

Research Article

Teaching Cognitive Behavioral Strategies to General Practitioners through Self-Experience

Sudarsky M^{1,2} and Cohen DA^{1,2*}¹Ruth & Bruce Rappaport Faculty of Medicine, Technion Institute of Technology, Haifa, Israel²Haifa Family Physician Department, Clalit Health Services, Israel***Corresponding author:** Cohen DA, Ruth & Bruce Rappaport Faculty of Medicine, Technion Institute of Technology, Haifa, Israel, 2 Ytzhak Rabin St, Kiryat Tivon, Israel**Received:** May 26, 2019; **Accepted:** July 16, 2019;**Published:** July 23, 2019**Abstract**

Objective: In recent years, a growing recognition of the importance of integrating cognitive behavioral health into primary care settings has been observed.

Cognitive Behavioral Strategies (CBS) are circumscribed psychological skills, based on Cognitive Behavioral Therapy (CBT) principles, which can be incorporated into general practice.

The aim of this article is to describe in detail a CBS training program for GPs, with an emphasis on learning through self-experience, in the multicultural environment of Israel.

Methods: The structured course is composed of 13 weekly sessions. The course provides an introduction to the CBT model and its basic concepts, and discusses CBT tools for managing anxiety, panic attacks, depression, insomnia, and chronic pain in relation to the cultural context. All topics were practiced by participants as part of the self-experience approach.

Results: Participants' questionnaires indicated that the learners were highly satisfied with the new tools they had acquired, and expressed their intention to implement them in their clinical work.

Conclusions: The training program enhanced physicians' motivation and confidence to use CBS techniques in their practice.

Keywords: Cognitive Behavioral Strategies (CBS); Cognitive Behavioral Therapy (CBT); Self-Experience; Primary Care Training; Multiculturalism

Abbreviations

CBT: Cognitive Behavior Therapy; CBS: Cognitive Behavioral Strategies; SMART: Specific, Measurable, Attainable, Relevant, Timely; PMR: Progressive Muscle Relaxation; DTR: Dysfunctional Thought Record

Introduction

The core premise of the Cognitive Behavioral Therapy (CBT) approach, as pioneered by Beck [1] and Ellis [2], proposes that maladaptive cognitions include general beliefs or schemas about the world, the self, and the future, giving rise to specific and automatic thoughts in particular situations, all of which contribute to emotional distress and behavioral problems. Therapeutic strategies aimed at changing these maladaptive cognitions were found to lead to emotional well-being and behavioral change [3].

CBT is an integrated structured approach, usually provided by specialist mental health providers, requiring in-depth training and ongoing supervision. CBT continually targets both the cognitive aspects (attributions and attitudes) and the behavioral aspects of the problem [4].

A meta-analysis published in 2012 examined CBT efficacy in relation to a wide range of psychological problems, e.g., depression, anxiety disorders, insomnia, anger, general stress, distress due to

general medical conditions, etc. This study demonstrated that CBT is very effective for various disorders, especially anxiety disorders. Furthermore, the currently existing body of evidence regarding CBT efficacy is very well-founded [3].

CBT consultations usually last for 30-60 minutes, and an average treatment series usually consists of 10-20 consultations [5]. The patient works collaboratively with the therapist. CBT's goal is to help the patient develop skills to identify, counteract, and cope with problematic thoughts, beliefs, and interpretations [5].

In recent years, there has been a growing recognition of the importance of integrating behavioral health into primary care settings to reflect the current needs of primary care patients and providers [6,7]. Data shows that most patients seeking mental health services turn to primary care as their first or only source of treatment [8,9]. As a result, more than half of the most common mental health problems are treated exclusively in primary care [6,10,11]. Cognitive Behavioral Therapy (CBT) is especially applicable in medical settings, given its brief, skill-based approach and well-based evidence of being effective for a number of presenting problems [12]. Moreover, there is a greater need for patients' *behavioral modification*, due to life-style risks, as well as an increase in the number of patients who could benefit from training and education concerning adjustment to chronic disease [13,14] Supplementary Table 1. There are numerous empirically supported cognitive and behavioral interventions for chronic disease

management (e.g., chronic pain and diabetes) [13,15-8]; lifestyle modification (e.g., insomnia, obesity and smoking) [19]; promoting adherence to treatment regimens [16]; as well as illness acceptance and coping flexibility for highly distressed patients with chronic diseases [15]. When dealing with patients' emotional problems, practitioners tend to use intuitive or self-taught consultation skills, rather than specific, therapy-based approaches. These skills might have therapeutic potential, but they have not been evaluated properly through evidence-based studies [5,6]. Providing specific psychological treatments in general practice can be challenging for GPs, who are often beset by multiple difficulties, such as lack of time, competing demands, and variable levels of psychological competencies [20,21].

Cognitive Behavioral Strategies (CBS) are circumscribed psychological skills that can be incorporated into general practice and need to be distinguished from Cognitive Behavioral Therapy (CBT) [17]. Similar to CBT, the leading principle of CBS is to help patients adopt more realistic attitudes and perceptions in order to achieve improved mental health [18]. Both CBS and CBT involve developing skills that enhance realistic interpretations of common life events, and decrease distorted thinking, such as catastrophic outcomes and negative thoughts. However, CBS is based on brief consultations, requires a relatively short training period, and is easily implemented in primary care settings.

In the literature, several CBT/CBS training programs for general practitioners are described and their outcomes were evaluated. The programs varied in their size, training content, schedule, methods, supervision, and evaluation. In 2016, a review article dealing with training GPs in CBT was published [22]. Only nine studies were included in this review. One example - an RCT by Blashki [23] that included 55 GPs who received 20 hours of training - consisted of methods including role-play and video demonstrations to explain how to use specific skills. Outcomes were assessed by pre- and post-videotaped simulated consultations. The intervention group demonstrated improvements in CBS skills and competencies; patients' outcomes were not evaluated [23]. King [11] conducted an RCT, which included 84 GPs who attended a brief CBT program (four half-days); however, specific training methods were not mentioned. Physician's outcome, which was evaluated using a depression attitude questionnaire, showed no major difference between intervention and control groups after 6 months. In addition, there was no impact on patient's outcome as evaluated by Beck's depression inventory [24].

Teaching methods described in a review article emphasized the use of oral presentation, role play, video demonstrations, self-help booklets, case studies [6], feedback from simulated patients and course facilitators [22].

Self-experience has been a well-known teaching technique since the time of Freud [25]. Personal therapy has played an important role in the training of psychotherapists and counselors and is highly rated by them [19].

More recently, several leading cognitive therapists have suggested that practicing CBT techniques on oneself may be a valuable contribution to effective therapist training [19,26].

These techniques are crucial for translating informative knowledge (i.e., what to do) into operational skills (i.e., how to do

it) [26].

CBT researchers emphasize the importance of CBT self-practice. For instance, according to Padesky: "To fully understand the process of therapy, there is no substitute for using cognitive therapy methods on oneself" [27].

Self-Practice (SP)/self-Reflection (SR) might have a range of potential benefits for CBS trainees - both professionally and personally, which apply to both novice as well as experienced practitioners. First, SP/SR can enhance trainees' professional development by furthering their understanding of CBS principles, improving their CBS skill, and boosting their belief in its value [26].

An early study [28] found that experiencing SP/SR positively improved quality of learning, self-reported knowledge and skills, and therapists' self-confidence levels [19]. Later studies reported similar findings [26].

In another research study that examined which teaching methods were perceived as the most effective by trained therapists in enhancing CBT competencies, *self-experience* was found to be most effective in augmenting reflective capabilities and interpersonal skills [29]. Hence, we perceive *self-experience* as a teaching technique that is crucial for promoting CBS/CBT training and learning.

Another issue that has attracted increased research attention over the last decade is that of multicultural awareness [30,31].

The term "multiculturalism" expresses the theoretical and philosophical variation in norms among different cultures. Multiculturalism addresses various issues such as age, intergenerational differences, religion and spiritual orientation, ethnic and racial identity, socioeconomic status, gender orientation, and nationality [31,32].

At the core of multicultural counseling is the ability to connect with patients and understand influences on identity development and diverse world perspectives referenced in the addressing framework [33]. Sue [34] describes two different approaches to counseling - the *etic* and *emic* approaches - the latter being a multicultural approach. The *emic* approach challenges the assumptions that mental health difficulties are of the same nature and development across cultures. This approach suggests that culture and life experiences significantly influence the development, course, and expression of anxiety, and should also be considered in relation to prevention and intervention efforts [34]. Multiculturalism is also an important factor among pre- and post-graduate students, especially in a heterogeneous population, such as that existing in Israel. It is essential to stress the complexity of cultural diversity to students, including acknowledging culture-related behaviors, identifying cultural strengths and support systems, working collaboratively despite differences, and respecting one another's core beliefs [31]. It was found that multicultural education enhances one's self-awareness and therapeutic sense of competence [30].

Supervision plays an essential role in the quality control of all psychotherapies (including CBT) during initial training and throughout therapists' careers. It is not sufficient to provide supervision, without also considering what constitutes good practice and current developments in the field [35].

The aim of this innovative article is to thoroughly describe the CBS course structure, including examples, in a multicultural environment in Israel. The current article describes the "What" and "How" of teaching CBS using the well-known method of self-experience, which has not yet been used in the context of physicians' training. CBS training stages and practice content are summarized and presented below in Supplementary Table 2.

Methods

The Training Program

We conducted three different courses during the years 2015-2018, in a CME program for family physicians. Each course was composed of 13 weekly sessions; each session lasted 90 minutes. The educator team was comprised of a family medicine physician and a social worker-psychotherapist, both specializing in CBT. The course included 13-17 trainees, family medicine residents, as well as family medicine specialists. The participant group members represented diverse cultural backgrounds (secular and religious), comprised of Arabs, Druze and Jews. The training program structure is described below.

The first five sessions dealt with an introduction to the CBT model, rational and principles: The ABC model is based on the cognitive behavioral model. The key message is that our beliefs about events determine the way we interpret feelings and reactions [17], and how we define automatic thought, distorted thinking patterns, Socratic Questioning, connotation of thought and core beliefs. CBS are powerful tools for breaking vicious cycles is *behavioral modification*, which can change emotions and thoughts, once they have become a habit. Those methods encourage patients to take responsibility for their actions, and give them a sense of control.

The next 5 sessions dealt with CBT strategies for managing common psychiatric conditions in primary care such as anxiety, panic attacks and depression. These strategies include: psycho-education, behavioral activation, pleasant activity scheduling, relaxation techniques (breathing techniques, progressive muscle relaxation, guided imagery and mindfulness), the ABC model, self-monitoring of daily thoughts records, and the use of Socratic Questioning for these disorders. Specific techniques such as "Happy Hour", for controlling anxiety, "Down Arrow" for identifying core beliefs, and behavioral exercises, such as graded exposure tasks and activity planning are also discussed.

During the lessons, we employed various teaching techniques such as structured case studies, small group discussions, real life cases from residents' experience in clinics, movies demonstrating implementation of the various methods, as well as role-play and *self-experience* techniques.

The next two sessions dealt with specific problems, common to family medicine:

CBS for insomnia: Sleep education, stimulus control, sleep hygiene, cognitive intervention regarding maladaptive thinking relating to sleeping, sleep monitoring through sleep diaries, and teaching the principles of sleep restriction/sleep consolidation.

CBS for chronic pain: We used the biopsychosocial model to approach chronic pain, including patient education, gate control theory

[36], setting attainable behavioral goals, cognitive reconstruction, family role in pain perception, and stress management. The students were encouraged to adopt these attitudes in order to manage their own personal past or present pain experience.

Gaming and self-experience: The last session creatively summarized the experiential learning acquired from different CBT-based games that can be implemented during patients' sessions. For example: Ask students to relate cognitively and emotionally to various presented pictures.

Main core elements and guiding principles

1. A multicultural approach - Clinical cases, examples from heterogeneous participants' clinics, and *self-experience* demonstrated throughout the entire course; the influence of culture and life experiences on symptoms' expression. We discussed the need for tailored interventions that utilize psychoeducation, cognitive restructuring, and behavioral changes to provide interventions that can be easily adopted by a wider variety of ethnic groups.

2. Supervision - Participants were encouraged to practice the learned strategies with their patients, along with counselling and guidance from the course teachers. Feedback and mentoring were applied in a structured timeframe within the weekly class, similar to time-framed therapy. Some examples of cases include:

A patient struggling with a weight problem - The educating team helped the physician apply various behavioral strategies to help the patient to lose weight: self-monitoring, SMART (Specific, Measurable, Attainable, Relevant and Timely) goal-setting regarding physical activity, stress management and stimulus control.

A patient who experienced insomnia due to stress provoked by his new job - The educating team advised the physician to teach the patient stress-reducing techniques such as "Diaphragmatic Breathing" PMR and guided imagery. The educating team also advised the physician to help the patient identify cognitive distortions and transform them into more realistic thoughts.

A depressed patient who experienced anhedonia - The educating team advised the physician to use psychoeducation techniques to teach the patient about depression and help him understand how to initiate pleasant activity scheduling.

Ethical considerations: We confirm that all students' personal identifiers were removed, so that the person(s) described could not be identified through the details presented in the research report.

Results

The class was heterogeneous in regard to seniority, culture, religion and geographic location of medical school. The class was comprised of Arab, Druze and Jewish residents and specialists, including some Jewish immigrants from Russia. The physicians were trained in medical schools in Israel, Eastern Europe and Jordan. None of them had any past experience with CBS or CBT,

Our main goal was to design a practical CBS training program suitable for a primary care clinic setting, which would effectively train family physicians to implement CBS techniques in their practices. During the course, the physician- trainees were asked to present specific cases from their clinics. They then received appropriate

supervision from the course instructors.

Questionnaires completed at the end of the course indicated that the learners were highly satisfied with the new tools they had acquired; the physician-trainees all showed a clear interest in expanding their knowledge of CBS in the future. They stated that the tools were very relevant to their practice and could be implemented easily. The physician-trainees also reported being actively involved and motivated throughout the course.

Discussion

Reviewing the literature about CBT/CBS training programs for general practitioners revealed part, but not all, of the content and methods used in this course. None of the programs cited in the literature used the "self-experience" learning method.

Our team designed a course targeted to the "what" and the "how", in terms of using CBS in daily general practice. Classes were repeatedly designed and taught according to the same format every week (similar to CBT therapy): starting with a review of the participants' experiences from the past week; a feedback and guidance session; followed by teaching and practicing new competencies, according to the syllabus. The session ended with the physician-trainees doing *self-experience* exercises to practice the newly-learned strategies, and handing out the homework assignment.

Our article provides a detailed description of the unique methods incorporated in the course, emphasizing *self-experience* and multiculturalism.

Conclusions

The article demonstrates a course model designed for family physicians, which discusses CBS principles and emphasizes the power of self-experience. This process encouraged physicians' motivation and increased their confidence to incorporate CBS techniques in their practice.

A follow-up study is, to be conducted six months post training, to examine the implementation of these techniques in practice, the physicians' sense of confidence in applying them, as well as their sense of personal accomplishment, and the facilitating factors or barriers related to using the CBS technique.

Practical Implications

Due to the success of this pioneering course in Israel's multicultural environment, we suggest expanding family physicians' CBT training, with a specific focus on physicians and patients' outcomes, as well as increased awareness regarding culture-sensitive issues.

We also recommend including the supervision component during physicians' practice, throughout and after the training period. We are currently planning a future research to study these issues.

Acknowledgements

We would like to thank:

1. Irit Gil-Lev, a clinical social worker, specializing in CBT training, and an important part of our educating team, who greatly contributed to the course's model, teaching and spirit.

2. Prof. Khaled Karkabi, Head of the Family Physician Department at the Technion, for his vast support and empowerment.

3. Sharon Erez for language editing.

References

1. Beck AT. Cognitive therapy: Nature and relation to behavior therapy. *Behav Ther* [Internet]. 1970; 1: 184-200.
2. Ellis A. Reason and emotion in psychotherapy [Internet]. L. Stuart. 1975; 442.
3. Hofmann SG, Asnaani A, Vonk IJJ, Sawyer AT, Fang A. The efficacy of cognitive behavioral therapy: a review of meta-analyses. *Cogn Ther Res*. 2012; 36: 427-440.
4. Barlow DH, Durand VM. *Abnormal psychology: an integrative approach*/ David H. Barlow, V. Mark Durand. - Version details - Trove [Internet]. Pacific Grove, Calif. : Brooks/Cole Pub. Co. 1995.
5. Aschim B, Lundevall S, Martinsen EW, Frich JC. General practitioners' experiences using cognitive behavioural therapy in general practice: A qualitative study. *Scand J Prim Health Care* [Internet]. 2011; 29: 176-180.
6. Maunder L, Milne D, Cameron L. Pilot evaluation of brief training in CBT for primary care practitioners. *Behav Cogn Psychother*. 2008; 36: 341-351.
7. Mario P, DeMarco, Renée M, Betancourt, Kelly M, Everard, et al. Identifying Prevalence and Characteristics of Behavioral Health Education in Family Medicine Clerkships: A CERA Study. *Fam Med* [Internet]. 2018; 50.
8. Cauce AM, Domenech-Rodríguez M, Paradise M, Cochran BN, Shea JM, Srebniak D, et al. Cultural and contextual influences in mental health help seeking: a focus on ethnic minority youth. *J Consult Clin Psychol*. 2002; 70: 44-55.
9. Wang PS, Demler O, Olfson M, Pincus HA, Wells KB, Kessler RC. Changing profiles of service sectors used for mental health care in the United States. *Am J Psychiatry*. 2006; 163: 1187-1198.
10. Bea SM, Tesar GE. A primer on referring patients for psychotherapy. Vol. 69, *Cleveland Clinic Journal of Medicine*. 2002; 113-127.
11. King M, Davidson O, Taylor F, Haines A, Sharp D, Turner R. Effectiveness of teaching general practitioners skills in brief cognitive behaviour therapy to treat patients with depression: randomized controlled trial. *BMJ Br Med J*. 2002; 324: 947.
12. Dorflinger LM, Fortin AH, Foran-Tuller KA. Training primary care physicians in cognitive behavioral therapy: A review of the literature. *Patient Educ Couns* [Internet]. 2016; 99: 1285-1292.
13. Weisberg RB, Magidson JF. Integrating cognitive behavioral therapy into primary care settings. *Cognitive and Behavioral Practice*. 2014; 21: 247-251.
14. Scheeres K, Wensing M, Mes C, Bleijenberg G. The impact of informational interventions about cognitive behavioral therapy for chronic fatigue syndrome on GPs referral behavior. *Patient Educ Couns* [Internet]. 2007; 68: 29-32.
15. Vriezolkolk JE, Geenen R, Van Den Ende CHM, Slot H, Van Lankveld WGJM, Van Helmond T. Behavior Change Behavior change, acceptance, and coping flexibility in highly distressed patients with rheumatic diseases: Feasibility of a cognitive-behavioral therapy in multimodal rehabilitation. *Patient Educ Couns* [Internet]. 2012; 87: 171-177.
16. Demonceau J, Ruppert T, Kristanto P, Hughes DA, Fargher E, Kardas P, et al. Identification and assessment of adherence-enhancing interventions in studies assessing medication adherence through electronically compiled drug dosing histories: A systematic literature review and meta-analysis. *Drugs*. 2013; 73: 545-562.
17. Blashki G, Richards JC, Ryan P, Pierce D, McCabe MP, Morgan H, et al. Cognitive behavioural strategies for general practice. *Aust Fam Physician*. 2003; 32: 910-917.
18. Safren SA, Gonzalez JS, Wexler DJ, Psaros C, Delahanty LM, Blashill AJ, et al. A randomized controlled trial of cognitive behavioral therapy for adherence and depression (CBT-AD) in patients with uncontrolled type 2 diabetes. *Diabetes Care* [Internet]. 2014; 37: 625-633.

19. Barnett-Levy J, Lee N, Travers K, Pohlman S, Hamernik E. Cognitive Therapy From the Inside: Enhancing Therapist Skills Through Practising What We Preach. *Behav Cogn Psychother*. 2003; 31: S1352465803002029.
20. Weisberg RB, Magidson JF. Integrating cognitive behavioral therapy into primary care settings. *Cogn Behav Pr*. 2014; 21: 247-251.
21. Zubatsky M, Brieler JA, Jacobs C. Training Experiences of Family Medicine Residents on Behavioral Health Rotations [Internet]. 2017.
22. Blashki GA, Piterman L, Meadows GN, Clarke DM, Prabakaran V, Gunn JM, et al. Impact of an educational intervention on general practitioners' skills in cognitive behavioural strategies: a randomised controlled trial. *Med J Aust*. 2008; 188: S129-S132.
23. Serfaty MA, Haworth D, Blanchard M, Buszewicz M, Murad S, King M. Clinical effectiveness of individual cognitive behavioral therapy for depressed older people in primary care: a randomized controlled trial. *Arch Gen Psychiatry* [Internet]. 2009; 66: 1332-1340.
24. Freud S. *An Outline of Psycho-Analysis*. SE 23. 1938; 141-207.
25. Bennett-Levy J, Lee NK. Self-Practice and Self-Reflection in Cognitive Behaviour Therapy Training: What Factors Influence Trainees' Engagement and Experience of Benefit? *Behav Cogn Psychother*. 2014; 42: 48-64.
26. Padesky CA, Salkovskis PM. Developing cognitive therapist competency: Teaching and supervision models. In: *Frontiers of cognitive therapy* [Internet]. 1996; 266-292.
27. Bennett-Levy J, Turner F, Beaty T, Smith M, Paterson B, Farmer S. Clinical Section The Value Of Self-Practice Of Cognitive Therapy Techniques And Self-Reflection In The Training Of Cognitive Therapists [Internet]. Vol. 29, *Behavioural and Cognitive Psychotherapy*. 2001.
28. Bennett-Levy J, McManus F, Westling BE, Fennell M. Acquiring and Refining CBT Skills and Competencies: Which Training Methods are perceived to be Most Effective? *Behav Cogn Psych other*. 2009; 37: 571.
29. Arredondo P, Ivey A, Sue DW, Parham T, Sue DW, Mio JS, et al. Guidelines on Multicultural Education , Training , Change for Psychologists. 2003; 58: 377-402.
30. Hays PA. Integrating Evidence-Based Practice, Cognitive-Behavior Therapy, and Multicultural Therapy: Ten Steps for Culturally Competent Practice. *Prof Psychol Res Pract*. 2009; 40: 354-360.
31. Jessica R. Graham, Sorenson S, Hayes-Skelton SA. Enhancing the Cultural Sensitivity of Cognitive Behavioral Interventions for Anxiety in Diverse Populations. *Behav Ther*. 2013; 36: 101-108.
32. Graham JR, Sorenson S, Hayes-Skelton SA. Enhancing the Cultural Sensitivity of Cognitive Behavioral Interventions for Anxiety in Diverse Populations. *Behav Ther* [Internet]. 2013; 36: 101-108.
33. Sue DW. *Counseling The Culturally Diverse: theory and practice*, eighth edition. [Internet]. JOHN WILEY & Sons. 2019.
34. Pretorius WM. Cognitive Behavioural Therapy Supervision: Recommended Practice. *Behav Cogn Psychother* [Internet]. 2006; 34: 413-420.
35. Melzack R, Wall PD. Pain Mechanisms: A New Theory. *Science* (80-) [Internet]. 1965; 150: 971-979.
36. Prac C. Behavioural modi cl strategies for general practice. 2003; 32: 715-721.