COGNITIVE-BEHAVIOURAL THERAPY: A PRIMER FOR PRIMARY CARE

Feb. 14, 2020

Dr. Elizabeth Hebert, Ph.D. C.Psych

Agenda

- 13:30 -13:40 Introduction and Disclosure
- 13:40-14:15 Didactic teaching on CBT: evidence, key principles for anxiety and depression
- 14:15-14:45 Small groups – 1st scenario
- 14:45-15:15 Small groups – 2nd scenario
- 15:15-15:30 Group discussion of cases, Q&A by participants

Learning Objectives

1. Explain the evidence that supports the use of Cognitive Behavioral Therapy (CBT) in primary care
2. List the clinical conditions for which CBT is indicated
3. Explore the CBT techniques that are useful in the primary care setting
4. Apply the CBT techniques in a standardized patient interview based on two different clinical scenarios

Speaker bio

- Clinical Psychologist and Assistant Professor
  - Dept. Clinical Health Psychology, WRHA & U of M
- Concordia University: Ph.D. Clinical Psychology
  - Main research area: development and evaluation of cognitive behavioural therapies for emotional disorders
- Current clinical position: Operational Stress Injury Clinic at Deer Lodge Centre
- Previously: psychologist for the Shared Care Program, servicing 27 primary care clinics in Winnipeg

Disclosures

- No commercial interests/conflicts of interest to disclose

A little about you

- Previous CBT training?
- Main learning goal for today?

CBT BASICS

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What is CBT?

- Cognitive-behavioural therapy (CBT) is a type of psychotherapy that is:
  - Focused on thoughts, behaviours, and emotions
  - Skills-based
  - Goal-oriented
  - Here-and-now
  - Active and requires client engagement

(Beck, 2011; Robichaud & Dugas, 2015)

CBT has demonstrated efficacy for:

- Depression
- Anxiety disorders
  - Panic, generalized anxiety, social anxiety, agoraphobia, specific phobia
- Stress and adjustment disorders
- OCD and related disorders
- PTSD and trauma related disorders
- Insomnia
- Chronic pain
- And more!

Who benefits most from CBT?

- Individuals who:
  - Have a clear diagnosis
  - Are motivated for change
  - Willing and able to actively participate, including homework exercises
  - Have relatively stable life circumstances
  - Are cognitively able to engage with materials
  - Value scientific, problem-solving approach

(Unger, 2019)

CBT: THE ROLE OF PRIMARY CARE

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CBT: Dosage and Delivery

- Empirical evidence largely based on RCTs
  - Manualized treatment protocols (standardized)
  - Typically delivered by mental health professionals (typically with M.A. and/or Ph.D. training in psychotherapy)
  - Standard protocols typically take 8-20 sessions to administer
    - Session 1-1.5 hours in length; weekly frequency

CBT in Primary Care

- Selected meta-analyses and literature review evidence:
  - CBT for anxiety/depression delivered in PC setting is more effective than PC as usual or no PC (see meta-analysis: Twomey et al., 2015)
  - Individual CBT delivered by specialized mental health professionals is helpful when given adequate session dosage (Høifødt et al., 2011)
  - Internet/computer-based CBT self-help materials helpful but only for mild-moderate anxiety/depression (Høifødt et al., 2011)

(Adapted from Unger, 2019)

CBT Delivered by GP's

- Mixed support for CBT sessions targeting specific concerns delivered by GPs (e.g., Arnold et al., 2009; Huibers et al., 2004, Leonie et al., 2006; Unger, 2019)

- Some evidence of improved use of CBT strategies with extensive training and supervision (e.g., Heatley et al., 2009; David & Freeman, 2006)

The Role of Primary Care Providers

Identify, refer, & prime for maximum engagement

- Key interventions:
  - ID patients who need "full-dose" CBT
  - Make appropriate referral
  - Motivational interviewing to resolve ambivalence toward change

CBT-Informed consult model

- Mild/subthreshold or early presentations to aid patients in getting back on track
- Key interventions:
  - CBT model
  - Psychoeducation
  - Brief behavioural skills

CBT-Informed Consultation

1. Build collaborative understanding of problem using basic CBT model
   - Guided discovery
   - Use patient example
2. Provide CBT-informed psychoeducation
   - Empathy is key
3. Assess readiness for change: motivational interviewing
   - If yellow/red light, maintain MI approach

Adapted from David & Freeman (2006)

CBT-Informed Consultation

4

- Use behavioural strategies:
  - Depression: increase in activity level, particularly meaningful activities
  - Anxiety: SMART goal setting, facing feared situations

5

- Facilitate social support

6

- Symptom monitoring
- Refer to more intensive treatment resources if necessary

Adapted from David & Freeman (2006)

CBT THEORY & CONSULT SKILLS

A Focus on Anxiety and Depression

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SKILL 1: Building the CBT Model

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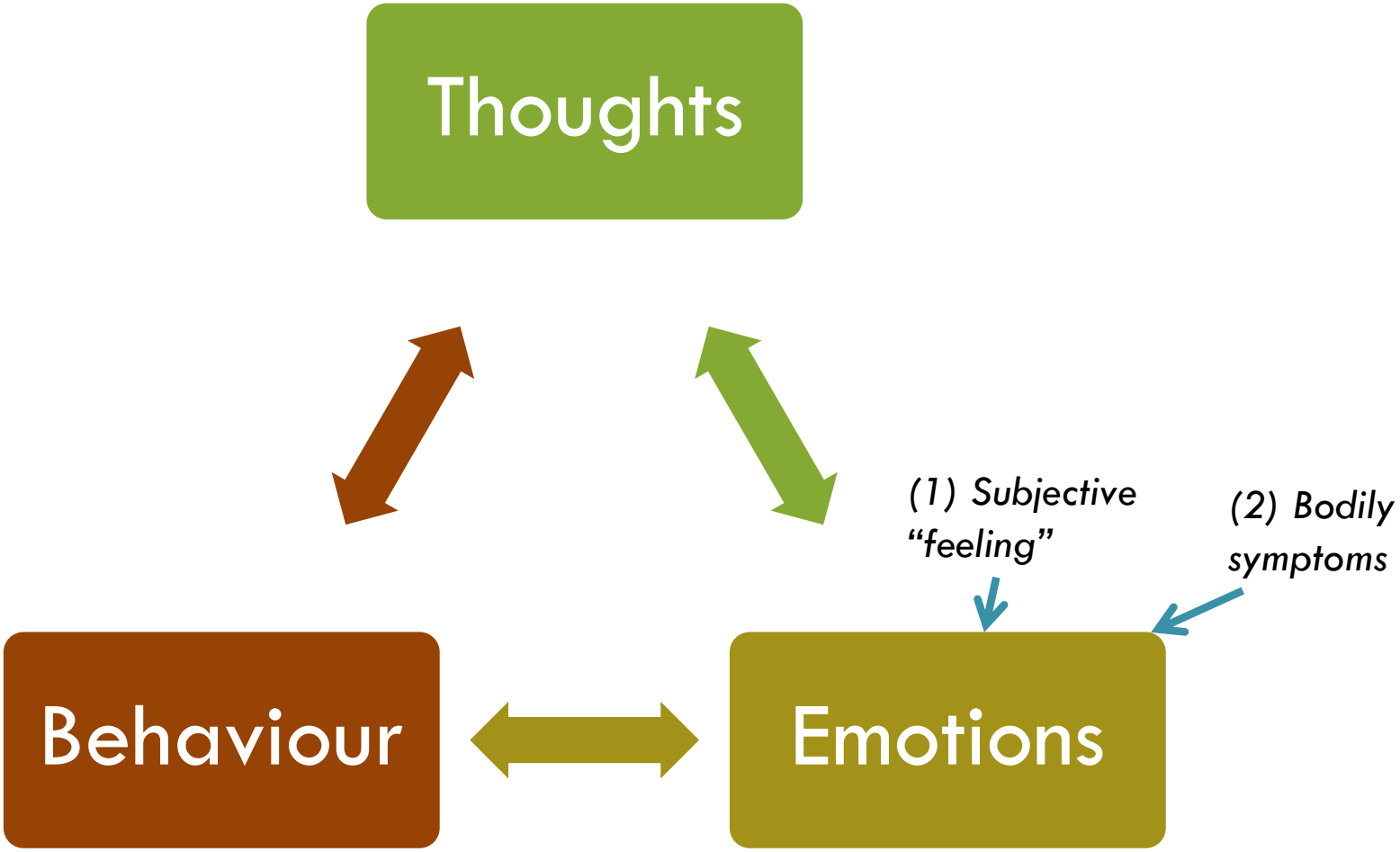
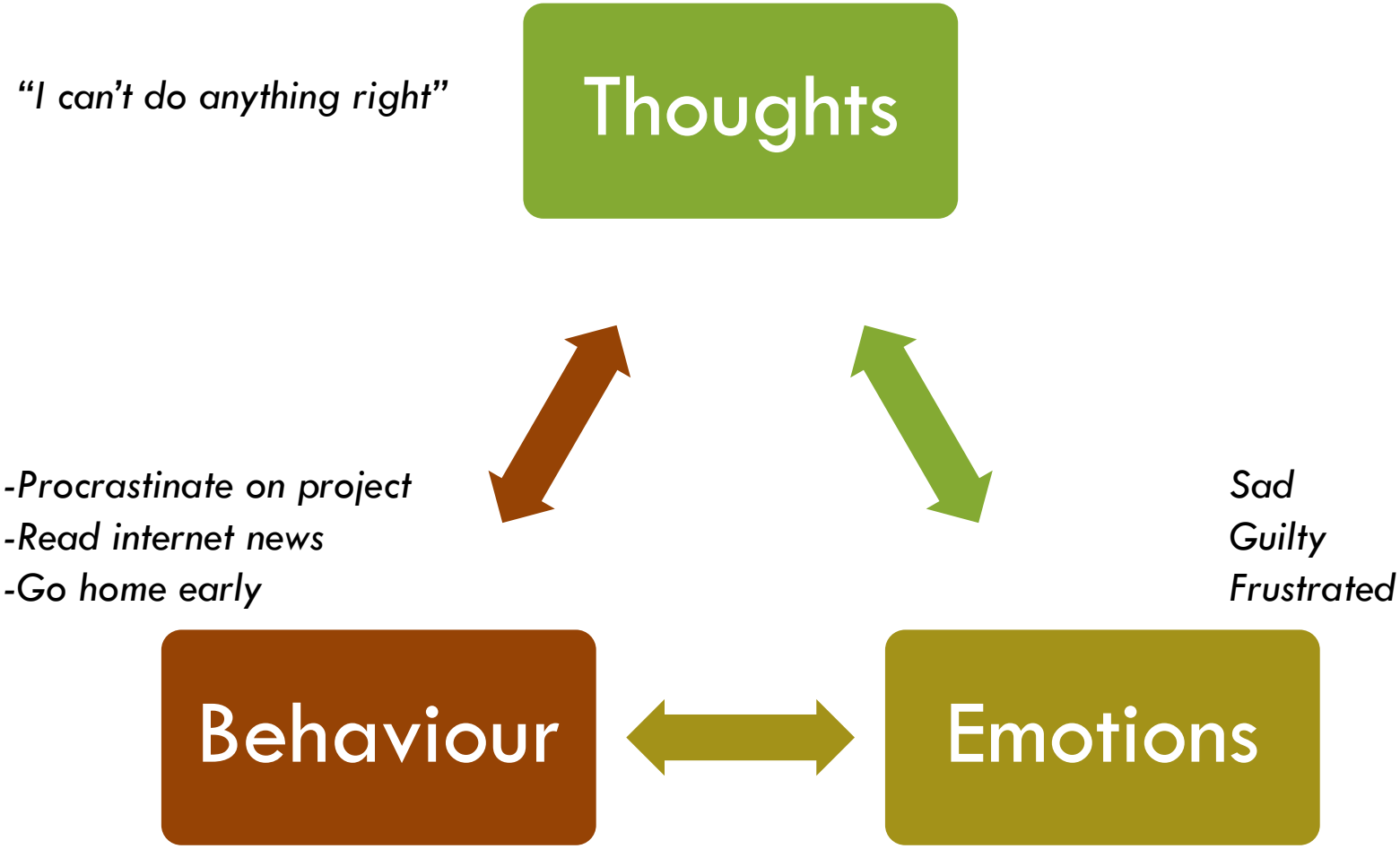
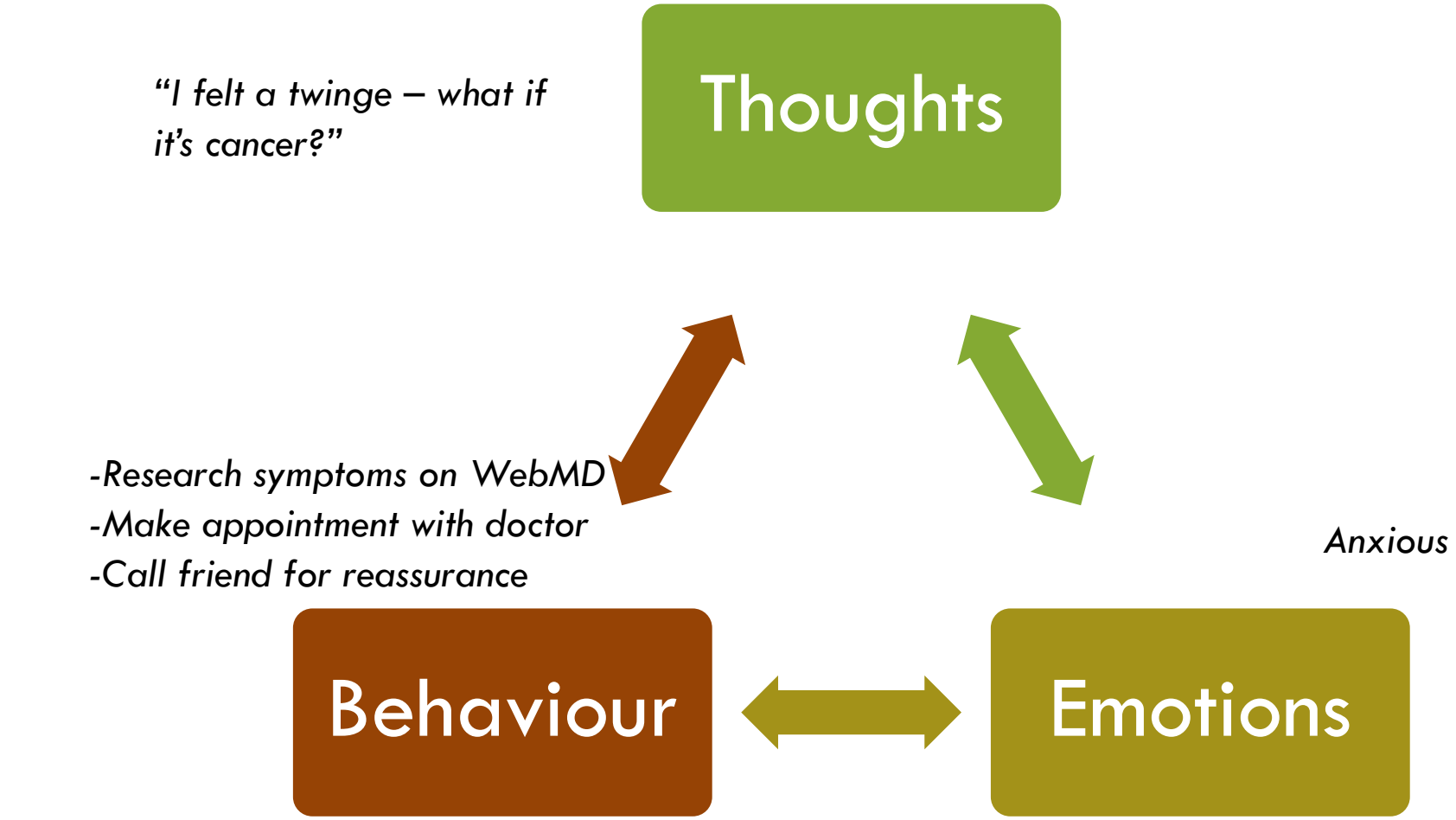
Using the Basic CBT Model



Using the Basic CBT Model



Using the Basic CBT Model



Keys to building the CBT model

- Ask patient for a *specific, recent* example
  - *"Tell me about a time when…"*
  - *"Walk me through what happened when…"*
- Record patient's response and organize into components (drawing helps!)
  - Prompt for missing pieces:
    - Thoughts: *"What was going through your mind?"*
    - Emotions: *"What was happening in your body? What were you feeling?"*
    - Behaviours: *"What did you do?", "How did you respond?"*

(Beck, 2011; David & Freeman, 2006)

Keys to building the CBT model

- Reflect your understanding of the model back to the patient
  - If you drew/wrote something, show the patient
    - Verifies your understanding
    - Engages patient
- Make an empathic statement
  - "*It makes sense that you…*"
  - Normalizes their difficulties
  - Enhances rapport
  - Increases your own empathy

(Beck, 2011; David & Freeman, 2006)

Goals for Building the CBT Model

- Create a shared understanding of the patient's difficulties
- Normalize patient's difficulties
- Facilitate collaboration
- Build trust and rapport
  - Empathy is important
- Guide treatment planning
- Structure and streamline your consult

(Beck, 2011; David & Freeman, 2006)

SKILL 2: Psychoeducation

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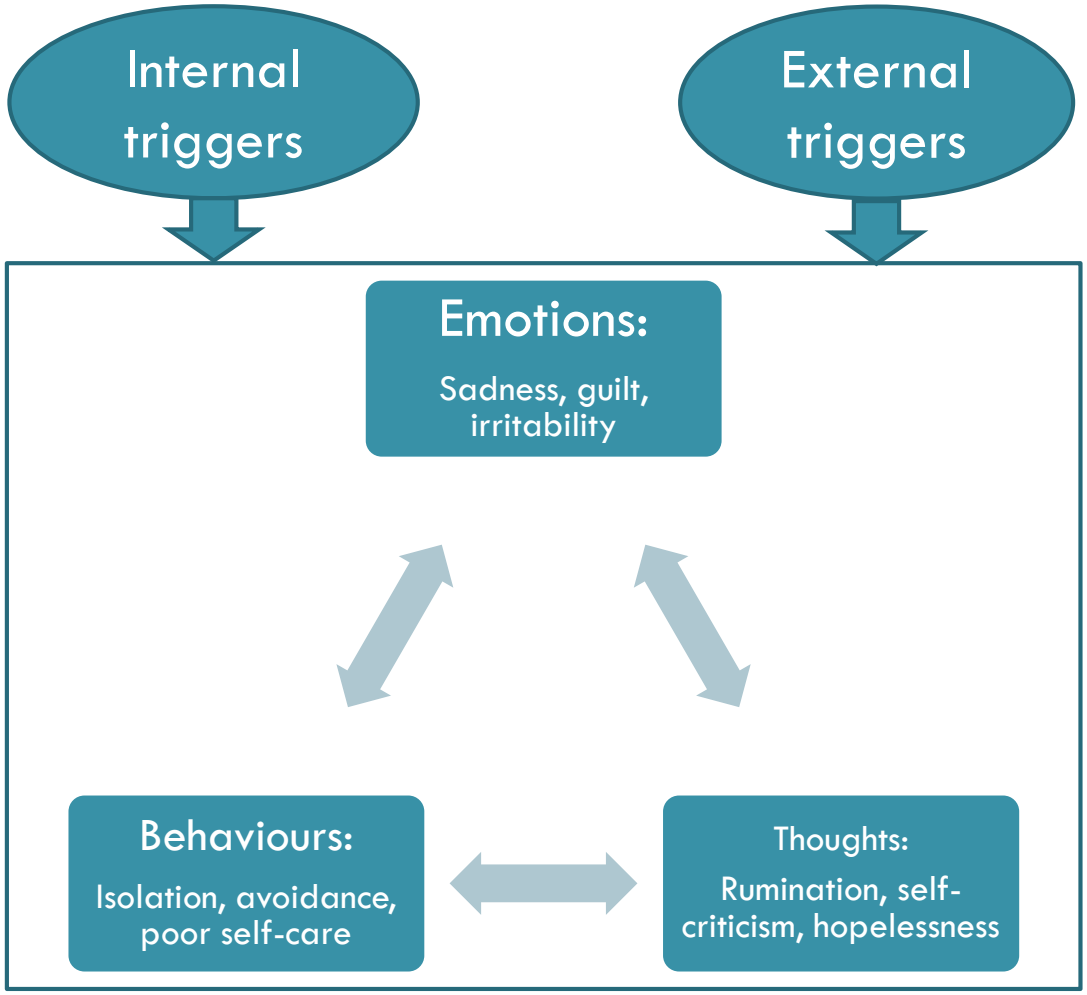
Goals of CBT-Informed Psychoed

- Bridge the gap between CBT model and behavioural intervention:
  - Provide brief rationale
  - Normalize patient's experience
  - Suggest treatment direction
- Can provide psychoed handouts *in addition to* brief verbal psychoed
  - Anxiety Canada website
  - Mood Disorders Association of Manitoba
  - Anxiety Disorders Association of Manitoba
  - Anxiety and Depression Association of America

CBT Model of Depression: Common themes



(Beck, 2011; Unger, 2019)

Typical CBT Components: Depression

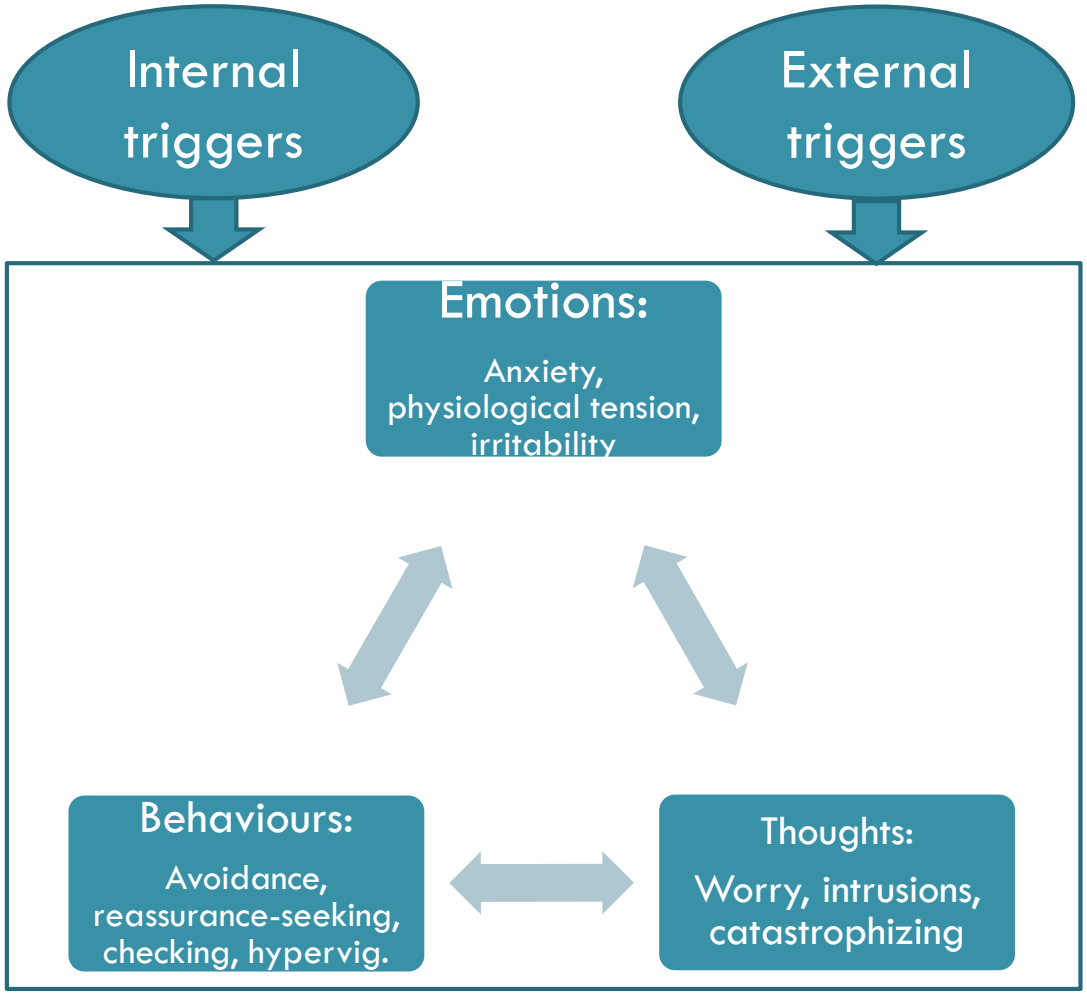
- Psychoeducation
  - CBT, depression symptoms
- Symptom monitoring
  - Daily (1-3 times) mood, activity level
- Behavioural activation
  - Goal setting (pleasure + mastery), activity scheduling
- Cognitive restructuring
  - Identifying & challenging unhelpful thought patterns
    - Common themes: overestimating effort, underestimating pleasure, self-critical core beliefs, unhelpful standards/expectations
- Relapse prevention planning

Key Component for Depression: Behavioural Activation

- Behavioural Activation
  - Goal: increase positive experiences, combat fatigue & anhedonia
  - Focus: *pleasure* and *mastery*
    - Also emphasize social connection
  - Generate activities and schedule them
    - Weekly basis, starting small
  - Motivational enhancement/supports may be needed
  - Paradoxical nature of energy & motivation

(Beck, 2011; David & Freeman, 2006; Unger, 2019)

CBT Model of Anxiety: Common themes



(Beck, 2011)

Typical CBT Components: Anxiety

- Differs significantly depending on type of anxiety
- Common elements include:
  - Psychoeducation
    - Sympathetic nervous system (fight-flight-freeze), false "alarms", avoidance
  - Goal setting
  - Symptom monitoring
  - Cognitive restructuring
    - Identifying and challenging negative thoughts (common themes: overestimating *probability* or *cost* of negative events)
  - Exposure
    - Identifying and entering into anxiety-inducing situations in a planned fashion
  - Relapse prevention

Key Component for Anxiety: Facing Fears

- Exposure
  - Avoidance reinforces fear
  - Exposure to feared situation leads to:
    - Habituation
    - Belief discomfirmation and inhibitory learning
  - Exposure exercises are:
    - Planned ahead of time
    - Done for a purpose (habituation and/or learning something about feared situation)
    - Done with the expectation of discomfort
    - Typically done in a gradual fashion
  - Powerful technique when done correctly, but complex and can be harmful if used incorrectly
    - In primary care, best to identify patient's functional goals (SMART), start small, focus on return to previous activities and reinforce the message of "avoiding avoidance"

(Beck, 2011; Unger, 2019)

SKILL 3: Behavioural strategies

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Depression: Activity scheduling

- Build an activity list:
  - Previously enjoyed activities
  - Activities that used to give a sense of purpose or achievement
  - New activities: pleasure and mastery
- Schedule activities:
  - *Facilitate patient* in choosing one or more activities they are willing to do in the coming week
    - Specific days/times
    - Get confidence/likelihood ratings

Bridging the gap with psychoed

- Link it to the CBT model:
  - *"So you notice that when you do less, you feel worse…"*
- Normalize
  - *"This is very common when folks are experiencing depression…"*
- Highlight key concepts:
  - Hard to change emotions directly, but we can change what we do to feel better
  - Natural withdrawal response to painful experiences
  - Paradoxical nature of energy/motivation
- Introduce strategy & invite engagement
  - *"I wonder if you might be willing to try something…"*

Anxiety: Facing fears

- As before, link to CBT model, normalize, & highlight key concepts:
  - Avoidance works in the short-term but is not helpful in the long-term in managing anxiety
  - Fight-flight-freeze system & "false alarms"
  - Anxiety symptoms are not dangerous
  - Facing fears in a slow and steady way builds confidence and decreases fear

Anxiety: Facing fears

- Facilitate the patient in identifying:
  - Functional goals/return to previous activities
  - Choose 1 to begin with
  - Break it down into small steps
  - Use SMART goal framework

- Ask patient for confidence/likelihood ratings
  - If low, problem-solve together

SMART Goals

- S: specific
- M: measurable
- A: achieavable
- R: relevant
- T: time-bound

You Are Your Best Tool

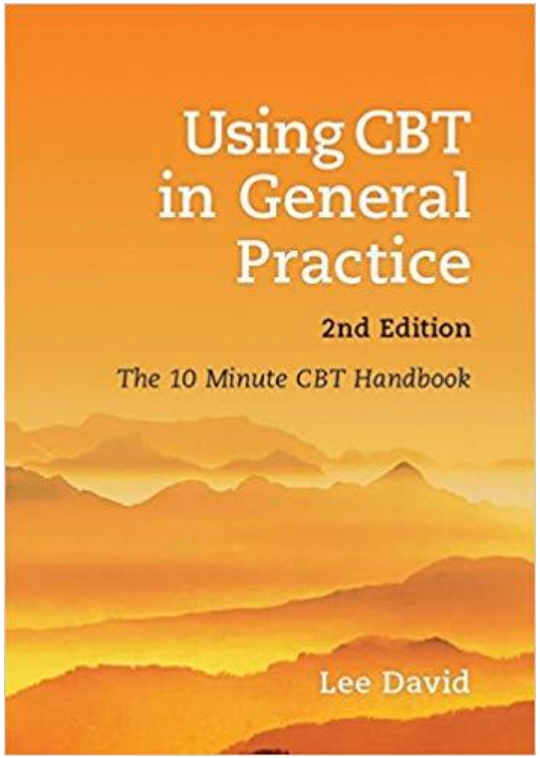
- Positive working relationship is the foundation of treatment
- Empathy is good for providers and patients:
  - Promotes greater work satisfaction and may help prevent burn out (Kerasidou & Horn, 2016)
- Patient-centered approach associated with improved emotional health outcomes and fewer diagnostic tests (Stewart et al., 2000)

(Adapted from Unger, 2019)

Additional Resources

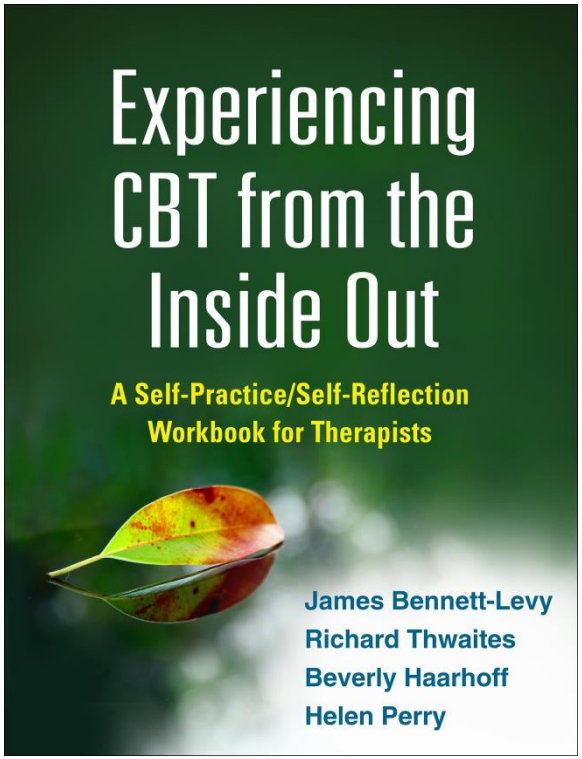
Selected resources for learning CBT

CBT consultation resource for GPs



http://www.scionpublishing.com/book-images/samples/9781904842934sc.pdf

Self-practice/self-reflection resource



https://www.guilford.com/books/Experiencing-CBT-from-the-Inside-Out/Bennett-Levy-Thwaites-Haarhoff-Perry/9781462518890/reviews

Video resources for primary care

Dr. David Lee's online videos demonstrating CBT in primary care:

https://elearning.10minutecbt.co.uk/

Referral Options

- Clinical Health Psychology (WRHA)
  - Psychologists in public practice: https://www.wrha.mb.ca/prog/psychology/referral.php/
- Mental Health Centralized Intake (WRHA)
- Embedded primary care services (WRHA)
  - Shared Care
  - My Health Teams
- Community Mental Health Program (WRHA)
- Canadian Mental Health Association Mental Health Resource Guide
- Manitoba Psychological Society referral directory
  - Private psychologists: https://www.mps.ca/

(Unger, 2019)

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