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Is a psychotherapeutic approach possible in primary health care?

Authors: Julio Torales**[1]**, Iván Barrios**[1]**, Susana Calero**[2]**

Affiliation:
[1] Facultad de Ciencias Médicas, Universidad Nacional de Asunción, San Lorenzo, Paraguay
[2] Asociación Psiquiátrica de América Latina, Buenos Aires, Argentina

E-mail: jtorales@med.una.py

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Abstract

The development of valid psychotherapeutic approaches, adapted to the characteristics of the consultation in primary care, is a subject in constant development. In order to work effectively in a model of psychotherapy adjusted to primary care, the health practitioner (psychiatrist, psychologist, or family physician) must constantly focus on finding the most efficient way to treat the patient, in a short period of time, and with different nuances from those usually used in secondary care: That is, an eclectic and pragmatic approach to dealing with the problems that patients bring to consultation, and a practical and direct way of assisting them, in order to achieve therapeutic goals. To try to answer the question of whether it is possible to perform psychotherapeutic approaches in primary health care, this brief analysis presents a reflection on the issue and a case example.

Currently, most patients with psychosocial problems or mental disorders consult first with primary health care professionals [1]. For example, anxiety disorders and depressive disorders are very prevalent in the general population and affected patients are being treated, with increasing frequency, in primary health care facilities [2], [3], while referral to more complex care centers is reserved for more severe cases [4]. It is for this reason that the development of valid psychotherapeutic approaches, adjusted to the characteristics of primary care consultation, is a task that health practitioners (psychiatrists, psychologists, family physicians) around the world are addressing.

In order to be effective, these psychotherapeutic approaches must fthe unique therapeutic context of health care in primary care facilities, where the limited time for consultation and the need to adjust interventions to few sessions are often essential characteristics. In many parts of the world access to psychotherapy services is limited [5], so psychological interventions offered in primary care facilities are usually of short duration (six sessions, for example) [6]. This contrasts with the duration of psychotherapy offered at secondary care centers, which usually runs for 12 to 24 sessions [7]. All of the above makes primary health care fundamentally different from that provided in secondary care. Furthermore, primary care in mental health is distinguished from secondary care, since in the latter the patients typically present themselves with more chronic illnesses, with a longer course and accompanied by many risk factors [8], [9].

Here we might ask: does psychotherapy really work in primary care? In short, we can say it does [10]. Recent research has confirmed the effectiveness of brief psychotherapeutic interventions (mainly cognitive behavioral therapy, problem solving therapy and counseling) for the routine treatment of psychosocial problems in primary care, taking into consideration that some patients should clearly be referred to facilities where longer term treatments could be performed [11], [12].

Likewise, Cape *et al*., through a meta-analysis and meta-regression study, have shown that most of the brief psychological therapies in primary care (cognitive behavioral therapy, problem solving therapy and

counseling) are effective for the treatment of anxiety disorders and depressive syndromes; and that, in addition, there are no significant differences between the three types of psychotherapy previously mentioned [10].

A case example

Mrs. B, a 70-year-old widow, presented herself to the Family Health Unit because of an eight-month history of "crisis" in which she found it difficult to breathe, felt herself choking, felt that she was going to "lose control" and with chest pain. She also felt very distressed when shopping at the supermarket or taking the bus. These attacks were repeated at least once a week. The family physician ruled out some organic process and referred the patient to the primary care psychiatrist's office.

In the consultation with the psychiatrist, the diagnosis of panic disorder with agoraphobia was reached. Mrs. B was medicated due to a number of medical conditions (hyperuricemia, hypertriglyceridemia, type II diabetes mellitus, vestibular syndrome, and hypertension). Because of the above, it was decided not to start psychotropic drugs, opting for a psychotherapeutic approach.

It was decided to design the treatment in eight sessions, taking into account the structure of a primary health care facility. The psychotherapeutic work consisted of training in breathing, training in relaxation and cognitive restructuring, avoiding exposure techniques due to the multiplicity of medical pathologies in the patient (e.g., vestibular syndrome) and the impossibility of having adequate medical care in case of complications. The following is a summary of the interventions made at each session.

- Session 1: Treatment expectations were discussed and therapeutic goals were established.
- Session 2: The patient was instructed on how to use abdominal breathing at the first sign of hyperventilation, anxiety or panic attack.
- Session 3: The patient was taught basic relaxation techniques. The patient was motivated to practice these techniques at home, even during symptom-free periods.
- Sessions 4-8: Cognitive restructuring was worked with the patient, first identifying her irrational beliefs (for example, "if I stop going to the supermarket, the attacks will no longer happen"), restructuring her thought process and teaching Mrs. B to manage her bodily sensations and physical symptoms of anxiety.

The patient had a very good adherence to the treatment, fulfilling all the sessions. The therapeutic response was good, and a considerable decrease in symptoms was observed from the fourth session. Currently the patient is free of symptoms and has only relapsed one time since the end of therapy (one year ago).

In primary health care, the challenge for every psychotherapist is to give up the idea of "healing" [8], [11], focusing primarily on trying to alleviate, at least in part, some of the many psychosocial problems that the patient may bring to consultation. This may represent a very difficult mentality change for many therapists [8].

In order to be able to work effectively in a model of psychotherapy adapted to primary health care, the mental health professional must constantly focus on finding the most efficient way to achieve the therapeutic goals, in a short period of time, which can often involve "directing" the patient to certain areas, and reduce the time of discussion in others. This is achieved by balancing the self-exploration processes of the patient with a more direct care approach.

In places where there are not enough psychologists or psychiatrists, family physicians should be trained and be able to offer brief psychotherapeutic interventions. This could be done through long-term educational reforms [4] or through ingenious solutions, in which patients are cared for together and at the same time by a psychologist/psychiatrist and a family physician. This will allow the family physician to be able to acquire practice in the art of psychological therapies [13].

In addition, the medical characteristics of patients should be taken into account when designing psychotherapeutic strategies. In the psychotherapeutic processes performed in primary care, it is the responsibility of the therapist to help the patient to maintain a fundamental balance between "change" and "stability". Due to time constraints, the therapist must be cautious in addressing coping mechanisms and coping styles that the patient has developed [14].

In summary, we can say that psychotherapy is useful in primary care and, to be truly successful, should take on different nuances than those usually used in secondary care. This means an eclectic and pragmatic approach to dealing with the problems that patients bring to the consultation and a practical and targeted way to assist the patient and achieve therapeutic goals.

Notes

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Author address:
[1] Hospital de Clínicas
Campus Universitario de la Universidad Nacional de Asunción
Avenida Mariscal López
San Lorenzo
Paraguay