# Cognitive Behavioural Therapy (CBT) In General Practice

Facilitator: Dr. Kimberly O'Keefe
Clinical Psychologist
Vita Healthcare

# Workshop Content

- Review & extend understanding of how to differentiate clinical anxiety vs non-clinical worry-practical tips for use in primary care settings
- Consolidating the complexity of the clinical presentation of anxiety vs non-clinical worry in routine primary care
- Understanding the use of CBT in General Practice
- Extend, consolidate & demonstrate the practical clinical application of the CBT evidence-based treatment model for anxiety in routine primary care
- Interactive Case Studies

# Uses of CBT in General Practice & Primary Care

- Cognitive Behavioural Therapy (CBT) is an evidenced-based treatment modality well demonstrated by research for use with common presenting problems in primary care including anxiety, depression and severe mental illness.
- Brief CBT can be used in times of acute stress to facilitate adjustment eg. Medical illness, chronic pain, diabetes, physical injury, work-related stress, marital/relationship issues
- Provides a structure & framework for treatment
- Helps provide containment to patient's distress
- Hofmann et al., 2012,

# Uses of CBT in General Practice & Primary Care

- Mental Health Conditions-anxiety, depression, eating disorders
- Diabetes
- Chronic Pain-attribution/experience of pain
- MS-adjustment to Dx, mood improvement
- Diagnosis of Medical Condition
- Physical Injury
- Chronic Fatigue Syndrome
- Fibromyalgia
- IBS
- Preparation for unpleasant procedures
- Coping with Chemotherapy
- Caregiver Burden
- Adjustment Disorder

Khoury, 2014
Kodal et al., 2018

# Why Use CBT in General Practice?

- Offers more choice in treatment
- Improves rapport and connection with patient
- Referral, prescribing medication and/or CBT?

- Time-effective
- Consistency/continuity amongst multidisciplinary treatment team
- Introduces hope for the patient-possibility in meaningful change

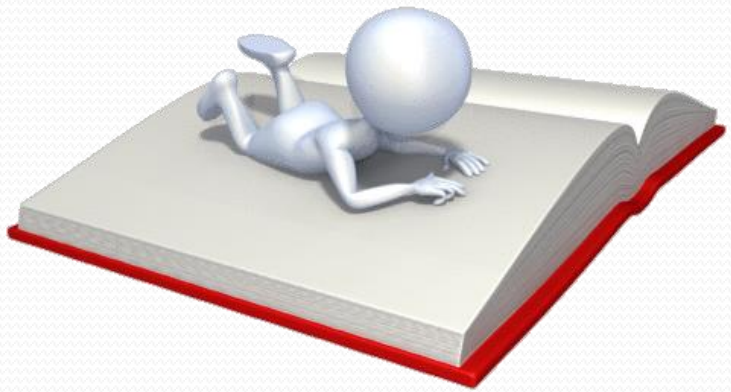
Khoury, 2014

# Anxiety – Clinical or Non-clinical?

# Differentiating Anxiety from Worry : Key Questions to be asking patients

- Does it cause significant distress?
- Does it cause changes in how you want to be going about your day?
- Does it bother you?
- Does it stop you from doing things?
- Does it affect your sleep?
- Are the thoughts difficult to switch off?
- Are they intrusive “gate crasher” thoughts?
- Ask about underlying emotional symptoms rather than just the medical aspects

# Identifying a Candidate for CBT



- Motivation to change
- Severity of psychopathology
- Level of insight
- Life stressors
- Cognitive functioning
- Identification of clear goals
- Educational level
- Time commitment

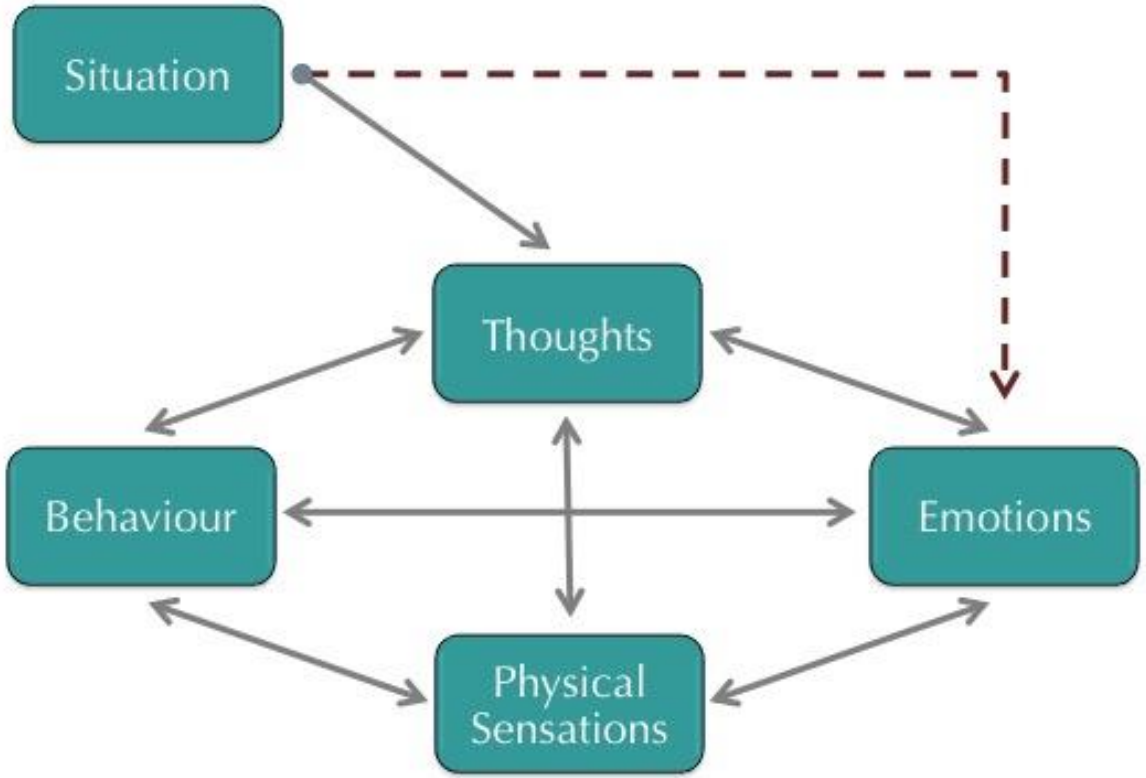
# Goals of CBT

- Reduces unintentional unhealthy or unhelpful lines of thinking and coping mechanisms
- Assists in identifying, evaluating and reframing our thoughts and reactions
- Through modifying our initial responses, we can reduce the amount of emotional distress and increase capacity regulation
- Enables the person to access task-focused coping

# Application of CBT: Automatic Thoughts, Assumptions & Beliefs

- Aims to disempower the initial unhelpful thought- attitude, belief, idea, visual image etc
- Provides thought-based tools to disarm the anxiety & underlying assumption
- It's not necessarily about replacing a negative thought with a positive one, it's about developing & maintaining accurate-thinking
- Links the thought to the feeling-emotion or mood following – therefore increasing control regarding mood state/mood stability and emotion regulation

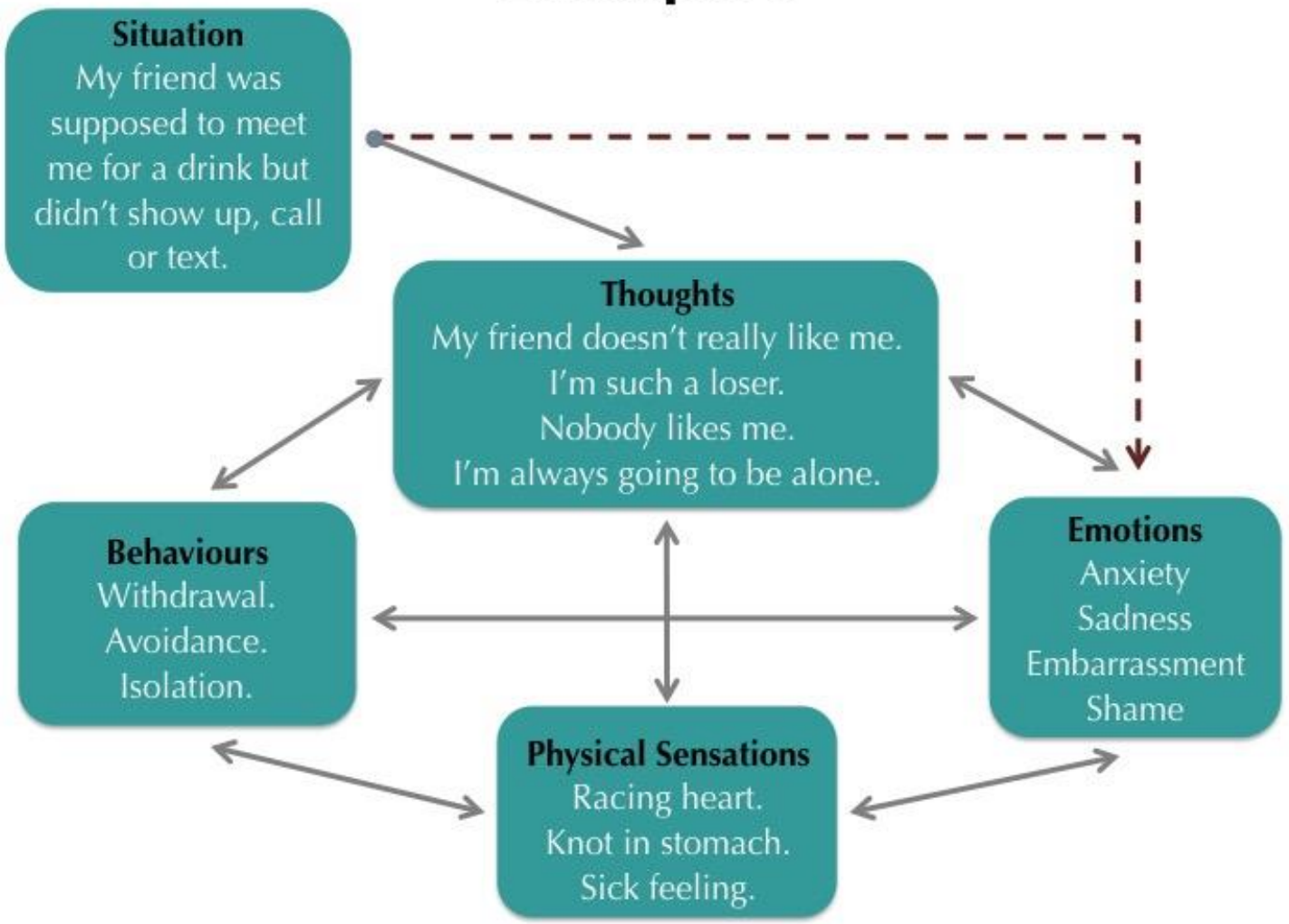
# The CBT Model




We experience our emotions as spontaneously occurring within a given situation (dotted red line). But, there are a set of thoughts that assign meaning to that situation, which in turn leads to the emotions that we experience. Those emotions are associated with certain physical sensations. We typically behave in a way that corresponds with our emotions, for the better or worse. All elements interact.

*Winters, 2015.*

# Example 1




Winters, 2015.

# Introducing CBT into the Consultation

- Identify a specific example of how the patient is describing their problem/situation/line of thought to you
- Ask them what is going through their mind?
- What are they feeling?
- What do they do/not do?
- Identify any vicious cycles
- Introduce CBT into the consultation by providing an empowering example of how thoughts influence feelings and behaviour
- Explore the example you have chosen using the CBT model
- Seek feedback and check in with patient understanding

# Key Principles of CBT: Introducing CBT & Providing Psychoeducation

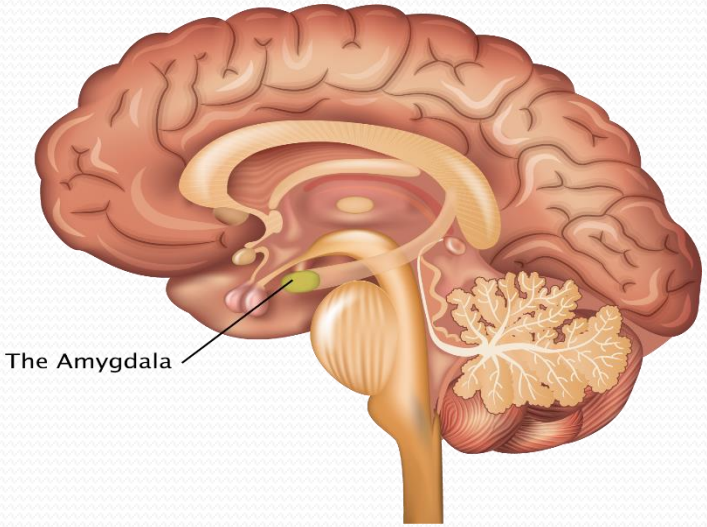
*ABC's of CBT*

How people **THINK**/initial cognitive appraisal,
affects how people **FEEL** emotionally and physically
which influences how they **BEHAVE**

Essentially "what goes through my **mind** makes me **feel**....
which makes me **do/not do**"

# Neurology of Anxiety

- Differentiate between anxiety and agitated thinking-
- Key questions for patients- Is there thought racing? A rapid firing of thoughts vs rumination and churning over one or two different worries?
- How “emotionally charged is thought?”



# Neurology of Anxiety

- Emphasize the role of the limbic system-this is particularly validating for the patient as they feel there is now a label for what's happening for them
- Avoid responses such as "don't worry" "stay calm" "stop thinking that way" "you don't need to worry"
- Validate the "power of intrusive-based anxiety thinking".
- Explain the fight, flight & freeze response
- Explain cognitive changes in the brain (battery saver mode)
- Overactivity of the limbic system.

# Application of CBT

- Aim to disempower the initial unhelpful thought- attitude, belief, idea, visual image etc
- Provide thought-based tools to disarm the anxiety
- It's not necessarily about replacing a negative thought with a positive one, it's about developing & maintaining accurate-thinking
- Use the patient's own words as much as possible
- Highlight links you see between the thoughts, feelings and behaviour
- Link the thought to the feeling-emotion or mood following – therefore increasing control regarding mood state/mood stability and emotion regulation

# Practical Tips

- Encourage patients to recognise that their initial thought is likely not the only one-just because it's the first doesn't mean it's the "right" "best" or "only" one.
- Gently remind them that it's a thought-not a fact. It could be neutral, helpful or unhelpful.
- This helps them create space for additional interpretations of perceived problems, situations or environmental/circumstantial stressors.

# Characteristics of Anxiety-Based Thinking

- Overestimates the likelihood of something bad happening
- Underestimates our ability to problem solve
- Often more powerful than a regular thought
- Fear of the unknown
- Falsely tries to prepare us
- Risk Ax vs anxiety
- Disproportionate responsibility for preventing things

# *IDENTIFYING* Anxiety-based Thinking Styles

- Catastrophising
- Worse Case Scenario
- Negative Filtering
- What if's?
- Mind-reading
- Fortune-telling
- Emotional reasoning
- Inability to disconfirm
- Regret orientation

# Key Points to Remind Patient

- **Identify, challenge and reframe!!!!!!!**
- Discuss priming-underlying templates we have are deeper levels of thinking which influence our “top level”/initial reaction.
- If it feels like you’re initially playing tennis with your thoughts or fighting between which radio stations to listen to, if it feels clunky initially-then you’re doing it right!

| Unhelpful Thought | Reframed Helpful Thought |
| --- | --- |
| I can't | I can….<br>What can I/how can I? |
| It is…../It will…. (worded as fact) | It may……I'm worried that (softens the wording to frame it as a fear) |
| When panicking-"I'm having a heart attack/going crazy/losing control" | These feelings are intense but they are not dangerous to me<br>The feeling/sensation is real but triggered by a trick thought |
| I can't control these sensations | I don't have to be in control of my body 100% of the time |
| I can't stop worrying | I'm thinking about this so much because it means something to me |
| This is the worse thing ever | This is anxiety and I'm not going to get stuck in this feeling forever |
| It happened last time…. | Yes it did happen then and also how many times has anxiety been wrong? |
| I need to escape | This is a false alarm, the right response at the wrong time. I am safe |

# ***CHALLENGING*** Anxiety-Based Thinking

- Is the thought accurate?
- Is it helpful?
- Is it the only one?
- Is it powerful?
- Is it pleasant?
- Identify specifically what anxiety is predicting will happen
- How likely is it that this outcome will occur?
- Identify the worse outcome
- Identify the best-case scenario
- Recognise the best is often most likely
- What is the evidence to warrant the worry?
- Are you using the feeling to drive the decision rather than what you know ?

- How many times has anxiety been wrong?
- Is the worry purposeful in any way? If so- problem solve to de-fuse it.

- Consider what you are worried about in the moment. How do you think you will fell about it in 2 minutes, 2 hours, 2 days, 2 weeks, 2 months, 2 years time-deescalates the intensity of it.

- Tap into what advice you would offer another person in the situation-this helps identify our natural coping tools.

Leahy et al., 2011

# Linking the Thought Feeling

- The person's thoughts may seem plausible-hence why the intensity of the emotion feels warranted.
- The "issue" is the validity of the thought –not the emotion they're having connected to it.
- Linking the thought to the feeling – "if I thought that, I'd expect to feel that too". Without agreeing with the thought-it validates the feeling given what they are thinking and assists the patient to see their own thinking from a different perspective and separate themselves from their own thoughts in order to allow more space for the healthy adult voice.

# ***REFRAMING*** Anxiety-based Thinking: Equipping the Patient

- Court-standard-helps externalise the thought and access rationale/logical thinking

- Possibility vs probability
- Fear vs fact
- Vertical Descent-if that happened, what would likely happen next
- Double Standard-would you apply these thoughts to others?
- Weighing the evidence-puts it into perspective
- Alternative interpretations-expands anticipated outcomes

- Decatastrophise – would that be so bad?

- Rule book-underlying assumptions eg "should, it must, I have to…"
- Do these standards give room for growth?
- Does it "have" to?
- Advocating acceptance

Leahy et al., 2011

# Linking the Feeling Behaviour

- Avoidance vs self preservation vs growth?
- Emotional reasoning-reaffirming the behaviour due to the emotion
- Use an example relevant to the patient's life to empower them
- Behavioural Changes-problem solving, behavioural activation, relaxation
- Reinforce meaningful, healthy and positive coping

# Patient Outcomes of CBT

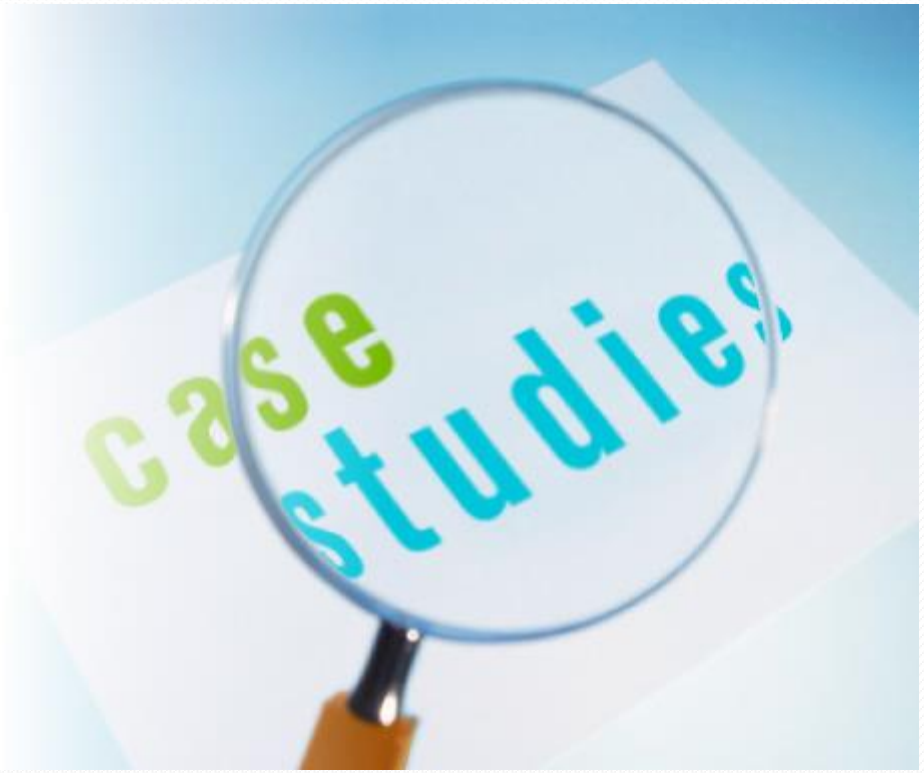
- Mood improvement
- Improved relationships
- Less emotional distress
- Increased self-management
- Improved symptom control
- Improved quality of life
- Increased functioning
- Acceptance
- Managing uncertainty
- Self reassurance
- Problem solving
- Healthy self talk
- Distancing from negative thoughts

Williams, 2015
Kodal et al., 2018

# Resources

- https://au.reachout.com/mental-health-issues/anxiety?
- https://www.cci.health.wa.gov.au/
- https://headtohealth.gov.au/

# INTERACTIVE CASE STUDY



# Questions