

Cognitive behavioural strategies for general practice

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This is the fourth article in the 'Psychological treatments in general practice' series describing a practical approach to cognitive behavioral strategies (CBS) using patient handouts and worksheets. The CBS approach can be integrated with other behavioural and structured problem solving approaches as part of the overall management of common general practice presentations such as depression, anxiety and somatisation.

Cognitive behavioural strategies (CBS) care circumscribed psychological skills that can be incorporated into general practice,¹ and need to be distinguished from cognitive behavioural therapy (CBT), a comprehensive therapeutic approach which requires more intensive training.² The CBS outlined in this article can be integrated with other behavioural³ and structured problem solving approaches.⁴

Why CBS?

There are a number of good reasons to encourage the use of CBS in the general practice setting. The most compelling argument is that their use is consistent with the direction of evidence based medicine. The American Psychological

Association has developed criteria for the identification of 'empirically supported treatments', the majority of which can be categorised as cognitive behavioural in nature.⁵ Numerous studies have demonstrated the efficacy of CBS for common mental disorders such as depression and anxiety in nonprimary care settings.⁶

Few studies of the efficacy of CBS have been conducted in the general practice setting.⁷ However, there are data suggesting that their use by general practitioners for a range of common mental disorders is more effective than usual clinical care, at least in the short term.⁸ However, this improvement appears to be dependent on GPs having the necessary skills to implement CBS. Clearly, further

research on the effectiveness of CBS in the general practice setting is necessary.⁹

A current incentive for GPs to incorporate CBS into their repertoire of clinical skills, is that these skills are recognised and supported by a new Medicare Benefits Schedule (MBS) item number as part of the 'Better Outcomes in Mental Health Care' initiative.¹⁰ Specific psychological treatments termed 'Focussed Psychological Strategies' can be provided by suitably trained GPs, and include a number of CBT approaches.¹¹

Another argument for GP delivery of CBS is patient preference. A significant proportion of patients are often resistant to taking psychotropic medications,¹²

expressing a preference for counselling and a desire to receive mental health assistance from their GP where possible.^{13,14}

Additional benefits for GPs who acquire CBS skills may be personal and professional benefit through better management of their own work stress and increased satisfaction through assisting patients with these techniques.¹⁵

What are CBS?

For the purpose of this article we have distinguished between CBT and its components, which we have termed CBS. The former is an integrated structured approach, usually provided by specialist mental health providers and requiring in-depth training and ongoing supervision. It has been defined as therapy: ‘...continually targeting both cognitive aspects of the problem (attributions and attitudes) and behavioural aspects (eg. overcoming avoidance of anxiety provoking situations, increasing activity, relaxation methods or improving social skills)’.¹⁶

Cognitive behavioural strategies typically involve teaching skills for enhancing more realistic interpretations of common life experiences and decreasing catastrophic interpretations. For example, patients with anxiety disorders usually overestimate the probability of feared events occurring and believe the actual occurrence will be catastrophic rather than inconvenient. Cognitive strategies involve drawing out these assumptions and challenging their rational basis. Behavioural exercises, such as graded exposure tasks, can be used to test the accuracy of various beliefs by gathering evidence for and against the old versus new beliefs. Behavioural procedures such as role playing or rehearsal may also be used.

Utilising CBS in general practice

In order to use CBS in general practice, the GP needs to be able to:

- engage the patient
- identify unhelpful behavioural patterns
- identify unhelpful thinking styles (or ‘habits’), and

- assist the patient to challenge negative unhelpful thinking to assist with emotional and behavioural change.

Engaging the patient

Which patients?

Patients who appear to benefit from CBS are those suffering from depressive disorders (Case 1), anxiety and somatisation disorders (Case 2), substance abuse and relationship problems, and some eating and sexual disorders. In these conditions, there is very often a set of behaviours, beliefs and patterns of thinking which are amenable to CBS.

As with any treatment approach, knowledge of the contraindications and pitfalls is essential. It would be unwise to proceed with CBS in a general practice setting if the diagnosis and/or risk assessment was uncertain (eg. suicide risk), if there were longstanding personality issues or personality disorder as the primary problem, or if the patient had an underlying psychotic disorder. In these cases, referral to a mental health specialist would be appropriate.

What type of problems?

As described in an earlier article in this series, a simple decision tree can be helpful to determine when to provide general support, when to proceed with structured problem solving, and when to employ a cognitive approach.⁴ It is the presence of unrealistic negative assumptions relating to the self or the world that suggests CBS may be suitable, eg. a new mother who believes she is a ‘terrible mother’ because she feels she should be able to manage looking after her baby together with her usual household tasks, while always maintaining positive feelings toward her partner and baby.

Educating the patient

To successfully employ CBS, the GP needs to spend time educating the patient about the cognitive model. This is necessary from the start, if the patient is going to engage with the exercises and work-

Case 1 – Major depressive disorder

John is a 52 year old man who attends the practice infrequently. He has come for a check up after pressure from his wife. Last week she expressed concern to the GP that she felt he was withdrawn, drinking far too much and she was worried that he may be depressed. A thorough assessment revealed major depression present for approximately six months.

Initially, John tells the GP that everything is fine, but it becomes clear on further questioning that he has very little self confidence despite being in the same job as a loans officer with a major bank for many years. When a customer took their business to another bank he felt it was his fault (self blame)*. His 16 year old son was recently suspended from school for a smoking offence even though otherwise he is achieving well, both academically and at sport. Again, he blames himself for his son’s troubles. He has a pervading sense of doom about the future. He is aware of his tendency to see the worst possible outcomes in life (catastrophising)*. He seems to jump to broad negative conclusions about minor events (mental filtering/over generalising)*. He has become fairly socially isolated describing how he gave up ‘Rotary’ because he felt people were saying negative things about him when their programs didn’t work very well (mind reading)*.

The GP spent some time educating John about the nature of depression. An antidepressant was commenced and the GP explained that the outcome was likely to be improved if he also learned some psychological strategies to help manage the depression. The GP initially commenced with some behavioural techniques such as activity planning to begin addressing the social isolation. It became clear that an underlying negative way of thinking was part of the problem. The GP and patient met regularly for six sessions in which they were able to identify his negative cognitions and challenge some of these beliefs as part of his overall depression management.

* See Table 1 for definitions of the types of unrealistic negative thoughts.

Case 2 – Panic disorder

Mary is a 32 year old married woman with two children aged three and five. She is a regular attender to the practice and presents with palpitations. Mary has no significant past medical history. However, her past psychiatric history does include an episode of postnatal depression following her second child (note, she is not currently taking any medications). Further history uncovered three episodes of panic attacks in the last six months, specifically following an event where her car broke down on a country road. Mary consequently displayed the beginnings of avoidance behaviours and had become somewhat apprehensive about driving. Physical examination was unremarkable and preliminary investigations were normal (including thyroid levels). Further exploration revealed a range of thoughts around the palpitations and the episodes of panic (eg. 'I thought I was going to faint or have a heart attack') (catastrophising)* and 'I'm really not safe to drive' (over generalising)*. Psychoeducation about the nature of panic attacks was provided and the patient was taught the slow breathing technique.

As Mary's confidence in the GP grew, the GP suggested she might return for some planned appointments to further address her difficulties. During these sessions the GP identified a number of faulty health beliefs about her risk of having a heart attack, and was able to help her to challenge these assumptions, eg. 'Did you actually have a heart attack?', 'What would have happened if you had fainted?', and 'Have you noticed you can bring on these symptoms by hyperventilating?' The GP helped the patient confront a series of feared situations using these cognitive strategies and a graded exposure approach.

* See Table 1 for definitions of the types of unrealistic negative thoughts.

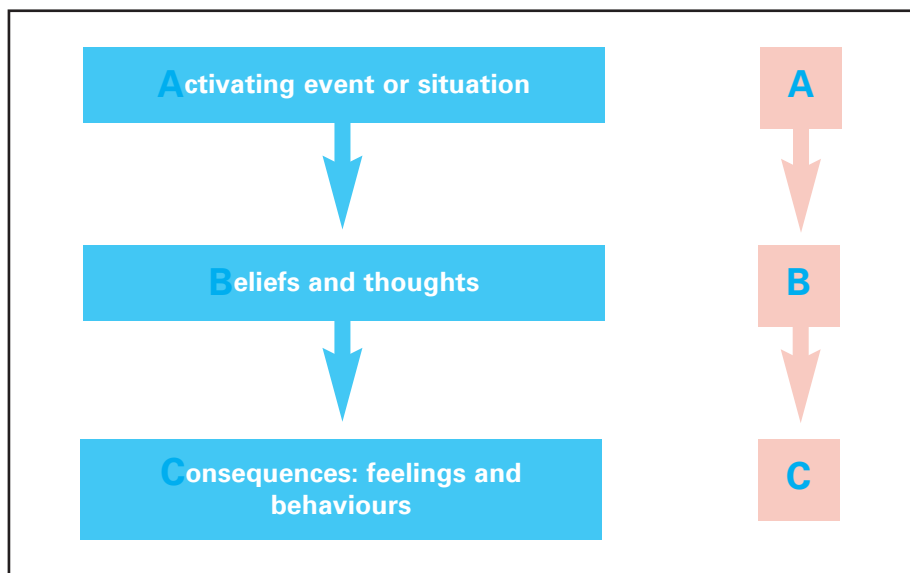


Figure 1. The A-B-C of thinking¹⁹
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sheets. The basic principle that the GP needs to impart is that: 'The way you think affects the way you feel'. Although this may seem obvious, many patients will not have actively turned their attention to the constant self talk that goes on in their mind. Importantly, patients often accept this self talk as accurate, without entertaining the notion that the thoughts may be unrealistic and unfair.

The GP can use the 'A-B-C model' to explain the cognitive behavioural model (Figure 1¹⁹). The key message is that our beliefs about events determine how we feel about them. This can be demonstrated using simple every day life examples. Consider two people each sitting in their own cars in a traffic jam, and both running late for work — one feels angry and frustrated, the other calm and relaxed. What is the difference? The angry driver might think: 'I'll be late for work and my boss will think I'm not a good employee. That would be terrible — he shouldn't think that about me ... it's so unfair'. The relaxed driver thinks: 'I can't do anything — I might as well listen to my favourite CD and explain to the boss what happened when I get to work'. A more in-depth understanding of CBS is only truly appreciated by applying them

to one's own experiences. This is true both for the GP who is learning CBS, and patients as they begin to apply them to real life situations.

General practitioners are experts at pitching explanations to patients, and each will develop her or his own 'patter' targeted to individual patient's needs. Clearly the patient's age, cultural background and language abilities are relevant. Patient education sheets can also assist.

Identifying unhelpful behavioural patterns

In many cases of depression and anxiety, simple behavioural strategies can be used to help with symptom management in the early stages of treatment (eg. sleep/wake cycle management, progressive muscle relaxation, slow breathing). The use of these simple behavioural strategies has been discussed in detail in a previous article³ and will not be covered again here. However, there are also more complex behavioural techniques that can be used in conjunction with cognitive restructuring in later stages of treatment, including graded exposure, behavioural tests, and the development of alternative behavioural responses for high risk situations. Identifying unhelpful behavioural patterns

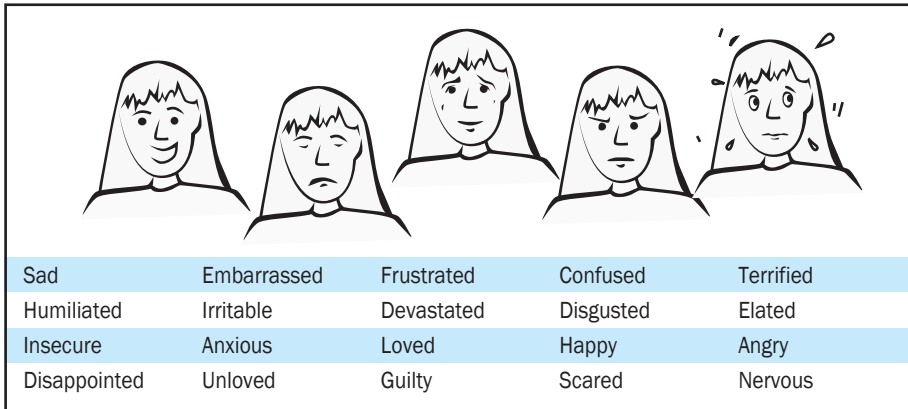


Figure 2. Identifying your feelings¹⁹

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before embarking on cognitive restructuring work, helps target CBS appropriately.

In order to identify unhelpful behavioural patterns, patients are generally asked to monitor specific types of difficult situations (eg. events or interactions that they avoid because of anxiety, the times of the day that are associated with particularly low mood, occasions of binge eating, drinking, or gambling, arguments with family or friends, etc). The type of situation being monitored

would depend on the patient's diagnosis (eg. periods of particularly low mood in depression, panic attacks in panic disorder, or feared social situations in social phobia). When monitoring these types of situations, patients are typically asked to note what was happening at the time, how they felt and how they responded to the situation (their behaviour). Behaviours may be helpful (eg. ring a trusted friend during a period of low mood) or unhelpful (eg. decline an invi-

tation in social phobia). Helpful behaviours can be praised and encouraged, while unhelpful behavioural patterns can be addressed during the course of treatment.

Identifying unrealistic negative thoughts

Drawing out feelings

Patients sometimes need assistance with learning to identify their feelings about a distressing situation. For patients to convey how they truly feel about an event, there clearly needs to be a high degree of trust between the GP and the patient. The patient needs to feel assured of the confidentiality of the consultation, and confident that the GP will listen in an open and nonjudgmental manner.

Encouraging patients to express how they feel about a particular event is not always simple. A good starting point is to ask the patient to describe a situation that is causing distress, and when appropriate, ask them how they feel about it; patients will often respond by describing what they were thinking, rather than how they

Table 1. Types of unrealistic negative thoughts¹⁹

Black and white thinking/perfectionism	<ul style="list-style-type: none"> Black and white thinking is when you think in extremes (eg. success versus failure) and forget that there are many steps between the two extremes
Mind reading	<ul style="list-style-type: none"> Mind reading is when you assume you know what other people are thinking about When you mind read, you generally believe that the other person is thinking badly of you
Catastrophising/predicting the future	<ul style="list-style-type: none"> Catastrophising or predicting the future is when you assume things will turn out badly in the future – that the worst thing will happen
'Should' and 'must' statements	<ul style="list-style-type: none"> This is when you use words that are extreme and make things seem worse than they really are (eg. should, never, always, must)
Over generalising	<ul style="list-style-type: none"> Over generalising is when you make a sweeping and exaggerated statement based on limited information or a single event (eg. labelling yourself as a hopeless driver because you had one accident)
Mental filtering	<ul style="list-style-type: none"> Mental filtering is when you focus on your weaknesses or bad events and ignore your strengths or the good things in your life
Self blame	<ul style="list-style-type: none"> Self blame is when you automatically blame yourself when things go wrong
Questions that have no answers	<ul style="list-style-type: none"> Questions that have no answers are questions you ask yourself that are unhelpful and generally pointless (eg. 'Why me?')

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felt. Some useful strategies include asking patients how they felt about an event in one word, eg. 'disappointed', 'angry', 'frightened', or 'guilty'. Another tip is to ask the patient to express how they felt in the first person, eg. 'I felt ...'. Asking patients to choose from a list can also assist as a prompt (Figure 2¹⁹).

Drawing out thoughts

Having drawn out the feelings around a particular event, the next step is to identify the associated thoughts. This is essential, because thoughts can be challenged whereas feelings cannot be disputed. Indeed, this is the basis of the CBS approach. Using the CBS worksheet is helpful at this stage, as the GP works through identifying thoughts associated with each of the listed feelings. Questions such as: 'What were you (insert the feeling) about?' or 'What were you saying to yourself that made you feel (insert the feeling)?' are usually sufficient to encourage patients to describe their thoughts.

Sometimes patients initially describe their thinking only at a very superficial level. Follow up questions such as: 'What would that mean about you?' or 'If that happened, what would be so bad about that?' may be helpful to further elucidate related thoughts or deeper core beliefs. Of course, not all negative thoughts will be unrealistic. The art of CBS is being able to distinguish between the realistic thoughts and the unrealistic (or self defeating) thoughts for which CBS may assist.

It is useful for GPs to have a framework for categorising common patterns of unrealistic negative thinking, as it helps the GP to understand patients' concerns and provides a structure for applying CBS principles. Usually, individual patients have a consistent pattern of unrealistic negative thinking that becomes more prominent during exacerbations of depression, anxiety or during times of stress. Helping patients to become aware of their particular thinking patterns is one of the main aims of the

- ① The aims of challenging your thinking are to create responses to your negative thoughts. These will:
 - 3 reduce your level of distress
 - 3 reduce the amount of time you spend feeling distressed

- ② It is important to challenge all levels of negative self talk, not just the first thought that pops into your head. The more rebuttals you create, the greater your chance of feeling better

- ③ Challenging your thinking (creating a rebuttal) involves:
 - 3 putting your worries and concerns into perspective
 - 3 looking for the shades of grey, rather than the black and white extremes
 - 3 debating and reasoning with your negative thoughts (gathering evidence for and against)
 - 3 acknowledging difficulties where they exist

- ④ Remember that challenging your thinking is not just 'positive' thinking. It aims to help you make realistic judgments based on accurate assumptions and beliefs

Note, it may be helpful to add problem solving to your rebuttal. An 'action plan' may help you deal with a difficult situation

Questions to ask when challenging negative thoughts

- n What evidence is there that the negative thought is true?
- n Is there an alternative explanation?
- n What would you say to a friend who had this concern?
- n What is the worst thing that could happen?
 - how likely is it that this will happen?
 - how would you deal with it if it happened?
- n What is the most realistic outcome?
- n How much will you still think about this in an hour? A day? A week? A month? A year?
- n What can I do to make things better? (develop an 'action plan')

Figure 3. Challenging negative unrealistic thinking¹⁹
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CBS approach.

Eight common patterns of thinking have been described in the SPHERE CBT Training Program (Table 1).¹⁹ The common features of these negative thoughts is that they tend to be extreme, not based on actual evidence, and usually involve a negative interpretation of the self or the world. In practice, there is often overlap between the different types of negative thinking. For example, the cognitive errors of over generalisation and personalisation often coexist:

'Nothing that I get involved in ever turns out right – I am responsible for everything bad that happens to my family'.

Identifying unrealistic negative thinking requires the GP to listen carefully to the patient, and often involves subjective judgment by the GP about the accuracy of the patient's interpretation of events. Some common phrases to listen for are: 'I should ...', 'I must ...', 'They might think ...', 'I always ...', 'I never ...', and 'It's my fault that ...'. The patient is encouraged to write down such phrases on the CBS

SITUATION	_____	

FEELINGS	_____	Rate your mood on a scale of 0–10 (0 = feeling miserable, 10 = feeling ok)
How did you feel in this situation?	_____	

What were you thinking in this situation?	_____	_____
Immediate thoughts	_____	_____
	_____	_____
↓		
Dig deeper	_____	_____
	_____	_____
↓		
Core belief	_____	_____
	_____	_____
↓		
FEELINGS	_____	Rate your mood on a scale of 0–10 (0 = feeling miserable, 10 = feeling ok)
How did you feel after the rebuttal?	_____	

Figure 4. Cognitive therapy worksheet¹⁹
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worksheet so they become a focus for discussion as part of the CBS.

Challenging negative unrealistic thinking

Unrealistic thinking can be modified directly, by challenging the content of one’s thoughts, or indirectly, through the use of graded exposure exercises and behavioural tests. Once the unrealistic and self defeating assumptions and cognitions have been identified, it is time to teach the patient how to challenge their thinking. Challenges involve teaching patients strategies for assessing their thoughts more accurately. Questions could include: ‘What evidence have you

got that the thought is true?’, ‘What’s another way of looking at the situation?’ (Figure 3¹⁹). In essence therefore, the doctor talks through the probabilities and all likely outcomes with the patient, until s/he comes to see the self defeating and unrealistic beliefs that s/he holds (ie. beliefs and attitudes that are unlikely to be confirmed by actual experience).

Utilising the patient worksheet

The SPHERE CBS worksheet (Figure 4¹⁹) provides a structure for the GP and patient, and assists the patient to view their thinking more objectively. The worksheet systematises the ‘A-B-C model’ (Figure 1) by encouraging the

patient to record situations or events that were unpleasant or confronting, how s/he felt, what the thoughts were and how s/he challenged these self defeating thoughts. The GP usually needs to start the patient off, but the aim is for the patient to record ‘situations, feelings, thoughts and challenges’ in between consultations. Using the worksheet requires that the patient be motivated, and also requires adequate language skills.

Graded exposure and behavioural tests

Graded exposure is a behavioural technique for learning how to manage and overcome fear about a particular situation or activity. It involves a gradual stepwise approach to confronting a feared situation or activity, made easier by using CBS for recognising and challenging unhelpful self talk. The patient rates their feared situations on a hierarchy, from least difficult to most difficult, and then s/he works through them one by one commencing with the least difficult situation. This process continues until the patient is able to confront the feared situation or engage in the feared behaviour successfully. If a particular situation causes quite severe anxiety, this situation may be broken down into a series of graded steps. For example, for someone with social phobia who has difficulty speaking up in a casual group situation, they may start by speaking up in a very small group of people they know well, eventually working their way in steps to speaking up in a larger group of people they do not know well. Usually, the patient does not proceed to the next step until the previous one has been successfully mastered.

Behavioural tests are another useful tool for enhancing cognitive and emotional change, and are particularly useful for anxious patients. Typically, when people feel uncomfortable in a situation, they withdraw into themselves and miss out on important information in their environment (eg. people with social anxiety may avoid eye contact because they believe people are staring at them).

Behavioural tests aim to encourage patients to try out a new behaviour and gather information that would otherwise have been missed (eg. look around to see if anyone is actually staring, allow silence in a conversation and let the other person break the silence first). The new information obtained from such experiments can be extremely useful for dispelling unhelpful beliefs.

Conclusion

Cognitive behavioural strategies are effective psychological techniques that can be delivered within general medical practice. Although GPs do not have the expertise of a clinical psychologist or psychiatrist, they can provide specific and limited CBS to assist patients with depression, anxiety and somatisation disorders, especially where unrealistic negative patterns of thinking are apparent. The time limited and structured approach makes it suited for use in routine general practice. General practitioners who undertake the required training are also being supported by a new MBS item number to deliver such treatments. The success of this approach requires that GPs receive adequate training that involves rehearsal of skills, and ongoing access to mental health specialists, particularly when they encounter difficult or complex patient problems.²⁰

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