Brief Intervention
Cognitive behavioural Therapy (CBT) in primary health care

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Faculty/Presenter Disclosure

- **Faculty:** Stacey Roles RN, MScN and Peter Pagnutti RN
- **Relationships with commercial interests:**
  - Grants/Research Support: None
  - Speakers Bureau/Honoraria: None
  - Consulting Fees: None
  - Other: None
Disclosure of Commercial Support

- **Potential for conflict(s) of interest:**
  - Stacey Roles and Peter Pagnutti both have private therapy practices and Center for CBT Sudbury which is a private training program offering different levels of training, consulting and supervision in Cognitive Behavioural Therapy which may be discussed during this presentation.
Mitigating Potential Bias

- Any potential biases are being mitigated by disclosing the personal business upfront and by it not being the focal topic of the presentation.
- Center for CBT Sudbury has also been certified to offer CEPD credits for all levels of their training hours being offered.
Stacey Roles rn mscn

- Academy of Cognitive Therapy Certified Trainer Consultant & Therapist
- Credentialed with the Canadian Association of Cognitive and Behavioural Therapies
- Pursuing a PhD
- Adjunct professor with the School of Nursing at Laurentian University
- Faculty in the Psychiatry Program at the Northern Ontario School of Medicine (NOSM)
- Leads the Center for CBT Sudbury; training and supervising clinicians, NPs & physicians
- Avid health care researcher
- Works at Health Sciences North
- Presented at numerous national conferences
- Maintains a private practice
Peter pagnutti RN

- Certified Cognitive Therapist with the Academy of Cognitive Therapy
- Case Manager at HSN
- Has been working in the mental health field for over 20 years
- Has experience working with clients who suffer from severe mental illness in both hospital and community settings
- Trains and supervises clinicians at the Center for CBT Sudbury
- Maintains a private practice
Questions To ponder

- What is counselling?
- What is therapy?
The two big questions

• What is CBT?

• Indications for CBT
Cognitive Model

Indications for CBT and subspecialties

• The cognitive model proposes that dysfunctional thinking (influences the patients’ mood and behaviour) is common to all psychological disturbances
• Started with depression (Beck)
  • Helping patients solve problems
  • Behavioural activation
  • Identify, evaluate and respond to depressed thinking especially to negative thoughts about themselves, their world and their future
• Modification about their underlying dysfunctional beliefs produces enduring change
Key Concepts of the therapeutic relationship (Dinga, 2008)

- Trust
- Communication
- Empathy
- Authenticity
  - Genuineness
- Listening-Active listening
- Time and timing
- Empowerment
Research supports

- More than 500 outcome studies have demonstrated the efficacy of CBT for a wide range of
  - Psychiatric disorders
  - Psychological problems
  - Medical problems with psychological components
Is CBT possible in ten minutes?
Psychoeducation

- Two main principles of CBT
  - Collaboration
  - Guided discovery
COLLABORATION

- We cannot do this work without the client
- We come with knowledge about disorders and CBT
- They come with the knowledge of their experience, thoughts, behaviours, environment and emotions
- Listen
GUIDED DISCOVERY

• Most beneficial intervention within CBT
  • A process used to help the client reflect on the way that they are processing information by answering questions and reflecting on thinking processes
• They come to the conclusions
• Teach them to become their own therapist
• Teach them to notice, identify and then intervene if needed to thoughts, emotions and behaviours
Information-processing model
Case example of client with pain & chronic fatigue

12 Common Cognitive Errors

1. All-or-nothing thinking (also called black-and-white thinking)
2. Catastrophizing (also called fortune-telling)
3. Disqualifying or discounting the positive
4. Emotional reasoning
5. Labeling
6. Magnification/minimization
7. Mental filter
8. Mind reading
9. Overgeneralization
10. Personalization
11. “Should” and “must” statements
12. Tunnel vision

What Does Brief Intervention therapy look like?

• Identify issue of concern
• Use Socratic Dialogue to identify behaviours/thoughts/emotions
• Challenge the thoughts
  • Thought records
  • Pros and cons lists
• Develop behavioural experiments
  • See what happens when they try it (be curious)
• Implement the smallest amount of achievable change possible
# CBT application

## Thought Record

<table>
<thead>
<tr>
<th>Where were you?</th>
<th>Emotion or feeling</th>
<th>Negative Automatic Thought</th>
<th>Evidence that supports the thought</th>
<th>Evidence that doesn’t support the thought</th>
<th>Alternate thought</th>
<th>Emotions or feelings</th>
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**Behavioural Activation and Mastery**

- Identify current or previous life goals
- Socratic dialogue and guided discovery
  - why they stopped persuading these goals
- Socratic dialogue to determine if these goals are still a priority and if not what have they shifted to
- Discover the dissonance from where they are now to where their goals are
- Determine if there is an openness to the belief that daily activation accumulates to long term goals
CBT application

Behavioural Experiments

• The goal is to collaboratively identify a hypothesis about the outcome of a behaviour and then determine what behavioural experiments would test that hypothesis
• It important to ensure you develop with your client a means of measuring the results
• Initially try to gear the outcome to a positive achievement
How do we do this?

- Socratic Dialogue
  - **They come up with their own COGNITIVE suggestions**
    - Identifying cognitive distortions (I can’t do it, I’ll never be able to do it, CATASTROPHIZING)
  - Have them come up with their own **BEHAVIOURAL** suggestions
    - Walk down the hall daily
    - Take stairs instead of elevator
Pleasant events for behavioural activation

- Rate different life events
  - How often it occurs
  - If the event is not pleasant, some what pleasant or highly pleasant
- Some events may include
  - Talking about sports
  - Breathing clean air
  - Being with animals
  - Scratching myself
  - Taking a bath
  - Dancing
- These can be used as behavioural activation by journaling them on a pleasant event calendar
Is Anxiety Bad?

• Goal will be to “get rid of anxiety”
• Anxiety is not bad, it keeps us safe
• What would happen if we didn’t have fear?

• Anxiety and fear response
  • Fight, flight or freeze
Fear is the common theme, so what is the common solution?

• Relaxation
• Deep breathing
• Mindfulness
• Meditation
• Progressive Muscle Relaxation
Prominent Cognitive Errors with Anxiety

1) Overestimating the probability that bad things will happen

2) Underestimating ability to cope

3) Underestimating rescue factors
Coping statements for patients

Normalize your anxiety:
- Anxiety is normal.
- Everyone has anxiety.
- Anxiety shows that I am alert.
- Anxiety may be biologically programmed (this may be the “right response at the wrong time”—there is no danger that I have to escape from).

Take the danger away:
- Anxiety is arousal; it is not dangerous.
- I've been through this before, and nothing bad has happened.
- Anxiety passes and goes away.

Challenge your negative thoughts:
- I'm having false alarms.
- I'm not going crazy or losing control.
- These sensations are not dangerous.
- People can't see my feelings.
- I don't need to have 100% control.

Learn from the past:
- I've made many negative predictions before that haven’t come true.
- I have never gone crazy, had a heart attack, or died from my anxiety.
- Remember that panic is overbreathing not underbreathing—I will not die from it.

Plan acceptance:
- I can sit back and watch my arousal.
- I can accept that my arousal goes up and down.
- I can observe my sensations increasing and decreasing.
- I can accept my arousal and examine my negative thoughts.
Habituation

• Simply means that we react less and less to stimuli over time with repeated presentation
  • If we watch a scary movie over and over again it usually becomes less scary
    • In-Vivo Exposures
    • Imaginal Exposure
Health anxiety

- Avoidance can be reassurance checking
- Exposure can be sitting with uncertainty (discomfort)
- Perceived risk vs actual risk with health issues
- How many times a day are they checking? How long does relief last once they get reassurance? How much worse does it get each time?
- Cost/Benefit analysis
Depression and Suicidal Thoughts

• Risk assessment:
  • If unsure of safety to client, self or others, always consult with or refer to crisis or other agencies in your area
  • Know these emergency services and how to contact them and ensure your client has access to a safety plan as well
  • Safety is paramount

- Crisis Plan:
  - Supports/contacts
  - Crisis phone numbers
  - Emergency department phone numbers and locations
When and Where to refer?

• Lets Discuss.....
  • Any imminent threat to self or others?
  • Differences between private practice and public
  • Differences between service providers
Questions?
References

• Leahy R. (2012). Treatment Plans and Interventions for Depression and Anxiety Disorders 2nd edition
• Theoretical Foundations of Nursing; Peplau [online] http://nursingtheories.weebly.com/hildegard-e-peplau.html
How to get more training

• We offer training for primary health care providers including CEPD credits for physicians
• On site or our location training requests for 4 or 7 hours directed at requested topic of focus
• Intensive training twice per year
• Website www.centerforcbt.ca
• Phone (705) 929-1612