Therapeutic consultations for patients with depressive symptoms

INTRODUCTION

This article discusses the state of our current knowledge about how GP consultations might be therapeutic for patients with depressive symptoms. This is important for two reasons: the GP consultation is the most common medical intervention for depressive symptoms in Western societies; and there is substantial uncertainty about the efficacy of the second most common medical intervention, the prescription antidepressant medication.[1]

Paul Little and colleagues have shown that a positive, patient-centred approach by GPs to the generic primary care consultation is associated with greater patient satisfaction and enablement, and also appears to reduce symptom burden and referral rates.[2] Components of such an approach are: a sympathetic doctor who is interested in the patient's worries and expectations; who discusses and agrees the problem and treatment; who knows the patient and their emotional needs; who is definite about the problem and when it will settle; and who expresses interest in the effect of the problem on the patient's life.

In consultations concerned specifically with depression, over and above any pharmacological effect of antidepressant medication, therapeutic benefit is derived if the GP conveys a sense of hope and optimism, and establishes a positive relationship with the patient.[3] Better outcome is also associated with the GP being rated, by patients or observers, as being skilful in providing empathy and support.[4,5]

AGREED BENEFITS

Let us accept that expressing warmth and attention, exploring the patient's concerns and expectations, and expressing interest in the effect of the problem on the patient's life are all highly likely to be intrinsically therapeutic.

Let us also accept, with two caveats, that a personal relationship, where the doctor knows the patient and their emotional needs, is likely to be intrinsically therapeutic. The first caveat is that such a relationship is not always possible and, indeed, in modern British general practice is becoming less common as practice sizes increase. The second caveat is that sometimes a personal relationship can be detrimental, with a risk of new symptoms being missed or ignored, leading to a sense of disempowerment.

> " ... a personal relationship, where the doctor knows the patient and their emotional needs, is likely to be intrinsically therapeutic."

Other assumed components of a therapeutic consultation, however, are not as clearly defined as they appear, particularly when considering a complex diagnostic entity such as depression.

BEING EMPATHIC

The assumption that empathy is therapeutic has face validity, but demonstrating this is hampered by definitional and observational problems. Some definitions of empathy are broad, overlapping substantially with generic attributes of warmth, attention, expressing interest, conveying optimism, and so on.[6] It may therefore be more useful to focus on evidence of identification with, and response to, the emotional content of the patient's story.[7] Observational problems centre on the question of whether empathic attitudes, competencies, and behaviours can be independently and objectively observed by others, or whether they are best judged subjectively by the patient. These two approaches may yield different results.[5]

THE NATURE OF THE PROBLEM

The assumption that it is beneficial to discuss and agree the nature of the problem is not straightforward, given the contested status of depression. First, what might the doctor and patient be agreeing about? Are depressive symptoms evidence of disease, or of illness, or of problems with life?[8] Doctors and patients may bring differing answers to these questions[9] and we should not presume that it is always the doctor who prefers a more biomedical approach.[10] Second, is it more important that doctor and patient reach an agreed understanding, regardless of the content of that agreement? Or are some understandings more correct than others? In which case, should doctors be persuading patients towards specific areas of agreement?

WHAT DOES IT MEANT TO BE POSITIVE?

We can broadly accept that if a doctor expresses hope and optimism, and takes a positive approach to the problem, more therapeutic benefit may derive than if the doctor expresses doubt and uncertainty.[11] However, there are several caveats here. If optimism is expressed too early in the consultation, before the patient has had adequate opportunity to tell their story, this may paradoxically be perceived by the patient as evidence of a lack of empathy or understanding.[12] Sometimes, acknowledging *lacrimae rerum*[13] (the tears of [or for] things), bearing witness to a patient's suffering in the face of overwhelming life experiences and difficulties, may be all that is possible, or necessary.

There are at least four ways in which the doctor might propose a positive approach. These can be summarised as doctor-focused, shared, patient-focused or time-focused: the doctor may indicate that he or she is an expert in this problem and can solve it for the patient; the doctor may indicate that doctor and patient can successfully work on the problem together; or that the patient has the resources to manage it him or herself; or that depressive symptoms usually resolve spontaneously without the need for intervention. These are all legitimate versions of a positive approach, and all convey hope and optimism. But they

> "The shaping of a patient's story by the GP in a more hopeful direction may be key."

> *"Is the process of reaching agreement on treatment intrinsically therapeutic, regardless of the agreed treatment?"*

are also very different in their orientation.

In particular, they vary in the extent to which they are positive about the outcome of the condition (prognostic confidence), or positive about the outcome of treatment for the condition (therapeutic confidence).

It is not clear whether any one of these differing positive approaches is more therapeutic than any other, whether any benefits are contextual, or whether it is the fact of being positive (regardless of content or direction of positivity) that is intrinsically therapeutic.

It is plausible that the benefit or disbenefit of a given approach might be affected by the patient's understanding of the nature of their problem. For example, a doctor-focused approach might be more helpful for a patient with a disease-based understanding of depression, whereas a self-care or time-focused approach might be more helpful for a patient who sees him or herself as having current problems with life's circumstances. The shaping of a patient's story by the GP in a more hopeful direction may be key.[14]

Benefits and disbenefits of these approaches may also be affected by the severity and duration of the problem. A patient with very severe depressive symptoms, including despair and low self-esteem, may find a doctor-focused approach more hopeful. Someone who has been depressed for several years may find a time-focused approach unconvincing.

TREATMENT APPROACHES

Then we have the matter of discussing and agreeing the treatment. In some ways this is more straightforward. Given the wide range of evidence-based interventions available to the GP for managing depressive symptoms — from encouraging self-care or personal resilience strategies, to prescribing antidepressant medication, referring for psychological therapies or involving psychiatrists and others in collaborative care — there is plenty of scope for GPs to discuss options and reach agreement with patients, taking account of their personal preferences. And we might assume — although this assumption needs testing — that the type of treatment preferred by patients relates to their understanding of the nature of the problem: antidepressants may be preferred by those with a disease orientation, whereas social interventions are chosen by those who see themselves experiencing problems with life circumstances.

Other aspects of discussing and agreeing treatment, however, remain unclear. Is the process of reaching agreement on treatment intrinsically therapeutic, regardless of the agreed treatment? Indeed, might this process be *more* therapeutic than the agreed treatment itself? If so, then an agreed decision to prescribe antidepressant medication for symptoms of mild depression may be justified, despite evidence of clinical ineffectiveness. Conversely, are there some circumstances, for example, very severe depression, where reaching agreement may be difficult or impossible, due to the patient's reduced capacity, or where evidence favouring specific treatment options is strong enough to preclude discussion of other options?

IMPLICATIONS

These questions are important not only in practice but also in research, given the need to improve specification of contextual elements and attentional controls in the design of primary care treatment trials. And, although the focus here is on depression, they are likely to be pertinent to other common clinical situations, such as the management of functional gastrointestinal disorders or unexplained physical symptoms.

Christopher Dowrick,
Professor of Primary Medical Care, Department of Psychological Sciences, University of Liverpool, Liverpool.

Acknowledgements
I am grateful to Jane Gunn, Stewart Mercer, and Joanne Reeve for comments on earlier versions of this article.

Provenance
Freely submitted; not externally peer reviewed.

Competing interests
The author has declared no competing interests.

DOI: 10.3399/bjgp15X687169

ADDRESS FOR CORRESPONDENCE

Christopher Dowrick
Department of Psychological Sciences, Waterhouse Buildings, University of Liverpool, Liverpool L69 3GL, UK.
E-mail: cfd@liv.ac.uk

REFERENCES

1. Dowrick C, Frances A. Medicalising unhappiness: new classification of depression risks more patients being put on drug treatment from which they will not benefit. *BMJ* 2013; **347:** f7140.
2. Little P, Everitt H, Williamson I, *et al.* Observational study of effect of patient centredness and positive approach on outcomes of general practice consultations. *BMJ* 2001; **323(7318):** 908–911.
3. Malt UF, Robak OH, Madsbu HP, *et al.* The Norwegian naturalistic treatment study of depression in general practice (NORDEP)-I: randomised double blind study. *BMJ* 1999; **318(7192):** 1180–1184.
4. van Os T, van den Brink R, Tiemens B, *et al.* Communicative skills of general practitioners augment the effectiveness of guideline-based depression treatment. *J Affect Disord* 2005; **84(1):** 43–51.
5. Jani B, Bikker AP, Higgins M, *et al.* Patient centredness and the outcome of primary care consultations with patients with depression in areas of high and low socioeconomic deprivation. *Br J Gen Pract* 2012; DOI:10.3399/bjgp12X653633.
6. Stewart M. Towards a global definition of patient centred care. *BMJ* 2001; **322 (7284):** 444–445.
7. Derksen F, Bensing J, Lagro-Janssen A. Effectiveness of empathy in general practice: a systematic review. *Br J Gen Pract* 2013: DOI: 10.3399/bjgp13X660814.
8. Dowrick C. *Beyond depression: a new approach to understanding and management.* 2nd edn. Oxford: Oxford University Press, 2009.
9. Karasz A, Dowrick C, Byng R, *et al.* What we talk about when we talk about depression: doctor-patient conversations and treatment decision outcomes. *Br J Gen Pract* 2012; DOI: 10.3399/bjgp12X616373.
10. Killingsworth B, Kokanovic R, Tran H, Dowrick C. A care-full diagnosis: three Vietnamese Australian women and their accounts of becoming 'mentally ill'. *Med Anthropol Q* 2010; **24(1):**108–123.
11. Thomas KB. General practice consultations: is there any point in being positive? *Br Med J (Clin Res Ed)* 1987; **294(6581):** 1200–1202.
12. White P, Bishop FL, Prescott P, *et al.* Practice, practitioner, or placebo? A multifactorial, mixed-methods randomized controlled trial of acupuncture. *Pain* 2012; **153(2):** 455–462.
13. Virgil. *The Aeneid.* Book 1, line 462.
14. Cape J, Geyer C, Barker C, *et al.* Facilitating understanding of mental health problems in GP consultations: a qualitative study using taped-assisted recall. *Br J Gen Pract* 2010; DOI: 10.3399/bjgp10X532567.