CBT for the Primary Care Clinician, Part 1: How to Know Whether Your Patient is Receiving State-of-the-Art Cognitive Behavioral Therapy (CBT)

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There is increasing evidence that CBT is an effective treatment for many children and adolescents with anxiety disorders and depressive disorders. Primary care clinicians have a substantial role in monitoring these conditions and considering medication treatments; therefore, it is helpful to have the skills to discern whether or not your patient is receiving true CBT. It is also helpful to be able to prepare the patient and family with what to expect from CBT. Part 1 of this two-part series will examine the major components of CBT. Part 2 will outline those disorders for which CBT has been found to be most effective.

Many therapists state that they practice CBT techniques. However, few have been formally trained and supervised to administer CBT therapy despite the robust evidence that this type of treatment is effective for a variety of childhood psychiatric disorders. While some therapists specialize in providing CBT, others describe themselves as eclectic and state that they integrate multiple therapy models. Sometimes these latter therapists lack formal CBT training. In this article, I will illustrate the core elements to help you determine whether or not your patient is receiving true CBT. To do this, I will illustrate some of the differences between CBT and what I'll call SIP (supportive and insight-oriented therapies) and suggest some questions you might ask your patients and their families to determine which type of treatment they are receiving.

Supportive and insight-oriented psychotherapy sessions are patient-driven. Patient-driven means that in these therapies, the content discussed at any given session is dependent upon what the patient chooses to discuss that day. Unless there are major safety issues, in SIP, the therapist follows the patient's lead in each session. The therapist will often have a working plan, called a "formulation" for the therapy. A formulation is an idea of the nature and origins of the problem – similar to the concept of a diagnosis in primary care. In SIP, the formulation is usually not made explicit to the patient or family at the outset of therapy. For example, a patient enters therapy because he is acting out in school. The therapist may have an idea that ongoing divorce proceedings between his parents are driving the problem behavior at school. The therapist will look for moments in which the patient mentions issues at home and may highlight these issues when raised. The therapist will likely explore the feelings associated with the issues raised and may explore the relationship between those feelings and the problem behaviors. These feelings may be discussed in direct conversation, may be discussed while playing a game together, or may be discussed indirectly through play in which characters are assumed to stand for real life people, and their actions are viewed as depictions of the patient's internal experience. Ultimately, however, the patient sets the agenda for the session, and the therapist follows along while keeping an internal mental compass driven by their

formulation and the material the patient presents in the sessions. While SIP does not have the robust evidence for effectiveness currently held by CBT treatments for certain childhood disorders such as generalized anxiety, OCD, and adolescent depression, many children and their families have received benefit from this type of therapy.

By contrast, in CBT, the therapist more actively directs the treatment. After evaluating the problem and choosing to use a CBT intervention, the therapist will present to the patient and family his or her understanding of the disorder and how it has developed for that particular child. The therapist will explain to the patient how the disorder evolved and will outline in detail what steps will be taken to help the patient gain symptomatic relief. For example, consider a child who has developed panic attacks at school and has stopped attending school for fear that the panic attacks will reoccur. The therapist will begin by teaching the patient and family about anxiety. In this phase of treatment, called "psychoeducation," the therapist will explain that avoidance of anxiety-provoking stimuli actually increases the anxiety symptoms and leads to avoidance as an entrenched strategy, which leads to further symptoms and functional impairment. After this phase, the therapist will teach relaxation strategies and develop a plan to help the child return to school by increasing tolerance of anxiety rather than by avoiding it. Therapies for anxiety often utilize an exposure hierarchy in which the patient actively participates in controlled exposures to the feared stimuli during therapy sessions. The patient then works on exposure activities at home and at school with the assistance of family (and teachers if the symptoms extend to school), until the child no longer responds to the anxiety with avoidance. CBT for depression utilizes mood-monitoring tools in which patients track mood symptoms during the week, discuss mood episodes during therapy sessions, and then explore the thoughts and behaviors related to the mood state. The goal of this intervention is to reduce dysfunctional reactions to mood states, which are seen as exacerbating negative moods and lead to functional impairment.

In both of the two CBT treatments described, there are several common elements. First, the treatment begins with psychoeducation. The problem is explained, and the treatment process is detailed. Sessions follow a preplanned progression in which elements of the treatment are taught, practiced in sessions, and then practiced outside of sessions until they are mastered, and symptom relief is experienced. If your patient is involved in CBT, he or she will be doing weekly homework exercises outside of sessions. Typical CBT homework assignments may include exposure activities, mood-monitoring charts, and written explorations of thoughts and behaviors associated with target symptoms. A CBT patient should be able to tell you (i.e., the PCP) what he or she is working on in therapy and how the work is connected to the problem he/she has presented to the therapist. The patient should be able to report that he or she does weekly homework between therapy sessions. **The patient should tell you that at the beginning of each session with the therapist, he/she will discuss the plan for the session and that the rest of the session is spent following that plan.**

A session with unplanned content would indicate that the patient is not receiving CBT. For example, if the patient says he/she spent the session reviewing his/her week

and then played a game together, the patient is not likely to have been receiving true CBT.

In summary, there are many key elements in CBT therapy about which you can inquire to determine whether the patient you have referred for CBT therapy is actually getting CBT. If you are unsure after talking with the family, consider having a conversation with the patient's therapist in which you inquire about the therapy elements above. Or if your practice has an affiliated behavioral health specialist, you could consider asking that colleague to consult with the patient's therapist about the nature of the treatment. You might also consult with the major CBT professional associations (listed below) to see whether a particular practitioner is on their referral list, or consult with a professional on the list. In reality, there is a shortage of therapists trained in CBT who work with children and families. Still, as empirical evidence for this type of treatment continues to emerge, hopefully the ranks of trained practitioners will continue to grow, increasing the availability of these treatments in the community.

Associations:

Academy of Cognitive Therapy

Association for Behavioral and Cognitive Therapies (ABCT)