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Depressive feelings as presented in primary care in the Netherlands

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Abstract. The article presents results of the study carried out in 2012—2013 and aimed at describing current primary care psychology in the Netherlands. Special attention was paid to diagnostics and treatment approaches to depression in primary care. Depression is currently ranked highly in the disease burden worldwide, and the problems of underdiagnostics of depression and the search for most effective treatment approaches are generally discussed. By means of literature analysis and interviews with practicing primary care psychologists we created a qualitative description of the process of recognition and approaching depressive complaints in primary care settings. The main findings on recognition of depression include described behavioral patterns that can become evident during a consultation with health care providers. These descriptions extend the accepted criteria for depression diagnostics to directions for observation during a consultation. Specific suggestions on treatment of depression expressed in interviews that compliment the steps of Multidisciplinary Guidelines for Depression in the Netherlands include addressing specific areas in a client's life, helping clients to restore relationships, activating the client, helping to express the feelings, and considering the etiology of current problems. The ultimate goals of counseling perceived by the primary care psychologists are generally oriented to increasing autonomy, freedom, and choice in clients. These concepts are likely to represent the important societal values currently in the Netherlands.

Keywords: Primary care psychology, psychological counseling, psychotherapy, depressive feelings, treatment approaches.

Bibliographic reference

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Introduction

Primary care is a well established heath care system in many European countries. In the Netherlands, primary care for people with mental health problems includes that of the general practitioner (GP), social worker and psychologists (Hutschemaekers, 2007), and recently also specially trained nurse practitioners and case managers. Coordinated as a part of the stepped care system, primary mental health care offers short-term psychological help that is close to the client and is meant for clients of all ages. Primary mental health care addresses complaints that appeared for the first time, last no more than 6 months, and are a reaction to an identifiable stressor. The general practitioner plays the role of a "gatekeeper" referring clients with psychosocial concerns to the primary care psychologist or other professionals. The very idea of offering such help emerged in the Netherlands in the end of the 1970-s (Derksen, 2009).

Currently the primary care system is referred to as a fascinating laboratory for psychologists to create innovative interventions for health problems in the 21st century (McDaniel & LeRoux, 2007). Having adopted the bio-psycho-social model as the theoretical background, primary care psychologists aim at clients' good quality of life and strong personal relations via strengthening the healthy characteristics of a client, involving client's

system (family, relatives and other important people) into treatment process, applying techniques from different psychological approaches, and close cooperation with other primary care providers (Derksen, 2009).

Extensive research has been devoted to various aspects of psychological practice within primary care like general effectiveness of treatment (Hutschemaekers, 2007; McDaniel & LeRoux, 2007; Ormel et al., 1990), approaching specific psychological issues or disorders (olde Hartman, 2011; van Os, 2003), presentation and recognition of complaints (Klinkman, 1997), cross-cultural aspects of care (Schoen et al., 2006, Simon et al., 1999). However, another important area to explore is the communication links between health care professionals involved in addressing certain psychological complaints: the general practitioner, the psychologist, social workers, case managers or caregivers when necessary, and the client. We assumed that discussing a specific type of complaint — depression or depressive feelings — would give important insights into the nuances of psychological primary care practice.

The choice of depression in this regard is not accidental. Prevalence of depression has been indicated to be high not only in the Netherlands (Conradi, 2007; Spijker, 2013). Major depression is currently ranked fourth in disease burden worldwide and expected to rank first in high income countries by the 2030 (Cuijpers et al., 2008). Also, depression appears to be one of the disorders that presents itself as *a continuum* from minor to major symptoms that are often masqued behind somatic complaints and are not recognized by health care specialists. Under-diagnostics of depression is being discussed as a problem in the practice of general practitioners (Ormel, 1993; Simon et al., 1999; van Os, 2003), as many depressed primary care patients present with non-specific somatic complaints that may divert attention from identification of depression.

Moreover, many studies address the recognition process of mental disorders from the quantitative approach (e.g. Ormel, 1990; van Os, 2003; Kool, 2005; Conradi, 2007). However, it is the communication between the mental health care professionals and the patient that provides a potential of the determining the most exact condition and, if required, the following intervention plan. It can be suggested that a qualitative research would give a different kind of insight into the process. Therefore, the research goal of the current study was to gain insight into early recognition of depression and the most effective interventions for depression, especially in mild and moderate cases. Achieving this goal helped to understand the communication process between the depressed person and health care specialists, to analyze the collaboration process of the general practitioner and primary care psychologist and to describe the organizational format and administrative process of counseling in primary care, which were also important interview goals.

Methods

Literature analysis applied at the start of our research helped creating a general understanding of the primary care principles and organization, roles of its specialists, approaches to addressing various psychological issues and specifically depressive complaints and feelings. However, this description would have been incomplete without the specific information about content and organization of primary care communicated from the immediate professional experience of primary care psychologists.

In January-March 2013 we held 6 interviews with 7 primary care psychologists working in health care centers or having their own private practice. Specialization of the interviewed psychologists, in terms of age of clients, included working with adults, older adults and their relatives, children and teenagers. The range of approaches of specialization varied from cognitive-behavioral therapy to psychodynamic therapy to neurofeedback approach. Primary care psychologists were recruited through www.lve.nl web-site (of the

society for primary care psychology) and also by means of the university network. A letter with an invitation to participate in current research project was sent to every prospective respondent.

The interviews lasted from 45 min to 1 h 10 min and took place either at the psychologist's practice site, or at the university. The interviews were fully audio recorded with psychologists' consent, and transcribed verbatim. All interviewed psychologists were, besides their primary care practice, involved in other professional activities (teaching at the University, teaching at professional organizations, working at a nursing home). Eleven original interview questions were formulated. In the process of interviewing additional questions about the organizational format of help were added.

Results and discussion

In the following descriptions, qualitative analysis of interviews is accompanied by the comparison with previous research and practice findings. Therefore, the presentation of immediate results interview results is combined with the discussion of specific issues and literature references.

Depression recognition and diagnosing

The research (Handbook of Depression, 2009) demonstrated that depressed people tend to show distinct communication patterns, among them are approval seeking behavior and negative feedback seeking behavior. In the interviews, we inquired whether psychologists can confirm it from their experience and possibly suggest other communication tendencies that could help a general practitioner or a psychologist to recognize depression, not only using the current diagnostic criteria of the classification systems like the DSM (Diagnostic and Statistical Manual of Mental Disorders), but considering a broader context of the patient.

Most of interviewed psychologists suggested specific behavioral or emotional patterns that can possibly be considered as the signs of depressive feelings:

- Change of behavior or feeling in a client: once a general practitioner knows the client for some time, it becomes possible to observe the changes of any kind that take place in the behavior of a person;
- Irritation shown by the client regarding anything that is being discussed in consultation;
- Expressed feelings of sadness, or even crying – in those cases when clients don't try to "masque" their feelings, but cannot fully make sense of what is going on in their life;
- Feelings of inferiority experienced by the client that can be assessed by asking such questions, as "do you feel that you are less important than everybody else?", "do you feel that other people are worth more than you?", etcetera.

Helping people to express their feelings is considered an important part in the consultation, as a lot of people may experience difficulties with finding the right words to describe how they feel. In regard to the communication patterns mentioned in other research, negative feed-back seeking behavior was evaluated as non-specific for depression and as a possible reflection of any mental health distress, and approval-seeking behavior to be more true for anxiety conditions. However, just the fact that primary care psychologists formulated specific suggestions about what and how can be observed in a client, allows to conclude that observation and asking the right interview questions besides the diagnostic instruments can contribute a lot to early recognition of depression in its mild stage.

At the same time, even when the correct questions are asked, a person may be reluctant to discuss his or her problems with a general practitioner, viewing psychological

disorders as something unacceptable and frightening, or seeing psychological issues as not belonging to the discussion with a doctor. This becomes especially true about older adults and clients from certain cultural backgrounds. Most interviewed psychologists admitted that working with clients from different backgrounds require some adjustment, for instance:

(in some cultures) "…they don't talk much about feelings… people talk more to the doctor about physical complaints. There are a lot of psychical complaints, and all the stress goes into the body. So in talking about feelings – they can tell, but mostly they don't see a relationship between their oppressed feelings and their complaints"

Another aspect is age. Due to generational conditions, clients of older age may be generally less used to discuss their emotional life and also be less informed about the roles that health care professionals can perform. From the experience of an interviewed psychologist, specializing in working with older adults:

"I have many clients, and I always ask: do you know what a psychologist does? Because many people don't know this word even. So it first starts with making contact, and looking at what their ideas are"

In such cases, a motivational invitation to discussing feelings will be likely to become the first step in the practice of professionals.

Another issue discussed in professional literature is differentiating between depression and other psychological problems. It is discussed that depressive feelings presented by the client can be as well indicators of other psychological disorders and have different origins (e.g. narcissistic personality, burn-out syndrome, prolonged grief, etc.). Interviews with primary care psychologists showed that these conclusions originate from the "disorder oriented thinking", as opposed to the "primary care thinking" that is oriented to investigation of various life spheres and situations that can potentially be causing distress and looking for the ways to improve the situation. However, it was also mentioned that possible implications of differences in those states to the process of psychological help include considering the character of the onset of problems (slow, gradual onset in case of depression, and presence of a specific factor or event in a situation dealing with loss). Also, clinical experience of one of the interviewed psychologists showed that depression seems to be recurrent, tends to run in families, and strongly involves biological level of being.

Effect of depression recognition on the client

Both the beneficial effect of recognition and provoking a dependant patient role is discussed in literature. On the one hand, "naming" the condition or a disease may provide a relief to a patient and prevent from further confusion or self-blaming if these had been taking place previously. Ormel et al. (1990) argue that recognition contains an "active ingredient" of re-interpretation of symptoms and signs, allowing the patient (and their social environment and the GP) to deal with the problem situation. On the other, as McDaniel and LeRoux (2007) state this, along with lifting the burden of blame in case of receiving a diagnose, a passive-dependant patient role can be encouraged. What can help make the effect of diagnosing already therapeutic for the client?

Answers of psychologists were different in nature. Radical positions included not working with diagnosis at all in primary care (*"label makes people passive"*), and opposed to that, the necessity of diagnosis when appropriate (*"diagnosis is necessary for protocolyzed treatment", "if it has a name, they are to know it"*). A more flexible way to address diagnosis is to explain it as imbalance, a sign of unhappiness (*"let's not call it depression, let's call it your "personal devil""*).

Most psychologists agree that generally changes in attitudes towards therapeutic practices have occurred over the last years in the Netherlands bringing more attention to

mental health issues and attitudes changing towards more acceptance of psychological services. Such client's reactions as "please don't send the bill to my home address, because the postman will see that I am going to a psychologist, and I am ashamed!" are less and less common.

Nevertheless, it seems to be important how the diagnosis is discussed with clients by a primary care psychologist, how it is integrated into further process of exploration the current situation and proposing the consequent steps for interventions. For example, a dominant position of a psychologist may indeed provoke a dependant patient role in a client, while inviting the client to participate actively in the treatment may be effective for maintaining clients' responsibility for their own health. A useful model is the consultation model (Van Audenhove, Hamelinck, & Bleven, 2006) in which client and health care professional are interacting equally. The professional provides information to the client and the client is active in considering what would be most helpful for her/him.

Primary care format allows to maintain the active role of clients by means of them choosing (a) whether to enter therapy or not, (b) the most relevant problem or life area, (c) frequency of the following sessions, etc.. Interviewed psychologists find that all these help increase a client's responsibility for treatment. Some psychologists consider personal financial input into therapy required by insurance companies to be also beneficial for treatment motivation. Thus, primary care appears to be a flexible health care system in such aspects as communication, engagement, motivation and activating clients, allowing psychologists and general practitioners to apply their own considerations on how to make discussion of diagnose more beneficial and therapeutic for clients.

Most effective interventions for mild or moderate depression

Multidisciplinary Guidelines for Depression in the Netherlands (www.trimbos.nl) suggest three forms of depression treatment, starting with low intensity interventions and progressing to more intense treatment when necessary: (1) first-step intervention, (2) psychological interventions, and (3) treatment with medicine (pharmacotherapy).

First-step interventions are to be given to patients with first-time light depression. There are six different first-step interventions, namely (a) bibliotherapy, (b) self-help or self-management (with or without e-health), (c) activating support, (d) physical exertion / bodily activating or running therapy, (e) counseling, (f) psycho-social interventions.

Psychological interventions that are given preference to in treatment of depression are problem solving therapy and short-term therapy. When interventions listed above are insufficient or it is the case of moderate to serious depression, the following psychological interventions are recommended (a) cognitive-behavioral therapy/cognitive therapy/behavioral therapy (CBT), (b) interpersonal therapy (IPT), (c) short-term psychodynamic therapy (SPT).

Treatment with medicine is performed by the doctors and includes various medicines that are effective for depression. Which medicine is given preference to depends on the severity and duration of depression.

Considering all these, an interview question was formulated inquiring what interventions or treatment approaches psychologists find most effective in addressing mild and moderate depression. The answers were expected to provide judgments originated from the actual experience of practicing primary care psychologists.

As a result, intervention approaches mentioned by the interviewed psychologists are generally in line with those recommended by the Multidisciplinary Guidelines. Cognitive-behavioral therapy, interpersonal therapy, and short-term psychodynamic therapy are mentioned by psychologists with equal frequency.

Among more specific directions of interventions pointed out by primary care psychologists are:

(a) address specific areas in client's life

"I don't think… in a disorder way of thinking… I think… maybe you have this because you have problems in your work, your manager is really aggressive to you, you have a quite busy family life, and a problem with parents who are in need and you have to help them and it's difficult to see where to say no… so I address that"

(b) help restore relationships, integrate the client's "system" into intervention

"…so that they seek help, talk to others, so that they are less lonely…"

"If you also integrate into the intervention the system – the partner, husband or a wife, if you also help them dealing with the kids, if you use the system approach and look at the system, you can also shorten the treatment even in case of complex disorders"

(c) activate the client

"I think… with adults… one thing — activate them, and not stay in bed all day"

(d) help to name and express feelings (especially for older adults)

"I say — what kind of feeling is not good? In Dutch, it's with "b" — bedroefd, bang, boos — sad, afraid, angry… The feelings that you have, belongs to which of these three? So I help because to name feelings is sometimes difficult for an elderly person"

(e) pay close attention to etiology

"Personally I prefer to look at etiology, to know what made the person depressed. So you look at what you think the core of the problem is, and you can see it by the symptoms, by how people say things, and you often quickly get an idea of where the pain in their life is"

Aside from these psychological nuances of the content of therapy, a closer look at the three recommended steps of treatment reveals that involvement of different health care professionals is often necessary in working on cases. For instance, some of the psycho-educational activities can be performed by a social psychiatric nurse, whereas treatment with medicine is the general practitioner's area of competence.

In such cases when psychological interventions are applied along with psychopharmaceutical help, a close collaboration between specialists seems to be crucial. Also, considering psychological help along with medical treatment by the general practitioner seems to be beneficial for clients in terms of better compliance. Previous research demonstrated that refusal rates are significantly higher for pharmacotherapy among patients with major depression: in a 6 month randomized clinical trial 32% of the patients refused the proposed pharmacotherapy while only 13% refused the combined therapy (Kool, 2005).

Primary care psychologists confirm from their practice experience that it is more beneficial for the client to start with psychological interventions in mild and moderate cases of depression, for such reasons that it (a) provides a better prevention for relapse; (b) helps strengthen the client, and not "medicalize" the symptoms; (c) gives people a sense that they can do it themselves.

Most of the interviewed psychologists mentioned that they work with clients who receive pharmacotherapy occasionally, both in situations when a client has already been on medication before starting the therapy, and when a psychologist may initiate subscribing medication by means of consulting the general practitioner. However, one psychologist seemed to hold a radical position considering "biological treatment for a psychological disorder" to be ineffective.

Interviews also confirmed that personal contacts with general practitioners seem to be essential for primary care psychologists. Those psychologists who have an opportunity to discuss cases of clients with general practitioners, report high satisfaction with collaboration. Although other primary care psychologists expressed the necessity of the general practitioner to know primary care psychologist(s) personally and a wish to have more chances to communicate not only through letters and reports, but also in phone calls or live contacts.

The ultimate goal of counseling / service provided to clients

The question about the ultimate goal of counseling helped to understand what, besides of reduction in symptoms, is an important aim for psychologists while working with a whole spectrum of psychological issues.

First, it is important to mention that all but one interviewed psychologists do have a counseling goal that lies beyond eliminating the complaints that the client came with. More specifically, their answers can be united under the concept of increasing the feeling of autonomy, freedom, or choice in clients with accents more on the emotional level ("feel good"), behavioral level ("organize their lives", "can help themselves afterward"), or working on unhealthy cognitive and behavioral patterns that block both emotions and behavior. These goals indeed seem to be oriented beyond current difficulties of a client, as well as reflecting a multi-dimensional understanding of a client's life. Besides, these goals reflect intention to activate a client and use the therapy time as productive as possible for a client's future life, and it appears to be an important feature of primary care practice.

From a societal point of view, a question that arises if a connection could be drawn between the values generally shared by a society and culture, and the ultimate orientations of psychologists when working with their clients. Values of autonomy, free will and ability to organize your life according to own aspirations seem to be congruent to the current Netherlands society. A larger sample of interviewed psychologists working on different levels of the health care system in different countries and with different cultural backgrounds may be able to clarify this question.

Conclusions

Interviews demonstrated that depressive feelings can be effectively diagnosed and addressed in primary care with proper attention to emotional processes and behavioral changes of clients paid by both general practitioners and psychologists. Because, in the Netherlands, general practitioners are responsible for referring their clients to psychological help, their understanding of psychological issues is very important. In addressing depressive feelings, shifting attention from a strictly medical approach to considering psychological reality of the patient becomes crucial. In theory, this is expressed through applying the bio-psycho-social model in primary care and by following the care guidelines for depression that start with psycho-social interventions and only then progress to treatment with medicine (stepped care model). In practice, reflected through interviews with primary care psychologists, suggestions to consider psychological aspects more are expressed.

Regarding collaboration between professionals in primary care, an overall effectiveness was expressed by the psychologists. However, certain suggestions for improvement of collaboration were also presented. It can be suggested that addressing the experience of

more primary care psychologists would allow to outline and describe more features of clients that are relevant to presentation of depression. Continuing research in this direction would be interesting in understanding the whole spectrum of depressive feelings and ways of their addressing.

In general, expressed positions of the interviewed psychologists reflect the primary care ideology, viewing psychological help as generally short term, aimed to address specific issues in the current life, and involving the life context of the client. At the same time, the primary care system allows space for unique personal contributions in methods of interventions (even within the accepted guidelines), attitudes and positions, and working as a part of a network with other health care providers. However, some of the still unanswered questions are what major difficulties general practitioners encounter when recognizing and diagnosing depression, which interventions of specialists are perceived as helpful by clients, etc.. Therefore, researching similar issues of recognition and treatment of depression from the positions of general practitioners and clients would provide a more complete perspective on various aspects of depression treatment. Another direction for further research may include such areas, as investigating a depressed client's decision-making process for and against psychotherapy: what factors influence the decision, how is it different for clients of different ages and different severity of depression.

When projecting the questions on organization of care and addressing the depression on psychological practice in Russian Federation, it becomes evident that some of the issues will be displayed differently. For instance, providing a diagnosis is not an element of a psychologist's duties in Russia, but the question of effect of diagnosis is likely to present itself in different positions that a psychologist takes toward a client: from directive knowledgeable expert position to "following" the client and trying to understand his/her unique feelings.

Also, according to Yaroslavl region reality, psychological counseling can be considered an additional service rather than an essential part of the health care system. However, experienced practicing psychologists seem to be well integrated into professional community: 72% of counseling psychologists admit that their clients are referred to them by colleagues or other specialists (data of survey among psychologists and psychotherapists conducted in June 2013 by the Regional Association of Counseling Psychologists). It makes issues of collaboration with other health care specialists urgent for Russian psychologists as well and opens possibilities for researching similar issues of psychological care in Russian Federation.

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