Q&As

Cognitive Therapy

Essentials for Family Physicians

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Q *What is cognitive therapy?*

A "Cognitive therapy is an active, directive, time-limited, structured approach used to treat a variety of psychiatric disorders… It is based on an underlying theoretical rationale that an individual's affect and behaviour are largely determined by the way in which he structures the world." (Aaron Beck, 1979)

Q *What do you do first?*

A The first task in cognitive therapy is the creation of scales for measuring progress towards negotiated goals. Scales ensure the accountability of both the doctor and the patient.

Scales may be very simple:

- For the generalized anxiety disorder (GAD) patient, it may include: *calmness, on a 1 to 10 scale.*
- For the lonely senior, it may include: *sense of connection, on a 1 to 10 scale.*
- For the depressed patient, it may include the antidepressant goal of: *happiness, on a 1 to 10 scale.*

If your practice style allows for detailed psychometric scales (*e.g.*, the 21-question Beck Depression Inventory), that's fine; however, for

? Patricia's case: A Q&A

Patricia, 42, presents with generalized anxiety disorder (GAD) and major depression.

1 What clinical goals might you negotiate with Patricia?

For Patricia's GAD, sensible goals might include:

- calmness, on a 1 to 10 scale; or
- feeling at ease, on a 1 to 10 scale.

For a positive spin on her dysthymia, you might negotiate such goals as:

- happiness, on a 1 to 10 scale;
- vitality, on a 1 to 10 scale; or
- the mediating variable of sense of social connection, on a 1 to 10 scale.

For more Q&As on Patricia's case, go to page 52.

Patricia's case: Q&As cont'd.

2 Given this patient's mood goals, what behavioural investments are most strategic?

Strategic behavioural investments might include:

- regular exercise (minutes/week),
- positive social investments (hours/week),
- nutrition regularity (self-rated 1-10),
- sleep habits (self-rated 1-10), and
- medication-taking behaviour (adherence rated as a percentage).

3 How might you restructure Patricia's clinically relevant cognitions?

Through a combination of listening, asking, and guessing, you might identify dysfunctional cognitions, such as:

a. "Nothing I do makes any difference."
***Viewpointing**: "What might you say to your best friend if she thought that?"*

b. "Worrying is going to kill me."
***Didactic method**: "Although it can certainly be unpleasant, to the best of my knowledge, worrying has actually never killed anyone. There's no need to worry about worrying!"*

c. "Worrying prevents bad things from happening."
***Examining the evidence**: What would be the evidence for and against the idea that worrying is like "white magic" and prevents bad things from happening?"*

most clinicians, simple, co-created 1 to 10 scales will suffice.

Q What are realistic behavioural changes?

A Good cognitive therapists are obsessed with the following question: "Given this patient's mood goals, what behavioural investments are most strategic?"

A wide variety of behaviour changes may help. However, the physician must consider what is most practical and what will likely have the most impact.

Commonly, behavioural recommendations include regular exercise, greater social

Frequently Asked Questions

1. What's the difference between cognitive therapy, behavioural therapy, and cognitive behavioural therapy?
Although historically a distinct discipline, there are now very few pure behavioural therapists. Today, the field is referred to as cognitive behaviour therapy (CBT).

2. Which is more important, cognitive change or behavioural change?
Without associated changes in behaviour, changes in thinking may be of limited value. For example, the socially anxious male who now thinks he's ready to date has likely progressed far less than someone out there gaining actual dating experience.

3. Where can I get training in cognitive therapy?
Unfortunately, most cognitive therapy training is designed for full-time psychotherapists and is unsuitable for the realities of family practice. See *www.cbt.ca* for a listing of family medicine-savvy education opportunities.

Dr. Dubord is the founder, Advanced Cognitive Therapy course, University of Toronto, the director, Toronto Centre for Cognitive Therapy, Toronto, Ontario, and the chief consultant for the national resource site, *www.cbt.ca*.

involvement, better nutrition, and better sleep habits. Strategic investment in these and other behaviours often helps patients make remarkable progress towards their mood goals. Such progress may be on par with that obtained with a drug treatment, but often with additional benefits.

Q How do I identify key cognitions?

A The physician's goal is to identify clinically relevant cognitions. There are three major routes:

1. Listen

The abandoned depressive may blurt out that he thinks nobody will ever love him again. The GAD patient may volunteer that she's "totally vulnerable". And the tearful post-traumatic stress disorder patient may tell you she believes she's now "damaged goods forever".

2. Ask

A key question in cognitive therapy is "What's going through your mind right now?"

The time to ask is when the patient is in front of you, struggling with the relevant emotion. The beliefs expressed at such times are clinically meaningful.

3. Guess

If you've lived an examined life, many of your "empathic conjectures" may be accurate. For example, you may know painfully well what it's like to lose a child and can help a grieving father map and prevail in his new cognitive world. The preferred articulation is: "To what extent are you thinking *X*?"

Table 1

Cognitive restructuring tools

1. Viewpointing

The patient is guided in examining the perspectives of "wise others" about the belief in question; *e.g.,* "If your grandmother were alive today, what might she say to sooth you about your upcoming chemotherapy?"

2. Examination of the evidence

A collaborative examination of the evidence for and against the belief in question; *e.g.*, "Nobody would care if I committed suicide."

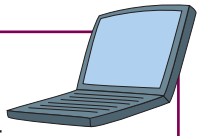
3. The didactic method

The doctor "tells the patient how it is"; *e.g.*, "I can assure you that a panic attack won't drive you crazy. Although understandably frightening, the fight-or-flight reactions you experience are actually harmless."

4. Belief cost-benefit analysis

A collaborative examination of the costs and benefits of a given belief, looking for potential self-fulfilling prophesies; *e.g.*, "What's the net result of continuing to think you can't go on without your wife?"

Surf your way to...



1. Canada's Cognitive Therapy site: *www.cbt.ca*

This Web site is a good general resource for Canadian family physicians. It contains tools for patients, information for doctors (*e.g.*, practical tips for managing borderline personality disorder, panic disorder, and post-traumatic stress), a Canada-wide referral list, and an index of CBT workshops accredited by the College of Family Physicians of Canada. The site is updated regularly.

How do I restructure cognitions?

Family doctors may need far fewer restructuring tools than seasoned cognitive therapists. The reason is the alliance: the sustained relationship that family physicians have with their patients is the most powerful predictor of therapeutic outcome. Examples of simpler cognitive restructuring tools are listed in Table 1. Dx

Suggested Readings
1. Dubord G, Manno M: Cognitive behavioural therapy: Incorporating CBT strategies into family practice. Hamilton, ON: Foundation for Medical Practice Education 2003; 11(16):1-9.
2. Lau MA, Dubord G, Parikh SV: Design and feasibility of a new cognitive behaviour therapy course using a longitudinal interactive format. Can J Psych 2004; 49(10).

Take-home message

What can the GP do?

- The first step in CBT is to create scales for measuring progress towards negotiated goals.
- Commonly, behavioural recommendations include exercise, better nutrition, better sleep habits, and greater social involvement.
- The keys to identifying cognitions are to listen, ask, and guess.
- Simple CBT tools are: viewpointing, examination of the evidence, the didactic method, and belief cost-benefit analysis.