropriate, reference has been made to meta-analyses or studies performed in other settings.

Results

Direct evidence for the effectiveness of counselling for major depression

We identified no published studies that specifically address the issue of the effectiveness of counselling for major depression in general practice. Indirect evidence was, however, available from two collateral sources: first, studies evaluating the overall effectiveness of counselling in general practice; and secondly, studies examining the effectiveness of psychological treatments, other than counselling, for depression. This review therefore examines this evidence.

Studies evaluating counselling in general practice

We identified five randomized controlled trials of generic counselling in UK primary care (Table 1). All compare the outcomes of counselling with routine management by GPs for a range of disorders. We examined the results of each to determine if there were any indicators for the effectiveness of counselling specifically for depressive disorders.

Findings from the Leverhulme Counselling study¹³ have never been published, possibly because of the methodological problems encountered, which included concerns about incomplete data collection. Analysis was based on only 34% of those originally randomized, and was not carried out on an intention to treat basis, although cases and controls were matched by age and sex. There were no differences in any of the main outcome measures between baseline and 12 months, or in General Health Questionnaire (GHQ) scores at 12 months. However, counselled patients who were taking tranquillizers at baseline were significantly more likely to have stopped at 12 months than controls, while there were no differences in the proportion of patients who stopped taking antidepressants between the two groups. This finding would be consistent with the possibility that counselling was less effective as an adjuvant therapy for depressive illnesses than for other types of morbidity.

Boot and colleagues employed the GHQ as an objective outcome measure at both baseline and six weeks.¹⁴ At follow-up, counselled patients had significantly lower mean GHQ scores than those who had received 'treatment as usual', with both groups having significantly lower scores than at baseline. Nine per cent of the counselled group were prescribed antidepressants compared with 23% of controls, and the former were also significantly less likely to have been referred to outside agencies. Patients who had received counselling were more likely to report that they were coping better, feeling happier, and satisfied with the treatment received. This study was limited by a short duration and an imbalance in numbers randomized to each group,¹⁶ although baseline demographic and morbidity characteristics were similar. Although many of the participating patients were subjectively depressed at baseline, there was no formal assessment of the presence of major depression and no indication of which groups of patients showed greatest improvements with counselling.

More recently, Friedli and colleagues performed a comprehensive evaluation of non-directive Rogerian counselling.¹⁵ Audiotapes of the counselling sessions were independently evaluated to ensure adherence to the therapeutic model. Overall there were no significant differences in outcome — which included the Beck Depression Inventory (BDI) — between the two groups, except that those receiving counselling reported significantly more satisfaction. All measures of severity decreased significantly over time. There was a significantly greater fall in BDI scores in counselled patients than those receiving treatment as usual who were among the sub-group whose initial BDI score was

greater than 14. This suggests that patients with depression may respond better to counselling than to 'treatment as usual'.

This study has advantages over previous research in that the attrition rate was relatively low, there was an attempt to standardize the intervention, a range of validated outcome measures was employed, and patients were followed up after completing treatment. However, while a high proportion of patients had depressive features, it is uncertain how many would have fulfilled criteria for major depression. Only one-fifth of patients receiving routine general practice care were prescribed antidepressants, which is lower than might be expected in the context of patients with such relatively high Beck Depression scores. Thus, as with all studies using 'treatment as usual' for comparison, it is unclear whether participants in the control group received 'best possible' treatment. A further criticism is that the counselling intervention was tightly controlled, and the results therefore only reflect the outcomes for non-directive Rogerian counselling, when, in practice, such approaches are often integrated with other techniques.¹⁷

Hemming's study¹⁸ did not report counselling outcomes in relation to specific reasons for referral, and so no inference can be made about its effectiveness for depression. Overall outcomes were similar between intervention and control patients; however, half of the control group were referred to outside sources of psychological treatment as part of the routine treatment by GPs.

Harvey and colleagues evaluated the effectiveness of generic counselling in general practice using a range of outcome measures including the Hospital Anxiety and Depression scale.¹⁶ There were no significant differences in outcome between patients receiving counselling and those receiving 'treatment as usual' on the depression sub-scale of this measure. However, as with other studies, 'treatment as usual' was not defined and may have been suboptimal in terms of the proportion of patients receiving adequate dosages of antidepressants. The study included an economic evaluation that demonstrated no clear cost advantage for either intervention.

Studies of psychosocial treatments for depression other than counselling

Counselling is a relatively poorly defined psychological intervention, with primary care counsellors using a range of therapeutic styles from Rogerian non-directive counselling to behavioural therapy and psychodynamic psychotherapy.¹¹ Many use an 'eclectic' or 'integrative' approach, employing features from different models. We therefore examined the evidence for the effectiveness of specific types of psychological treatment for depression in primary care. Such treatments vary in their theoretical basis, content, and duration (Box 1).

Cognitive therapy (CT) has been most extensively evaluated. Studies from a variety of settings have been subject to meta-analysis that have concluded that, at the end of treatment for mild to moderate depression, CT is at least equivalent in effectiveness to treatment with antidepressants and may also reduce the risk of relapse.^{5,19,20} Two meta-analyses concluded that CT was superior to pharmacotherapy and other forms of psychotherapy, but both used the BDI as an outcome measure, which, since it focuses on cognitive symptoms, would tend to be biased towards a positive outcome for cognitive therapy.^{19,20}

Studies of CT that have been conducted specifically in UK primary care are harder to interpret since they have used different comparison groups, outcome measures, and durations of follow-up (Table 2).

Overall, CT appears to be more effective than routine treatment by a GP at the end of a course of treatment, with any significant differences disappearing on follow-up. The exception is

Table 1. Randomized controlled trials comparing brief generic counselling with treatment as usual by a GP in UK general practice.

Reference	Setting	Intervention	Main outcome measures and timing (in <i>italics</i>)	Sample size/follow-up rate	Patients with depression (%)	Principal results
Ashurst and Ward, 1983 ¹³	Two practices in Hampshire	Two counsellors Unspecified duration	Psychotropic prescribing GP consultation rate Subjective improvement GHQ (end point only) <i>Baseline & 12 months</i>	726 randomized: 453 controls and 273 counselling Data available and analysed for 248 (34%)	43% (GP recorded) (73% had depressive symptoms)	No overall differences between groups except reduction of tranquilliser prescribing in intervention group.
Boot et al, 1994 ¹⁴	Seven practices in Northamptonshire	Five counsellors Six one-hour sessions	GHQ Psychotropic prescribing GP consultation rate External referrals Patient self-assessment <i>Baseline and six weeks</i>	192 randomized: 68 controls and 124 counselling 108 followed up (56%)	62% (patient self-report)	Intervention group had significantly improved GHQ scores, fewer psychotropic drug prescriptions, and greater satisfaction at follow-up
Friedli et al, 1997 ¹⁵	Fourteen practices in NW London	Four counsellors — specifically using Rogerian non-directive counselling Between one and 12 50-minute sessions	Beck depression inventory Brief symptom inventory Revised clinical interview schedule Modified social adjustment scale <i>Baseline, three months, and nine months</i>	136 randomized: 66 controls and 70 counselling 110 (81%) followed up at three months 117 (86%) followed up at nine months	52% (patient self-report) 51% (GP reported) 74% (based on BDI threshold of 14)	No differences in clinical outcomes overall Satisfaction was significantly higher in intervention group Subgroup of patients with higher BDI did better
Hemmings, 1997 ¹⁸	Three practices in East Sussex	Three counsellors Up to 14 sessions	Symptom index Inventory of interpersonal problems Repertory grids Psychotropic prescribing GP consultation rate External referrals <i>Baseline, four months, and eight months</i>	188 randomized in ratio of 2:1 cases to controls 154 (82%) followed up at four months 100 (53%) followed up at eight months	No details provided	No differences in main outcomes Control group was more likely to have been referred for external psychological treatment
Harvey et al, 1998 ¹⁶	Nine practices in South Wales	Nine counsellors Six 50-minute sessions	Hospital Anxiety and Depression Scale Dartmouth COOP Charts Delighted-terrible faces scale <i>Baseline and four months</i> Costs	162 randomized (2:1 ratio): 51 controls and 111 counselling 122 (75%) followed up	24% (GP recorded)	No differences between groups in outcomes or costs

Subjects in all trials were aged 16 years and above with social, psychological, or emotional problems and excluding serious psychiatric morbidity. GHQ: General Health Questionnaire.

Cognitive therapy	Aimed at modifying the negative thinking that occurs in depressive disorders and that is believed to contribute to their onset and impede recovery.
Problem-solving therapy	Aimed at helping patients to use their own skills and resources to deal with present and future problems by means of identification and clarification of the problem, goal setting, brainstorming and selecting solutions, clarifying implementation, and monitoring progress.
Social work intervention	A potentially broader approach that may encompass non-specific counselling and directive advice and provision of practical help to deal with adverse circumstances when appropriate.
Interpersonal therapy	Aimed at reducing some of the social problems that may provoke or prolong depression by helping the patient to identify and understand his or her interpersonal problems and conflicts, and develop more adaptive ways of relating to others.

Box 1. Psychological interventions for depressive disorders.

Scott and Freeman's study suggesting that antidepressants, prescribed by a psychiatrist, may actually result in more rapid response.²¹ Differences between studies may therefore reflect the use made of antidepressants in the 'treatment as usual' comparison groups.

Problem solving therapy has been shown to be effective in treating emotional disorders in primary care²² and has recently been evaluated in major depression.²³ Mynors-Wallis and colleagues undertook a randomized controlled trial of problem-solving treatment versus antidepressants or drug placebo in general practices in Oxfordshire. Treatment in all arms was provided by a psychiatrist and two specially trained GPs who provided a similar amount of contact time for all three groups. At 12 weeks, 60% of patients receiving problem-solving treatment had 'recovered', according to the Hamilton rating scale threshold, compared with 52% taking amitriptyline and 27% on placebo (based on intention-to-treat analysis). The authors concluded that problem-solving treatment was at least as effective as antidepressants and superior to placebo in the management of major depression at six and 12 weeks.

Social problems are prevalent among patients consulting with depression,²⁴ and social work interventions may involve practical help as well as supportive listening and advice. The Edinburgh primary care depression study compared efficacy and cost of a social work intervention with antidepressants, cognitive therapy, or routine GP care for patients with depressive illness.²¹ After 16 weeks, the severity of depressive symptoms had declined in all groups, and differences in efficacy were not commensurate with differences in length or cost of treatment. Only the social work intervention was superior to GP care, although the baseline severity of depression was lower in this group than the others. Social work counselling was rated most helpful by patients.

Interpersonal therapy has been widely evaluated in the United States of America but not, to our knowledge, in the UK. It appears to be as effective as antidepressant treatment for mild to moderate depression but less so for more severe forms.^{25,26} There is evidence that continued treatment may reduce the risk of recurrence.^{27,28}

Table 2. Randomized controlled trials evaluating cognitive therapy (CT) for major depression in UK primary care patients.

Reference	Setting	Comparison group	Main outcome measures and duration of follow-up	Sample size/follow-up rate	Principal results
Blackburn et al, 1981 ³⁴	Edinburgh Single practice	Antidepressants (AD)	HRS, BDI Baseline, then two to three times weekly to 20 weeks	39 randomized: 24 (62%) completed treatment	CT superior to AD at 20 weeks
Teasdale et al, 1984 ³³	Oxfordshire 13 practices	'Treatment as usual' (TAU)	BDI, MADS, HRS Baseline, post-therapy, and three months later	44 randomized: 77% followed up	CT superior to TAU at end of treatment but no significant difference three months later
Ross and Scott, 1985 ³⁵	Liverpool Single practice	Waiting list 'treatment as usual' (TAU)	MADS, BDI Baseline, post-therapy, then three months, six months, and 12 months later	51 randomized: 19/30 (63%) of immediate therapy group completed treatment	CT superior to TAU at end of treatment
Scott and Freeman, 1992 ²¹	Edinburgh 14 practices	1. Antidepressants (AD) 2. 'Treatment as usual' (TAU)	HRS Baseline, four weeks, and 16 weeks	91 randomized in these three arms: 92% follow up to 16 weeks	AD superior to other groups at four weeks but no significant difference at 16 weeks
Scott et al, 1997 ³⁶	NE England 11 practices	'Treatment as usual' (TAU)	DSM-III-R, HRS, BDI Baseline, seven weeks, three months, six months, and 12 months	48 randomized: 34 (71%) followed up at seven weeks; and 24 (50%) at 12 months	CT superior to TAU at end of treatment with no difference three months later

Subjects in all trials were aged between 18 and 65, and fulfilled either Research Diagnostic Criteria or DSM-III-R Criteria for major depressive disorder. HRS: Hamilton Rating Scale for Depression; BDI: Beck Depression Inventory; MADS: Montgomery-Asberg Depression Scale.

Discussion

Much of the available evidence of the effectiveness of psychological treatments for depression comes from studies of limited duration, with no details of relapse or recurrence rates. Common difficulties of study design include limited sample size; relatively high attrition rates; the use of differing outcome measures; the use of atypical, highly skilled, and motivated therapists for the psychological intervention; and the failure to use antidepressant treatment as the 'gold standard' for comparison.

The evidence presented suggests that a range of specific psychological treatments may be as effective as antidepressants in treating depression in primary care in the short term. This raises the issue as to whether the effectiveness is a result of the specific type of treatment employed or of a more generic effect that could equally apply to other psychological interventions including counselling. In support of this, several studies have suggested that outcomes of psychological treatment are unrelated to the theoretical basis of therapy and are more closely correlated with non-specific aspects of the interaction such as exploration and warmth.²⁹⁻³²

If therapeutic contact *per se* is the active ingredient, then it might be expected that this would show a 'dose-response' relationship, with duration of treatment correlating with outcome. Dobson failed to demonstrate this in one meta-analysis of studies of cognitive therapy for depression.¹⁹ Equally, Teasdale and colleagues,³³ reviewing past literature, concluded that 'therapeutic attention', or time spent with the therapist, does not necessarily produce a reduction in symptoms in patients with major depression. The evidence for a non-specific effect of psychological treatments in depression is therefore equivocal and, at present, insufficient to suggest that any psychological intervention, including generic counselling, will be an effective form of treatment.

Conclusion

Studies of primary care counselling provide only weak evidence of a specific benefit in depressive disorders, and results of studies of other specific psychological treatments for depression cannot readily be extrapolated to generic counselling. However, the increasing availability of counselling services, positive lay attitudes about the benefits of counselling for depression, and reported higher levels of satisfaction from counselling in comparison with usual GP care, all increase the pressure for GPs to refer patients with depression to a counsellor. In the absence of clear evidence, unless a counsellor is known to employ specific techniques of proven benefit, GPs might consider restricting referrals for counselling to patients with major depression in whom antidepressants are unacceptable, poorly tolerated, or ineffective. The results of trials comparing the effectiveness and cost-effectiveness of counselling with antidepressants in patients with major depression are awaited.

Key points

- Psychological treatments for depression are favoured by patients and employed by GPs.
- There is good evidence that certain specific forms of psychological therapy are as effective as antidepressants in treating depression in primary care.
- No studies have been published evaluating the effectiveness of generic counselling for depression, despite its widespread availability and use.
- General practitioners should be cautious in referring patients with major depressive illness to counsellors as their sole mode of treatment, unless specific therapeutic models are used.

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