Management of mild depression in general practice: is self-help the solution?

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Summary

Mild depression is a common but often hidden problem in patients attending general practitioners. Current evidence is unclear about whether these patients need to be identified. The best management strategy is also unclear. There are very few data from general practice studies to guide us, however there seems to be no evidence to support the use of antidepressants in mild depression. Psychological strategies, St John's wort and self-help strategies may be of assistance to patients with mild depression. An approach that allows people to ventilate their concerns and have them validated, combined with self-help strategies, such as cognitive behaviour therapy programs or exercise programs, may be of most assistance to mildly depressed patients.

Key words: antidepressants, cognitive behaviour therapy, counselling.

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Introduction

Depression is a large cause of disability in Australia. It is mainly managed in general practice, but current guidelines for treatment are generally based upon data that have not been collected in general practice.[1] Despite much national effort to implement management guidelines and the availability of effective treatments, around half the patients experiencing depression are unlikely to be diagnosed as 'depressed' by their general practitioner. About 40% of the group that do receive treatment will experience persistent or relapsing depression.[2] General practitioners seem least likely to miss patients with severe and persistent episodes of major depression, where antidepressant pharmacotherapy should be considered as part of their treatment.

The cases general practitioners miss seem more likely to be towards the mild end of the spectrum. Minor depression is a major factor underlying the use of general practitioners' services.[3] Is it a problem that minor depression is missed or not treated by general practitioners?

What is mild or minor depression?

The depression seen in general practice often coexists with physical conditions. It has a fluctuating course and usually is of shorter duration and meets fewer of the diagnostic criteria for major depression than the depression seen in psychiatric clinics. Distinguishing between the different types of depression is often very difficult and the DSM IV classification system[4] is not useful for many general practitioners.

Mild or minor depression often overlaps with dysthymia and mild major depression. However, general practitioners tend not to use these definitions and, like their patients, see depression as mild, moderate or severe. Both general practitioners and their patients view depressed mood as being in response to the patients' social situation, life events or chronic physical illness. They may not make the distinction between emotional distress and depression occurring in the absence of an external precipitant.

What is the natural history of mild or minor depression?

Major depression occurs in about 5% of patients attending general practice and minor depression is thought to be two to three times more common.[5] Many studies only enrol patients with major depression who are taking, or willing to take, antidepressant medication. This excludes the large group of patients who are seen in primary care. As a result, little is known about the natural history of mild or minor depression in the primary care setting.[2]

General practitioners who initially miss depression, particularly in patients who present with somatic symptoms, often diagnose it at subsequent visits. However, in one study 14% of the patients who were initially missed remained significantly depressed three years later.[6] There is no evidence that routine screening for depression would necessarily result in a better outcome for these patients.[7]

How should mild depression be treated?

The management of any patient who is depressed should include:

- discussion with the patient about the nature of depression and its course
- discussion about treatment options and likelihood of response to treatment

- reassurance as to the effectiveness of treatment – this is important in combating the feelings of hopelessness and in maintaining treatment adherence
- consideration of specific psychological strategies, for example cognitive behaviour therapy, interpersonal therapy, problem solving therapy (Table 1).

In clinical practice, psychological strategies are generally used to help patients with mild depression and may be considered as first-line treatment. The main non-pharmacological treatment used by general practitioners is still supportive counselling.

Counselling at a basic level involves active listening, allowing patients to tell their story over a series of visits and to be listened to in a way that enables them to reflect on the path that they could take to recovery. Active listening is an interactive, engaging process whereby the listener focuses attention on the person and attempts to understand and interpret the non-verbal and verbal messages. The listener then uses verbal and non-verbal techniques to communicate that they have heard and understood the message. This requires attending, following, directing and reflecting skills. However, there has been no published randomised controlled trial involving general practitioners using active listening techniques for patients with minor depression.

The Australian Government has introduced initiatives, which include incentives for general practitioners to undertake further mental health training in the belief that this will improve their management of depression. This training has particularly encouraged the use of focused psychological strategies which have some evidence to support them, for example cognitive behaviour therapy and problem solving therapy.[8]

A systematic review comparing brief psychological therapy (cognitive behaviour therapy or interpersonal therapy) with usual care for patients with major depression included six primary care studies.[8] Overall, patients were more likely to experience remission of the depression in the psychological therapy group, although there have been no published studies examining cognitive behaviour therapy or interpersonal therapy in patients with minor depression or dysthymia.

Some small randomised studies have looked at problem solving therapy and shown that it may be as effective as antidepressants for moderate depression. However, there are very limited efficacy data on patients in general practice with mild depression.

St John's wort

St John's wort, also known as *Hypericum perforatum*, is one of the many herbal remedies readily available over the counter to the general public in Australia. There is growing evidence that St John's wort can effectively treat mild to moderate forms of depression in the short term, although there are no long-term efficacy and safety data available on its use. St John's wort has been well tolerated in trials, with fewer adverse effects being reported than with antidepressant drugs, although it does have the potential for a variety of drug interactions.[9] The potential interactions with commonly used medications have considerable implications for general practitioners, regardless of whether they would actively encourage their patients to use St John's wort. The Therapeutic Goods Administration in Australia has issued an 'Information sheet for health care professionals' to outline the potential risks.[10]

Table 1

Specific psychological strategies

Type of therapy	Method used
Cognitive behaviour therapy	Uses structured approaches to modify thoughts and behaviours Challenges automatic negative thoughts and irrational beliefs, and encourages the development of constructive responses
Interpersonal therapy	Focuses on current interpersonal experiences Improves quality of relationships
Problem solving therapy	Identifies significant problems Generates practical and achievable solutions Evaluates the preferred solutions

For minor depression, there are insufficient research data to support the efficacy of 'newer antidepressants'

Antidepressant use

The use of antidepressant drugs has increased dramatically over the last decade, in response to greater awarenesss by general practitioners and patients and the availability of selective serotonin reuptake inhibitors. Much of this prescribing may be to primary care patients with minor depression. This is despite the fact that for minor depression, there are insufficient research data to support the efficacy of 'newer antidepressants' such as selective serotonin reuptake inhibitors and there is no good evidence that tricylic antidepressants work.[11] Even for mild major depression, psychological strategies using cognitive behaviour therapy or problem solving techniques have similar efficacy to antidepressants. For dysthymia or chronic mild major depression there is evidence that tricyclic antidepressants and selective serotonin reuptake inhibitors are as effective as each other.

If the patient is presenting with either a recurrent episode of major depression or an initial episode with moderate to severe

depression or with psychotic features, then psychological therapy is not first-line. Antidepressants may similarly be indicated for people who are not responding to psychological therapy.

Self-help

In Australia, it is very difficult for depressed patients to find accessible, affordable and timely counselling by psychologists or psychiatrists. Many general practitioners have recommended self-help books and more recently the internet to help their patients. What is the evidence that this is of any use? Recent systematic reviews have found that bibliotherapy (self-help books and leaflets)[12] and computerised cognitive behaviour therapy programs[13,14] can assist patients with depression and/or anxiety over and above usual care. For mild depression, it may be that access to these resources could be the cheapest and most effective management strategy that general practitioners can use. Exercise has also been shown to be of assistance in improving mood and in one study it lowered relapse rates compared to antidepressants for patients with persistent depression.[12]

Conclusion

Mild or minor depression is very commonly managed by general practitioners, and the majority of patients probably get better by themselves or with a supportive 'waiting' approach. In a small proportion of patients, the depression becomes chronic and disabling.

All of the management strategies have been studied in patients with major depression, mostly in secondary or tertiary care settings. There is no evidence to support the use of antidepressants in general practice patients who do not meet the criteria for major depression or dysthymia. There are limited data from primary care settings on the usefulness of psychological strategies, St John's wort and self-help strategies.

Supported self-help programs based on cognitive behaviour therapy and exercise programs may be the most appropriate strategies to use with patients experiencing mild depression. Listening carefully to patients' stories can be an intervention by itself and will allow the many social factors (work, relationship, family) and other factors (abuse, illness, alcohol) that interact with depression to emerge. Patients who are not improving should be reassessed as they may be becoming more depressed and may require the addition of drug treatment.

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Conflict of interest: none declared

Self-test questions

The following statements are either true or false (answers on page 23)

3. Clinical trials show that antidepressant drugs are the most effective treatment for minor depression in general practice.
4. Screening for depression in general practice improves the outcomes for patients.