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CBT in Primary Care

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CBT in Primary Care

Brianna Spano, B.S.

Thomas Chittenden Health Center

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The University of Vermont
LARNER COLLEGE OF MEDICINE

Problem Identification

- Mental health disorders, including depression and anxiety, are widely prevalent in the US. 1 in 5 adults in the US experience mental illness, and depression alone affects 6-7% of adults in the US (7). Mental health disorders have been further exacerbated since the pandemic.
- The COVID-19 Mental Disorders Collaborators conducted a study to quantify the impact of the COVID-19 pandemic on the prevalence and burden of major depressive disorder and anxiety disorders in 2020; they estimated an additional 53.2 million cases of MDD globally, an increase of 27.6%, and an additional 76.2 million cases of anxiety disorders globally, an increase of 25.6% (2).
- The prevalence of depression was 39%, anxiety 42%, and psychological distress 39% after the initial lockdowns during the COVID-19 pandemic in the US (6).
- There is a shortage of healthcare providers, especially in mental health. According to the US Health Resources & Services Administration (HRSA), a total of 157 million people in the US live in areas with a shortage of mental health professionals. There is a total of 6,469 mental health professional shortage areas, 11 of which are in Vermont (4).
- In addition to a shortage of mental health providers, many patients are hesitant to seek mental health treatment, and instead seek care from their primary care physicians with whom they have an established relationship (1).
- People with mental health concerns are faced with a sense of stigma amongst healthcare workers, making it difficult to navigate the healthcare network and preventing them from seeking or accessing health care (5).

Public Health Costs

- Mental health disorders, especially depression and anxiety, are the leading causes of global health-related burden (2).
- In 2020, around $280 billion were spent on mental health services in the US. A quarter of this came from the Medicaid program (3).
- A patient with major depression disorder can spend up to an average of $10,836 per year on total health costs in the US (7).
- In a large, multi-country comparison study, the US was found to have a wider gap in healthcare access between those with mental health concerns and those without (5).
- Evidence shows that mental health variables, including depression and anxiety, are strongly associated with poor health outcomes, including non-adherence to medical care, cardiovascular disease, disease progression, and health-related quality of life (1).

Community Perspective

Emily Greenberger, MD, UVM Outpatient Internal Medicine, on creating her CBT training program and incorporating CBT into her practice:

- *“I know this probably isn’t going to cure someone’s depression, but for me it makes me feel closer to my patient, and it feels like I am doing something.”*
- *“The patients really appreciate it; they appreciate that I am talking to them about something other than a medicine. I find that I learn a lot about my patients and it makes me closer to them. More than anything it improves the doctor-patient relationship and it probably improves their trust in their provider. My hope is that it also breaks down some barriers for patients to go to therapy, decrease the stigma, and help them understand what therapy might look like… maybe teach them a skill or two that they can use in the meantime… it might be a starting point.”*

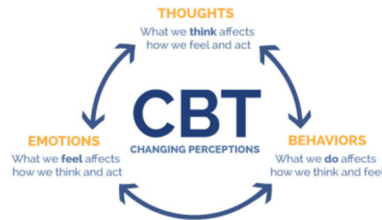
Anonymous, Psychologist, on barriers to mental health and creating a CBT training specifically for primary care providers:

- *“There are long waits to be seen– our waitlist is over a year, and we’re the only clinic in the state that does evidence-based treatment for the largest variety of things. Even for more intensive inpatient programs there is a waitlist, so a lot of people are being held in the hospital for 1-2 weeks because they don’t have openings. There’s also financial [barriers]– Vermont is good with providers taking insurance, but other states aren’t. In Illinois for instance, psychologists are reimbursed by insurance so little that they wouldn’t be able to pay rent. So a lot of therapists are out-of-pocket because they have to be. Then there’s people who don’t have the knowledge about therapy, why therapy could be helpful.”*
- *“PCPs have such great relationships with their patients, so there is so much potential... [Using CBT in primary care can] help make it seem more appealing to patients who may have a stigma or hesitancy [about therapy]. If a really brief intervention of CBT could be effective, that can also bridge the gap. It could also be a form of triage – some patients can benefit from just a brief intervention, and this can help lighten the waitlist, while other patients still on the waitlist could have decreased hopelessness because they have gained at least one thing for their toolbelt.”*

Intervention & Methodology

- One possible solution to the increased burden of mental health and decreased availability of mental health providers is for primary care providers to provide brief, targeted therapy in their practice, in the form of Cognitive Behavioral Therapy for depression and/or anxiety.
- CBT is an evidence-based approach created by Judith Beck, PhD, that trains patients to recognize maladaptive thoughts and behaviors, understand how these thoughts and behaviors are related to and impact their mood and functioning, and find ways to replace these thoughts and behaviors with functional ones (1).
- There is a need for studies that focus on CBT training for PCPs, specifically whether a training program can be designed that is effective, efficient, and feasible for PCPs, and assess if PCPs feel proficient enough and begin to include CBT in their practice (1).
- A brief introduction to CBT based off materials and information from the Beck Institute was developed for primary care providers to use as a resource in the clinic.

Intervention & Methodology



Introduction

- CBT is an evidence-based approach based on the idea that thoughts, behaviors, and emotions are connected.
- Patients are trained to recognize maladaptive thoughts and behaviors, understand how these thoughts and behaviors are related to and impact their mood and functioning, and find ways to replace these thoughts and behaviors with functional ones.
- CBT can be introduced in the clinic to help patients with depression and anxiety understand what therapy may look like, feel more open to a referral to therapy, and gain another tool for their toolbelt while waiting for a referral or therapist availability.

Image: https://med.uth.edu/psychiatry/2019/11/27/what-is-cbt/

CBT Tools That You Can Use

- The Thought Record and Testing Your Thoughts worksheets were both designed by Judith Beck, PhD and original founder of CBT.
- The Thought Record helps patients focus on any thoughts they may be having in a given situation, mood, or behavior pattern. The goal is to explore these thoughts, challenge them in a logical way, and identify behaviors that may help break the thought pattern.
- The Testing Your Thoughts worksheet takes a very similar approach in a more open-ended fashion.
- One or both of these worksheets may be introduced and filled out with your patient during an office visit. The patient can also take the worksheet home for continued practice.

Resources

1. Dorflinger LM, Fortin VI AH, Foran-Tuller KA. Training primary care physicians in cognitive behavioral therapy: A review of the literature. *Patient Education and Counseling*. 2016;99:P1285-1292.
2. Beck Institute for Cognitive Behavioral Therapy. https://beckinstitute.org/cbt-resources/resources-for-professionals-and-students/cbtresources/

Cognitive Behavioral Therapy

in Primary Care

A Brief Guide to Introducing CBT to Your Patients in the Clinic

Brianna Spano, B.S.

The brochure manual designed to help PCPs gain a basic understanding of CBT and brief instructions on how to use the Beck CBT worksheets with patients

Intervention & Methodology

THOUGHT RECORD SIDE ONE: WORKSHEET

Remember, thoughts may be 100% true, 0% true or somewhere in the middle.

JUST BECAUSE YOU THINK SOMETHING, DOESN'T NECESSARILY MEAN IT'S TRUE.

Spend just 5-10 minutes to complete the Thought Record. Noe that not all questions will apply to every automatic thought. Here's what to do:

1. When you notice your mood getting worse, or you find yourself engaging in unhelpful behavior, ask yourself, **"What's going through my mind right now?"** and as soon as possible, jot down the thought or mental image in the Automatic Thought(s) column.
2. The situation may be external (something that just happened or something you just did) or internal (an intense emotion, a painful sensation, an image, daydream, flashback or stream of thoughts—e.g., thinking about your future)
3. Then fill in the rest of the columns. You can try to identify cognitive distortions from the list below. More than one distortion may apply. Make sure to use the questions at the bottom of the worksheet to compose the adaptive response.
4. Spelling, handwriting and grammar don't count.
5. It was worth doing this worksheet if your mood improves by 10% or more.

Cognitive Distortions

All-or-nothing thinking	Example: "If I'm not a total success, I'm a failure."
Catastrophizing (fortune telling)	Example: "I'll be so upset, I won't be able to function at all."
Disqualifying or discounting the positive	Example: "I did that project well, but that doesn't mean I'm competent; I just got lucky."
Emotional reasoning	Example: "I know I do a lot of things okay at work, but I still feel like I'm a failure."
Labeling	Examples: "I'm a loser." "He's no good."
Magnification/minimization	Example: "Getting a mediocre evaluation proves how inadequate I am. Getting high marks doesn't mean I'm smart."
Mental filter (selective abstraction)	Example: "Because I got one low rating on my evaluation [which also contained several high ratings], it means I'm doing a lousy job."
Mind reading	Example: "He's thinking that I don't know the first thing about this project."
Overgeneralization	Example: "Because I felt uncomfortable at the get-together, I don't have what it takes to make friends."
Personalization	Example: "The repairman was curt to me because I did something wrong."
"Should" and "must" statements	Example: "It's terrible that I made a mistake. I should always do my best."
Tunnel vision	"My son's teacher can't do anything right. He's critical and insensitive and lousy at teaching."

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THOUGHT RECORD: SIDE TWO WORKSHEET

Date/time	Situation	Automatic Thought(s)	Emotion(s)	Adaptive Response	Outcome
	1. What event (external or internal) is associated with the unpleasant emotion? Or what unhelpful behavior did you engage in?	1. What thought(s) and/or image(s) went through your mind (before, during or after the event or unhelpful behavior)? 2. How much did you believe the thought(s)?	1. What emotion(s) (sad/anxious/angry/etc.) did you feel (before, during or after the event or unhelpful behavior)? 2. How intense (0–100%) was the emotion?	1. (optional) What cognitive distortion did you make? 2. Use questions below to compose a response to the automatic thought(s). Indicate how much you believe each response.	1. How much do you now believe each automatic thought? 2. What emotion(s) do you feel now? How intense (0–100%) is the emotion? 3. What would be good to do?

Questions to help compose an alternative response: (1) What is the evidence that the automatic thought is true? Not true? (2) Is there an alternative explanation? (3) If the worst happened, how could I cope? What's the best that could happen? What's the most realistic outcome? (4) What's the effect of my believing the automatic thought? What could be the effect of my changing my thinking? (5) If [person's name] was in this situation and had this thought, what would I tell them? (6) What would be good to do?

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TESTING YOUR THOUGHTS: SIDE ONE WORKSHEET

Remember, thoughts may be 100% true, 0% true or somewhere in the middle.

JUST BECAUSE YOU THINK SOMETHING, DOESN'T NECESSARILY MEAN IT'S TRUE.

1. When you notice your mood getting worse, or you find yourself engaging in unhelpful behavior, ask yourself the questions on the reverse side of this worksheet and write down the answers. It will probably take about 5-10 minutes.
2. Not all questions apply to all automatic thoughts.
3. If you'd like, you can use the list below to identify cognitive distortions. You may find that more than one distortion applies.
4. Spelling, handwriting and grammar don't count.
5. It was worth doing this worksheet if your mood improves by 10% or more.

Cognitive Distortions

All-or-nothing thinking	Example: "If I'm not a total success, I'm a failure."
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The worksheets designed by Beck, available on the Beck Institute online, selected to be brief CBT interventions appropriate for use in the primary care setting

Results / Data

Feedback from Providers at TCHC: Adriane Trout MD, David Simcoe MD, Jeff Haddock MD, Pamela Dawson MD

Strengths:

- The worksheets and brochure manual are easy to have on hand.
- They are helpful for navigating the conversation about therapy and CBT; it's nice to know some specific parts of CBT that is recommended frequently but not well taught in training.
- They are very applicable for many patients, especially patients who are resistant to medications or resistant to therapy.

Barriers / Areas for Improvement:

- Limited knowledge about CBT would make it more challenging to use these worksheets appropriately; there is a lack of confidence in applying these worksheets. More in-depth training for PCPs would be helpful in being able to use these worksheets.
- Time is a large barrier to using these worksheets in the clinic, especially for the first few times. It may be more useful to explain the worksheets to patients and have them fill them out at home. Maybe helpful to have a more abbreviated version of the worksheets for primary care use.
- Some patients may not benefit from these worksheets; it requires work and effort, and follow-up. Many patients get lost to follow-up but are higher risk, and would need a medication in order to be best cared for. These worksheets are only applicable to patients with whom the provider has a well established relationship and who are not high-risk.

Evaluation of Effectiveness, Limitations

Evaluation:

- A follow-up survey for providers at TCHC asking whether they have been able to incorporate the CBT intervention into their practice and whether they feel confident in providing the CBT intervention. Additionally may ask whether patients have found the intervention to be helpful through this survey or through a survey for patients.

Limitations:

- **Time:** Though this intervention is designed to be a brief introduction to CBT for patients, it may take over 30 minutes depending the patient, and would certainly take over 15 minutes. Typical appointment lengths for mental health follow-ups at TCHC are 15-30 minutes.
- **Availability of Providers:** Many providers at TCHC are booking out a few weeks to months in advance, and CBT is designed to have frequent follow-ups for active participation and training. This intervention is designed to be an introduction that would provide patients with a tool while awaiting referral to therapy or their follow-up appointment, but some patients may require more frequent follow-up if they are higher risk.
- **Level of Training**: CBT is an evidence-based therapy that usually requires more intensive training to be properly administered. Many training programs exist for psychologists, psychiatrists, social workers and other mental health professionals, but there are limited trainings available that are designed specifically for PCPs. This intervention is not an adequate training material for PCPs.

Recommendations for Future Projects

Evaluate the effectiveness of an existing CBT training model for PCPs

Or

Design a CBT training model for PCPs and evaluate its effectiveness

Perform a RCT comparing the PCP-CBT intervention to the standard care (medication and referral) for patients with depression and/or anxiety

Continue to study and adjust the training and implementation of CBT in primary care

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Interview Consent

Thank you for agreeing to be interviewed. This project is a requirement for the Family Medicine clerkship. It will be stored on the Dana Library ScholarWorks website. Your name will be attached to your interview and you may be cited directly or indirectly in subsequent unpublished or published work. The interviewer affirms that he/she has explained the nature and purpose of this project. The interviewee affirms that he/she has consented to this interview.

Consented

- Name: Emily Greenberger, MD
- Name: *Anonymous community psychologist*