Practice Tips

Cognitive-behavioural therapy in a family practice

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Major depression is one of the most common conditions in community family practices.[1] Cognitive-behavioural therapy (CBT) is recognized as an effective intervention for this illness,[2] and for other mental health disorders. Family medicine involves longitudinal care: this could facilitate counseling because a relationship is already established, and we already have some knowledge of our patients' personalities and problems.

Recent research has shown that one of the most important determinants of whether patients improve with CBT is adherence to the model rather than therapist experience.[3] Manuals have been published to help patients and physicians apply the principles of CBT; one of these manuals (*Mind over Mood*[4]) was recently used in a randomized controlled trial of CBT in primary care.[5]

Research has also shown that depressed patients do best when they are allowed to choose which therapy they prefer; patients expressing a preference for pharmacotherapy tend to improve most on medication, while those who prefer psychotherapy do best with that therapeutic choice.[6] Both CBT and medication have been associated with similar rates of improvement in acute depression.[7]

Expanding my bag of tricks

I decided to implement this approach in my practice. I took a course on CBT offered at my hospital and then purchased the *Mind over Mood* manual and its clinician's guide.[8] I became familiar with their contents and recommendations and completed several of the exercises from the manual to ensure that I was comfortable with them and would be able to explain them to my patients.

When patients present with symptoms compatible with depression according to DSM-IV criteria,[9] I use their first visit to make the diagnosis. If there is time during that visit, I outline a therapeutic plan and explain briefly what psychotherapy and pharmacotherapy would entail. Often, there is insufficient time, so if patients are not acutely suicidal, I explain the diagnosis and assure them that effective therapy is available.

I give patients a booklet on depression and book a second, longer appointment. At that appointment, treatment is discussed, and patients are offered a choice. I have found that many patients choose both therapeutic modalities.

If patients express a preference for CBT, either alone or combined with pharmacotherapy, I give them the name of the manual and ask them to buy it at one of the large bookstores (or obtain it from the publisher, Guilford Publications, by calling 1-800-365-7006). At that time, they are also assigned their first homework: they are to grade the severity of their symptoms using a list of depressive symptoms from the manual, and they are to make a list of problems. I assign chapters in the manual according to a set pattern (I have the pattern stored in my Palm personal digital assistant).

Patients are to bring their manuals, along with their homework, to my office for each visit. We review the homework and correct and discuss difficulties; I assign further work. I have found that some patients are very compliant with this approach. They bring back large amounts of work. Others require a great deal of encouragement. This is somewhat similar to other conditions involving self-management, such as diabetics reviewing blood glucose readings.

I sometimes remind patients that the more work they do at home, the fewer visits they will have to make to my office. Patients also find it encouraging that they are

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responsible for their own progress: this is a very active, cooperative form of psychotherapy.

Traditionally, 12 to 16 sessions are recommended for CBT. This might not be practical in most family practices due to time constraints. There is evidence that even brief CBT can be effective.[10] I have found that most of the work is concentrated early in therapy, with four or five weekly visits at the beginning. As patients improve and become more proficient at completing work at home, I space visits out to monthly and then every 2 months. Patients have the manual and copies of their work at home to review as needed for the future.

Modifying practice

Offering CBT is possible within a broad-based family practice. It requires some modifications in the way we practise psychotherapy, such as using a manual that patients are required to purchase, assigning homework, and following a set model. The results in my practice, in terms of my patients' improvement and satisfaction with this therapy, have been encouraging.

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