CBT FOR PRIMARY CARE

PART 1: BACKGROUND AND THEORY

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DISCLOSURES

- The speakers have no conflict of interest, financial agreement, or working affiliation with any group or organization.

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LEARNING OBJECTIVES

- Describe the evidence base supporting the effectiveness of CBT
- Identify rationale for incorporating CBT techniques
- Describe and provide examples of appropriate goal setting

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WHY LEARN CBT

- Strong Evidence Base
- Keeps being mentioned in Guidelines
- Don't believe in "Give medicines first – ask questions later"
- Barriers to Referral – often patients don't get evidence based treatment when referred to psychologists
- Without our knowing CBT patients don't get optimal care

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REVIEW OF CURRENT APPROACHES (NON-CBT)

- Pharmacologic
- Therapy
  - Flying by the Seat o Your Pants
  - Psychodynamic
  - Psychoanalysis
  - Interpersonal
  - Supportive

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THEORETICAL BASIS

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BACKGROUND IDEAS

- People are not troubled by things, but our beliefs about things" – Epictetus
- Human beings, by changing the inner attitudes of their minds, can change the outer aspects of their lives. - William James
- The mind is its own place and in itself can make a heaven of hell, a hell of heaven – John Milton

THEORETICAL FOUNDATION

- The Cognitive Model stress the central role of cognition in emotion. - Robert Leahy
- The Cognitive Model states that the interpretation of a situation, rather than the situation itself, often expressed in automatic thoughts, influences ones subsequent emotion, behavior and physiological response."-Judith Beck, Cognitive-Behavioral Therapy Handbook

THEORETICAL FOUNDATION

- Dysfunctional thinking is common in many psychological disturbances.
- As people learn to evaluate their thinking in a more realistic and adaptive manner, their emotional and behavioral responses improve.

TECHNIQUE

- Collaborative empiricism

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TECHNIQUE

- Cognitive Restructuring

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COGNITIVE BEHAVIORAL THERAPY

- Cognitive – Challenge your interpretation of reality.
- Behavioral – test your conclusions through behavioral experiments - translate insight into experience.

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THE EVIDENCE BASE

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EVIDENCE BASE

- Over 500 studies showing the effectiveness of CBT for a variety of psychological illnesses:
  - Depression
  - Anxiety – GAD, Social Phobia, Panic Attacks, Health Anxiety (Somatization disorder), OCD, Agoraphobia, PTSD
  - Other – Insomnia, Caregiver distress, Substance Abuse, Chronic back pain, headache, other

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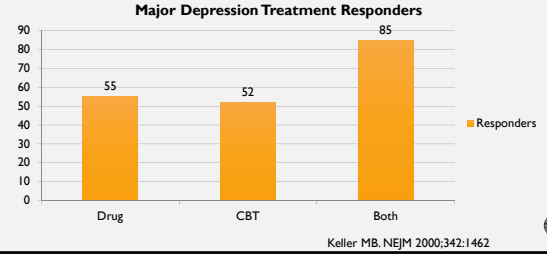
NAFAZODONE, CBT, OR BOTH IN TREATMENT OF CHRONIC MAJOR DEPRESSION DISORDER



Keller MB. NEJM 2000;342:1462

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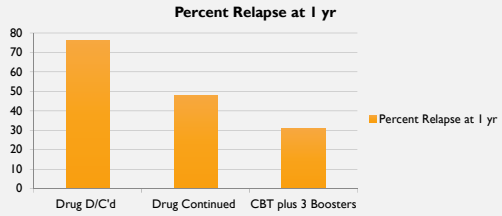
PREVENTION OF RELAPSE FOLLOW COGNITIVE THERAPY VS. MEDICATIONS IN MODERATE TO SEVERE DEPRESSION



58% initial response rate, enrolled in continuation study

Arch Gen Psychiatry 2005;62(4):417-22

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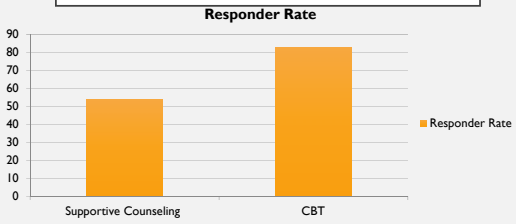
PROLONGED EXPOSURE VS. SUPPORTIVE COUNSELING FOR SEXUAL ABUSE–RELATED PTSD IN ADOLESCENT GIRLS



Foe E. JAMA. 2013;310(24):2650-2657

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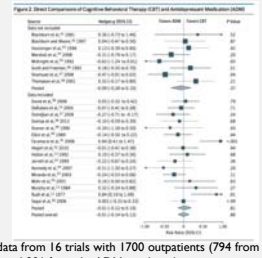
PHARMACOTHERAPY VS. CBT



Primary data from 16 trials with 1700 outpatients (794 from the CBT condition and 906 from the ADM condition)

JAMA Psychiatry. 2015;72(11):1102-1109

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META-ANALYSIS
REVIEW OF 16 META-ANALYSES

- Large effect sizes were found for CBT for unipolar depression, generalized anxiety disorder, panic disorder with or without agoraphobia, social phobia, posttraumatic stress disorder, and childhood depressive and anxiety disorders.
- CBT was superior to antidepressants in the treatment of adult depression.

Clinical Psychology Review Volume 26, Issue 1, January 2006, Pages 17–31

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EVIDENCE-BASE
CONCLUSION

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CHARACTERISTICS OF CBT

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CHARACTERISTICS OF CBT

- Collaborative Approach between patient and therapist
- Goal oriented and solution focused
- Emphasizes the present
- Teaches patient skills (ie- to be one's own therapist) to improve relapse prevention
- Time limited
- Structured
- Teaches patients to identify, evaluate and respond to dysfunctional thoughts and beliefs (collaborative empiricism – collaborative exploration of the evidence)

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WHERE DOES EMPATHY FIT IN?

- "Warmth, accurate empathy and genuineness ..are necessary but are not sufficient to produce an optimum therapeutic effect." Aaron Beck et al – cognitive therapy of depression (1979)
- Empathy is seldom curative.

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A DOSE OF EMPATHY

- 1mg
- 2mg
- 5mg
- 10 mg
- 25 mg

Empathy can be a seductive drug.

?

There is an optimum dose of empathy, excessive empathy creates iatrogenic illness.

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CBT APPROACH

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STEP 1: ESTABLISH RELATIONSHIP

- "First Seek to Understand , then seek to be understood."
  - Steve Covey
- Develop enough of a therapeutic alliance to sustain pushing the patient

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STEP 2: UNDERSTAND THE PROBLEM

- Understand the problem - Take a detailed enough history to understand the problem and its consequences

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UNDERSTAND THE PROBLEM

- How do we Determine Patients Pathogenic Beliefs?
- Ask open-ended questions
  - Why do you feel that way?
  - When you feel that way what are you thinking about?
  - What was going through your mind?

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STEP 3: EXPLAIN THE PROCESS

- Align expectations with reality
- Establish expectations for collaboration and active Participation

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PROCESS

- Home Exercises are Important

  How often are patients with us?

  We cannot be mood stewards for them.

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RESPONSIBILITY CLARIFICATION

- Reflect back to the patient: Are you satisfied with the outcome?
- If not, lets be honest about the relationship between effort and reward.
- Then re-frame things as a choice.

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4. TREATMENT PLANNING

- Set Goals
- Discuss Model
  - Cognitive model
  - Schema – selective information processing.
    - Automatic thoughts
    - Core Beliefs

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CHANGE FROM COMPLAINT TO GOAL

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GOAL FINDING

- Reframe emotions, such as sadness as a CUE:

Constructive Unpleasant Emotion

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GOAL SETTING

- How would you like your life to be different as a result of therapy.
- Set behavioral goals.
- Break larger goals into more manageable ones
- Make sure goals are under patients control.

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STEP 5: CREATE A SCALE

- What would you rate your success in achieving your goal, in general?
  - Today
  - Over the last week? Month?

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STEP 6: THE EFFORT - REWARD CHART (PLANTING AND HARVESTING)

Efforts	Visit 1	Visit 2	Visit 3
SSRI/SNRI			
BMAD			
Social Interactions			
Rewards			
Happiness	2/10		

* Consider splitting "effort cells" diagonally. Enter the negotiated effort in the top left, and enter the patient follow-through in the bottom right: 3/2.

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STEPS OR GOALS OF VISIT

1) Develop a good therapeutic Alliance
2) Understand Patients Problems
3) Explain the process - Establish expectations for collaboration and active Participation
4) Treatment Planning: 1.) Set Goals , 2.) Discuss the cognitive model – thoughts affect feelings
5) Create a Scale
   a. How will you measure if Goal is being accomplished.
6) I/O Charting

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SUMMARY

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