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Cognitive behaviour therapy

Incorporating therapy into general practice

Background

Cognitive behaviour therapy is a talking therapy that looks at the connections between our emotions, thoughts and behaviours within the context of specific circumstances and symptoms.

Objective

This article describes cognitive behaviour therapy, its evidence base and applications. Pathways for further training for general practitioners in cognitive behaviour therapy are described.

Discussion

Cognitive behaviour therapy is an effective treatment for mild to moderate depression, generalised anxiety disorder, panic disorder with or without agoraphobia, social phobia, post-traumatic stress disorder, and childhood depressive and anxiety disorders. At its simplest, it can take the form of an exercise prescription, teaching relaxation techniques, assistance with sleep hygiene, scheduling pleasurable activities and guiding the patient through thought identification and challenge. With some basic training in the area, GPs are well placed to provide basic cognitive behaviour therapy treatments, particularly to patients at the mild end of the spectrum of mental health disease, as they already know their patients well and have a therapeutic alliance with them. In some cases, this may be all that is needed; however, patients who have more complicated issues or more severe symptoms may require specialist psychiatrist or psychologist referral.

Keywords

cognitive therapy; psychotherapy

CPD

I have always enjoyed listening to patients' stories and often struggled to keep to time. I could see that unless I changed my practice I would lose some patients and possibly gain those who other general practitioners felt talked too much. It was in this context that I decided to learn a skill that would enable me to see these patients with a more structured approach. I decided to learn cognitive behaviour therapy (CBT), especially to help my chronic somatising patient population who had come to see me because I listened. This group will be familiar to many GPs. Cognitive behaviour therapy enabled me to provide a structure to my discussions with anxious somatising patients who would otherwise keep 'rambling' about their symptoms. The first courses I attended were very general and really did not impart many useful specific skills for use in the consulting room. Then I chanced upon a CBT treatment manual for anxiety disorders written by Gavin Andrews et al[1] (see *Resources*). This textbook clearly delineated how to identify specific anxiety disorders and provided sample treatment manuals that could be photocopied for patients.

The first case I treated with my newly acquired skills was an anxious chronic somatising patient who would typically take more than 45 minutes whenever she attended (*Case study 1*). Her main symptom was chronic fatigue. To my surprise, she made steady improvements with CBT and began to be involved in life again – taking up tai chi, quilting and holidays, which she had previously not felt she could do. This came from simple activity scheduling and experiments with brief periods of exercise to see when her fatigue occurred. I decided to try it with other patients, with mixed success. Some would agree to attend for 30 minute weekly appointments but would not do the homework tasks. Some got stuck on cognitive restructuring; others had complex issues such as addictions and personality issues, which didn't lend themselves to a structured program. However, while my initial success encouraged me to keep going, I began to wonder if there was a deficiency in my CBT technique when patients did not continue. I did a supervised clinical attachment under a psychiatrist, which involved attending a 4 week CBT day program at a private hospital. During this attachment, I discovered that my CBT skills were not deficient but that there may be multiple reasons why a patient might not return for follow up. This includes the fact that some patients only need limited CBT skills to enable them to master an issue causing distress (*Case study 2*), discomfort with the requirements

of CBT, or with pursuing these matters with a GP. Lack of engagement could also reflect an ongoing pattern of avoidance, regardless of the treatment options presented to them. The cases I have seen over the years who have done well are patients with anxiety disorders and mild to moderate depression (*Case study 1* and *2*). There is a great sense of personal achievement when patients get better as a consequence of the collaboration that occurs within a good therapeutic alliance and their willingness to do their part in the treatment process. I have also benefited from the application of CBT principles to my own life and I believe my anxious children have benefited from this life skill.

Case study 1

My name is Jane.* I am lucky because I got seriously sick when I was relatively young, in my 40s. I say that I am lucky because at that time there were some good people to help me. But especially because it meant that I learnt some valuable lessons, which have been very helpful since.

The most valuable lesson that I learnt was that I can help myself. Not only to help myself by going to ask good people for help. Not only to help myself by taking the proper medicine as instructed and changing my eating habits. But also knowing that I can help myself feel physically and emotionally better by thinking in a different way. By changing the way I look at my actions and my feelings and my thoughts (changing my perception). By using thinking skills to help me deal with my emotions and to start new, helpful thinking habits. Once I understood the processes and could change my thinking I could 'break vicious cycles' of stress, pain, physical and emotional symptoms and help myself feel better.

That is how I was able to improve from several conditions, but especially from chronic fatigue and anxiety. To help with this retraining of my thought processes I found that I greatly benefited from a doctor who was trained not only in the medical aspect of treating disease but who also understood the interplay between the mind, the emotions and the physical body, who treated my whole being, not just isolated parts of me. It also required the doctor to give me time to think aloud so that we could problem solve together, so that I could gain confidence and techniques so that I could do similar problem solving on my own. This has been most useful to me.

* Not her real name.

Case study reproduced with permission from the patient.

Case study 2

Rose,* 52 years of age, attended because she was feeling breathless. She had attended a number of other GPs and had extensive tests for asthma and heart conditions, and also attended a thoracic physician, who had confirmed that she didn't have asthma or a heart condition. The specialist suggested that she might like to see a psychiatrist. This didn't sit well with her and she made an appointment to see me (her GP) instead. There was no evidence of clinical depression. Rose did not think she was overly anxious but she did identify that she was under stress. Her symptoms began when her boss indicated that he wanted to sell the shop she had been working in for the past 10 years. She had never thought she could be a business owner but her partner had encouraged her to apply for a business loan. Her symptoms coincided with the application being accepted and the start of her owning the shop. She felt the stress of financial insecurity that comes from stepping into a role she had not previously attempted. She did not qualify for a mental health plan as she did not fulfil the criteria for a mental health disorder. Mental health item numbers were not used for her visits.

Rose attended twice. We discussed the physiological responses to stress (via the adrenaline story) and I gave her some simple breathing and progressive muscle relaxation techniques. I used a simple thought challenging activity to address her concerns about running the business. After the second session, Rose did not attend again for some years. I chanced to walk into her shop one day – she recognised me and told me what a difference the CBT made to her being able to take on the business. She thanked me profusely.

*Not her real name.

Case study reproduced with permission from the patient.

Background

Since ancient times, philosophers have pondered the connections between reasoning and actions, emotions and symptoms. Cognitive behaviour therapy is a talking therapy that looks at the connections between our emotions, thoughts and behaviours within the context of specific circumstances and symptoms. A meta-analysis by Butler et al[2] in 2006 showed that CBT was an effective treatment in mild to moderate depression, generalised anxiety disorder, panic disorder with or without agoraphobia, social phobia, post-traumatic stress disorder, and childhood depressive and anxiety disorders.[1] Some benefit was also seen in patients with marital distress, anger, childhood somatic disorders and chronic pain.[1] This skill set also has the potential for wider applications in the setting of acceptance of chronic illness, compliance with medication, stress management, insomnia, weight control issues and many other nonmental health scenarios.[2] While this therapy takes time (which may be limited in the general practice setting), it tends to be shorter than other psychological techniques as it is highly structured. With some basic training in the area, GPs are well placed to provide basic CBT treatments, particularly to patients at the mild end of the spectrum of mental health disease as they already know their patients well and have a therapeutic alliance with them.[3] In some cases, this may be all that is needed; however, patients who have more complicated issues or more severe symptoms may require specialist psychiatrist or psychologist referral. Cognitive behaviour therapy can still be beneficial to these patients, particularly if there is a long wait for the upcoming appointment. Cognitive behaviour therapy strategies may also be helpful for patients who have been started on antidepressants to impart strategies to cope while waiting for the onset of the antidepressant effect. Cognitive behaviour skills can assist GPs

with their own life issues. They provide a framework for dealing with stressful life events, a way to work through emotional trials, problem solving with work stressors and valuable information for dealing with anxious children or family members and making lifestyle changes.

What is cognitive behavioural therapy?

Cognitive behaviour therapy is a very structured form of talking therapy with specific time limits, structured activities and homework tasks. It involves working with patients to challenge and change unhelpful ways of thinking that lead to negative emotions and hence psychological or other symptoms and to change habitual and unhelpful behaviours that may be associated with these emotions.[4] In its simplest form it can take the form of an exercise prescription, teaching relaxation techniques (*Table 1*), assistance with sleep hygiene, scheduling pleasurable activities and guiding the patient through thought identification and challenge. Factors which influence success with treatment are shown (*Table 2*).

The initial consultation involves information gathering and exploration of the patient's story. The patient is given an explanation of CBT and how it works. Expectations of therapy are discussed and a plan made for the following sessions. There is negotiation of how often the sessions will occur and how long the therapy is planned for. It is not open ended and should have a defined endpoint. Often handouts are given to reinforce the session. Each session also has a homework task: for example, a brief breathing exercise if the patient is anxious, or a discussion about a routine task that has been neglected if the patient has depression.

Importantly, CBT doesn't involve the doctor 'doing therapy' on the patient, rather the doctor acts as a coach to help the patient make their own lifestyle changes. Allowing patients to take responsibility for themselves, make good choices and problem solve the issues that arise is empowering and has the potential to improve outcomes. It is helpful to collect patient stories to describe to other patients considering working with CBT. This can engender hope and confidence that this is a worthwhile skill to learn and that their condition is not dissimilar from others who have experienced CBT and have improved.

Table 2. Factors associated with success for cognitive behaviour therapy[5]

Patient factors
• Can the patient recognise and talk about their thoughts?
• Is there an awareness of emotions and ability to label feelings and understand the link between feelings, thoughts and behaviours?
• Does the patient accept a personal responsibility to change?
• Can the patient explore their anxiety or is there a high level of avoidance?
• Is the patient able to develop trust in the process and develop a therapeutic alliance?
• Is there a previous positive experience of therapy or a general optimism and willingness to give therapy a go?
• Is there a capacity to remain focused and work on issues in depth?
Therapist factors
• Engagement with the patient by active listening
• Development of a formulation and plan that the patient agrees with
• Equal collaboration – therapist provides skills and structure, patient provides setting and history
• Nonjudgemental and focused on 'here and now'
• Expectation of good outcome/optimism about therapy
External factors
• Therapy is affordable in terms of money and time
• Support from friends and family to persevere with tasks and changes

Table 1. Simple relaxation strategies

Teaching relaxation skills to patients is a worthwhile activity as it targets physical symptoms of tension, gives the patient mastery over their body, and is a positive activity for depressed patients as well as being a distraction technique for anxious patients and a way to reduce the symptoms of hyperventilation. An example of a simple relaxation strategy is:

- Find a safe, quiet place to sit where you will be comfortable
- Plant your feet firmly on the ground and push down to feel the solidity of the ground or floor
- Gently clasp your hands together across your lower abdomen below your belly button
- Notice your breathing – notice the pace, the depth and how your muscles are working automatically
- When you are ready, take a slow deep breath over about 5 seconds. Hold the breath for a few seconds
- Breathe out again, slowly noticing your hands over your abdomen rise and fall with the breath – again taking about 5 or more seconds to let the breath escape
- Breathe in slowly again, but this time clasp your hands together tightly while you breathe in – making sure that you don't cause pain with the clasping
- As you breathe out slowly over the next 5 seconds, relax your hands and arms fully
- Repeat the slow breathing, going in over 5 seconds and out over 5 seconds, but now tighten other muscle groups where you feel tension as you inhale and then relax the muscles when you breathe out. Repeat this exercise three or four times, focusing on any areas of tension in your body

This technique can be utilised as a start of a mindfulness meditation exercise

Training in CBT

The federal government has encouraged GPs to be more involved with treating their mental health patients with focused psychological strategies (FPS) and provides higher rebates for GPs who are trained in these skills. There are training programs accredited by the General Practice Mental Health Standards Collaboration (GPMHSC) in most states. These can be located through the RACGP website, privately run training programs and mental health networks (see *Resources*). The GPMHSC website also has application forms for doctors who wish to submit prior training. However, the GPMHSC will not accept training that is more than 3 years old and favours training that is specific to general practice.

Medicare item numbers

Medicare outlines specific activities that qualify as FPS under the explanatory notes for the FPS item numbers (*Table 3*). In practice, if the GP wants to use the specific item numbers, the patient needs to have a mental health plan whether they are being referred elsewhere or having CBT provided by the GP. Thus, to claim the items, the patient needs to have a mental health disorder. While CBT is useful for patients without a mental health disorder (*Case study 2*), GPs cannot use the FPS item numbers for these patients. General practitioners can access other time based attendance item numbers, which makes CBT a useful skill as these patients would only be able to access allied health practitioners privately. If you become skilled at CBT then it becomes part of your practice and becomes applicable across the patient spectrum.

Table 3. Specific activities that qualify as focused psychological strategies under Medicare (items 2721–2727)

- Psycho-education (including motivational interviewing)
- Cognitive behaviour therapy including:
  - behavioural interventions
    - behaviour modification
    - exposure techniques
    - activity scheduling
  - cognitive interventions
    - cognitive therapy
- Relaxation strategies
  - progressive muscle relaxation
  - controlled breathing
- Skills training
  - problem solving skills and training
  - anger management
  - social skills training
  - communication training
  - stress management
  - parent management training
- Interpersonal therapy

Source www.racgp.org.au/gpmhsc/fps

Summary

Cognitive behaviour therapy is a valuable resource for time poor doctors as it provides a structure for mental health consultations so that GPs can use their time more efficiently. General practitioners with an interest in mental health disorders are encouraged to become familiar with this technique by researching it further and locating a suitable training program to familiarise themselves with the skills and strategies. They can then start to implement this in their practice settings and may even be pleasantly surprised by the outcomes, as I was with my very first patient.

Resources

- GPMHSC: www.racgp.org.au/gpmhsc
- Information from the RACGP/GPMHSC about training opportunities in FPS: www.racgp.org.au/gpmhsc/findtraining
- Australian Government Department of Health and Ageing. MBS Online notes on focused psychological strategies for item numbers 2721–2727: www9.health.gov.au//mbs/fullDisplay.cfm?type=note&q=A47&qt=noteID&criteria=2721
- Mental Health Professionals Network: www.mhpn.org.au.

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Conflict of interest: The author facilitates the CBT for GPs Training Program.

References

1. Andrews G, Creamer M, Crino R, Hunt C, Lampe L, Page A. The treatment of anxiety disorders – clinician guides and patient manuals, second edition. Cambridge: Cambridge University Press, 2003.
2. Butler AC, Chapman JE, Forman EM, Beck AT. The empirical status of cognitive-behavioral therapy: a review of meta-analyses. Clin Psych Rev 2006;26:17–31.
3. Heatley C, Ricketts T, Forrest J. Training general practitioners in cognitive behavioural therapy for panic disorder: randomized-controlled trial. J Ment Health 2005;14:73–82.
4. David L, Freeman G. Improving consultation skills using cognitive-behavioural therapy: a new 'cognitive-behavioural model' for general practice. Educ Prim Care 2006;17:443–53.
5. Saffran J, Segal Z, Vallis TM, Shaw BF, Samstag LW. Assessing patient suitability for short-term cognitive therapy with an interpersonal focus. Cognit Ther Res 1993;17:23–38.

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