Scandinavian Journal of Primary Health Care, 2011; 29: 176–180

informa
healthcare

ORIGINAL ARTICLE

General practitioners' experiences using cognitive behavioural therapy in general practice: A qualitative study

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Abstract

Objective. To explore GPs' experiences using cognitive behavioural therapy (CBT), with a focus on factors that promote or limit the use of CBT in general practice. *Design*. Qualitative study using data from written evaluation reports and focus-group interviews. *Setting*. Norwegian general practice. *Subjects*. GPs who participated in a longitudinal CBT course in the continuous medical education (CME) programme for GPs in Norway, of whom 19 filled in evaluation forms and 15 participated in focus-group interviews. *Main outcome measures*. Experiences with the use of CBT in general practice. *Results*. GPs used CBT mainly in the treatment of patients with anxiety disorders and depression. Factors that promoted the use of CBT in general practice were structured supervision and group counselling, receiving feedback on individual video-recorded consultations, and experiencing that one mastered the therapeutic techniques. Limiting factors were that it took some time before one mastered the techniques, lack of eligible patients, constraints related to attending group supervision during office hours, and the lack of financial incentives to use CBT in general practice. *Conclusion*. Tailored training programmes in CBT for GPs may contribute to more frequent use of CBT in general practice. A formal recognition of CBT in the reimbursement scheme for GPs might counter limiting factors to an increased use of CBT in general practice.

Key Words: *Anxiety disorders, cognitive therapy, depressive disorder, family practice, physicians*

The lifetime prevalence of mental disorders in the Norwegian population is 50% [1]. The majority of patients with mental disorders who seek health care are managed in primary care, and psychiatric illness represents about 9–10% of contacts in regular GPs' daytime practices [2]. Four out of 10 Norwegian GPs suggest that improvement of GPs' skills and knowledge would be helpful to improve treatment of mental disorders [3]. The methods GPs use for treating mental disorders, apart from medication, are often self-taught, not based on a specific approach, and often referred to as "talking therapy" or "supportive therapy" [4].

Cognitive behavioural therapy (CBT) is a time-limited, structured psychological intervention aimed at treating patients with various mental disorders. CBT consultations usually last for 30–60 minutes, and a treatment series usually consists of 10–20 consultations. CBT aims at helping patients change how they think and what they do, and CBT focuses on problems and difficulties at present, rather than issues from the past. The patient works collaboratively with the therapist. CBT aims at helping the patient to develop skills to identify, to counteract, and to cope with problematic thoughts, beliefs, and interpretations, and to learn how these affect symptoms, feelings, and problems. CBT is effective for treatment of anxiety disorders and moderate depression in primary care [5,6], but only a minority of GPs use CBT systematically. Lack of time and confidence, and practice distractions have been identified as barriers to GPs using CBT in their clinical practice [7]. In Norway, CBT has usually been taught to GPs in the format of one- to three-day courses, mainly based on lectures. Recently, a new course has been introduced in the Norwegian continuous medical education

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(Received 14 January 2011; accepted 5 June 2011)

ISSN 0281-3432 print/ISSN 1502-7724 online
DOI: 10.3109/02813432.2011.595582

Cognitive behavioural therapy (CBT) is effective for treatment of anxiety disorders and moderate depression in general practice, but the use of CBT in general practice is limited.

- GPs experienced increased confidence in using CBT after completing a longitudinal course in CBT, involving seminars and group meetings with individual case supervision.
- A formal recognition of CBT in the reimbursement scheme for GPs might facilitate more frequent use of CBT in general practice.

(CME) programme for GPs, involving seminars and group meetings with individual case supervision.

As medical doctors with an interest in management of psychiatric conditions in general practice, we wanted to understand more about the factors that influence the use of CBT in general practice, and what challenges and advantages GPs experience when they start using CBT in their own practice. The purpose of this study was to explore GPs' experiences with using cognitive behavioural therapy (CBT), with a focus on factors that promote or limit the use of CBT in general practice.

Material and methods

We chose a qualitative approach as most suitable, and obtained data from written evaluation forms and focus-group discussions with GPs who had participated in a CME course in CBT in Norway.

The CBT course

The course was developed by BA and SL from the Norwegian Medical Association, in collaboration with EWM from Norwegian Association for Cognitive Therapy. The course lasted for nine months, from June 2008 to March 2009, and consisted of 50 hours' teaching and 15 hours' supervision. The course started with a weekend seminar for two half-days, where the participants learnt the basics of CBT as well as getting acquainted with each other. All were given a DVD, demonstrating the use of CBT in general practice. After the initial seminar followed three one-day seminars, centred on the use of CBT for the management of depression, anxiety, chronic pain, and somatization. GPs, psychiatrists, and clinical psychologists served as teachers and supervisors. At the fifth seminar, the core elements of CBT were repeated, and participants shared their experiences of using CBT. In between these seminars, the GPs were divided into five smaller groups and were given a total of 15 hours of group supervision in three or four sessions at district psychiatric centres (three of the groups) or with other supervisors in CBT (two groups). In these sessions, the participants presented one or two videos of their own consultations with patients.

Written forms and focus groups

Twenty out of 22 GPs who signed up completed the course. Nineteen GPs, 10 women and nine men, submitted written forms concerning their background and their expectations at the start of the course. At the end of the course they completed evaluation forms regarding their experiences with the course and the use of CBT in their own practice. GPs' mean age was 47.2 years (range 34–61), and 17 were certified GPs. During the course they had used CBT in the treatment of a total of 68 patients (mean 3.6 patients per GP, range 1–8), of whom 58 (85%) patients were treated for anxiety disorders, depression, or both, and 10 (15%) were treated for other psychiatric conditions.

Fifteen of the 19 GPs who submitted evaluation forms participated in focus-group interviews at the end of the course. BA and SL moderated one focus group each. The focus groups were conducted in March 2009. Data from audiotapes of focus-group interviews were transcribed verbatim.

Analysis

Free text comments from the evaluation reports were written into a file. Free text comments and the data from the focus-group interviews were analysed by BA, SL, and JCF according to the principles of Giorgi's phenomenological analysis, modified by Malterud [8]. The analysis included four steps: (i) Reading the material to obtain an overall impression and bracketing previous preconceptions, (ii) identifying units of meaning representing different aspects of using CBT in general practice, and coding for these, (iii) condensing and summarizing contents of each coded group, and (iv) making generalized descriptions and concepts regarding the use of CBT in general practice. Quotes from the material were translated from Norwegian to English by the first author in the process of writing the article. The GPs signed a written consent form in which they agreed that the data could be used to evaluate the course.

Results

We identified several factors linked to GPs' use of CBT in clinical practice (Table I), and we elaborate on these below.

Table I. Main promoting and limiting factors to use of cognitive behavioural therapy (CBT) in general practice.

Promoting factors:
Clinical case supervision in groups
Collaboration with local specialists
Setting aside sufficient time for treatment sessions
Experiencing that CBT has positive effects
Limiting factors:
It takes time to master CBT
Difficulties with finding eligible patients
Constraints with attending group supervision during office hours
Difficulties with changing working style
Lack of financial incentives to do CBT

Experiences with group supervision

GPs agreed that clinical case supervision in groups with individual feedback on personal video-recorded consultations was a factor that encouraged them to use CBT, as expressed by one participant:

> *The small-group sessions have been very useful. Feedback from the facilitator at the local district psychiatric centre and from the other participants is essential. It's time-consuming, but I get a lot back, it's a positive experience. I like to see that not everybody succeeds, we make the same mistakes, have the same problems. (Focus group 1)*

It took some time before the participants experienced that they had mastered the therapeutic techniques, and the group sessions were an arena for learning, receiving feedback, and support. GPs experienced the collaboration with specialists at the local district psychiatric centre as useful.

Duration and the organizing of consultations

Participants reported that using CBT required a clear plan on how to organize treatment sessions and sufficient time for consultations:

> *I quickly decided that having chosen to use time and money on this course I really wanted to learn how to use CBT. So I reserved half a day a week for CBT patients, and in this way I think I learnt it more efficiently. (Focus group 2)*

A common strategy, also in order to avoid being interrupted, was to schedule CBT sessions for the last office hours on a particular day, and to schedule these patients for consultations lasting 30–60 minutes.

Mastering CBT

Participants stated that they had been unsatisfied with just doing "talk therapy", and they experienced that using CBT helped them to structure and focus consultations in a better way, as explained by one GP:

> *I have a tool to structure the consultation, it has helped me to limit the topics on the patients' agenda…. I have more enjoyment and inspiration in my job. It prevents me from getting tired of certain patients. (Focus group 1)*

They also experienced that they had been able to adopt a more proactive approach that encouraged the patient to take a more active role in the therapeutic process:

> *I'm able to enhance the patients' own self-reflection, to make them think about their own way of thinking. I do not just sit and support them; I challenge them in quite a different way than I did before. (Focus group 2)*

Working as a team with the patient and sharing some of the responsibility was recounted in positive terms, and they reported positive experiences with giving patients homework assignments for the next session. GPs' experiences of mastering CBT and witnessing the positive effects in their clinical practice promoted future learning and motivation to use CBT. Participants reported that they had become more aware of how they structured consultations:

> *I have managed to keep a better structure in my consultations. This is useful not only with patients with mental disorders but also with other patients. (Focus group 1)*

This suggests that learning CBT might have a positive impact on GPs' general consultation skills.

Limiting factors

Some participants said that it had been difficult to find eligible patients, and it could be challenging for the learning process that it took some time before they learnt to master the CBT techniques. Some lacked confidence and feared that it would be difficult to continue practising CBT when the course and the supervision ended. Having worked as GPs for a long time, some of the participants had established a certain style of work and found it difficult to change patterns. They considered continuous reminders and supervision as necessary to continue using their new competence. Although supervision was seen as essential, some reported that attending group supervision during office hours was inconvenient, because being absent could conflict with other duties in the practice. GPs reported that a limiting factor for using CBT was the lack of a financial incentive to use CBT in general practice. One GP stated:

> *We earn half of what we earn compared with [participation in] meetings with the Welfare and Work Administration. (Focus group 1)*

Another GP suggested that CBT should be recognized in the reimbursement scheme for general practice:

> *The reimbursement should change, I would ask for an economic acknowledgement for doing CBT in the same way that other clinical competences give reimbursement, but there have to be some criteria, some certification. (Focus group 2)*

Discussion

Principal findings

We found that GPs used CBT mainly in the treatment of patients with anxiety disorders and depression. Factors that promoted the use of CBT in general practice were structured supervision and group counselling, receiving feedback on individual video-recorded consultations, and experiencing that one mastered the therapeutic techniques. Limiting factors were that it took some time before one mastered the techniques, lack of eligible patients, constraints related to attending group supervision during office hours, and that there were no particular financial incentives to use CBT in general practice.

What does this study add to previous knowledge?

Our findings are in line with previous research, which found that lack of time and confidence, and practice distractions are limiting factors to more frequent use of CBT in general practice [7]. Our findings suggest that a longitudinal structured supervision programme, involving individual feedback, might promote GPs' confidence in using CBT. Our findings suggest that it is important to set aside sufficient time for treatment sessions, and that scheduling consultations on a particular day in the practice might be a strategy that promotes the use of CBT. GPs who learn to master CBT report experiencing positive effects with regard to their consultation skills in general. Use of new therapeutic techniques depends on the organizational context [9], and our findings suggest that lack of financial incentives to use CBT might be a limiting factor to more frequent use of CBT in general practice.

Building skills and confidence

Training is important for GPs' confidence in managing depressed patients in primary care [10]. Previous research indicates that active learning strategies, such as role-play, self-experiential work, and reflective practice, are effective methods for developing procedural skills in CBT [11]. Our study suggests that GPs experience increased confidence in using CBT after completing a longitudinal course in CBT. The course involved seminars and active learning strategies such as group meetings with individual case supervision. Tailored training programmes in CBT for GPs will probably contribute to a more frequent use of CBT in general practice. Such educational efforts will need qualified supervisors who are familiar with general practice, and supervision might be offered after office hours.

Need for a financial incentive?

Norwegian guidelines state that psychological interventions should be used for treatment of mild to moderate depression, before medication is introduced in primary care [12]. The majority of patients with mild mental disorders receive treatment in primary health care, most of them by their GPs [2], and using CBT will be an effective treatment for some of these patients [5,6]. CBT is time-consuming, and does not easily fit into 15- to 20-minute consultations in general practice. Time will always be a limiting factor in a GP's work, and the current reimbursement scheme does not encourage time-consuming treatment methods such as CBT. The lack of adequate reimbursement for CBT might therefore be a limiting factor to use of CBT in general practice. Reimbursements for a series of diagnostic and therapeutic procedures exist, and a formal recognition of CBT in the reimbursement scheme might encourage GPs to invest time and effort in learning to use CBT.

Strengths and weaknesses of the study

The participants in this study represent a self-selected sample of GPs, who signed up for and completed a CME course. Participants were experienced GPs, and they are likely to be more motivated to use CBT compared with GPs in general. They may also have a special interest in managing psychiatric conditions. We consider our findings valid for experienced GPs, who are motivated to learn more about CBT.

Conclusion

Tailored training programmes in CBT for GPs will probably contribute to more frequent use of CBT in general practice. A formal recognition of CBT in the reimbursement scheme for GPs might counter limiting factors to increased use of CBT in general practice.

Acknowledgement

The project was financed by the Norwegian Directorate of Health and the Norwegian Medical Association's Fund for Quality Improvement.

Conflict of interest

None.

References

[1] Kringlen E, Torgersen S, Cramer V. A Norwegian psychiatric epidemiological study. Am J Psychiatry 2001;158:1091–8.
[2] Johansen IH, Morken T, Hunskår S. Contacts related to mental illness and substance abuse in primary health care: A cross-sectional study comparing patients' use of daytime versus out-of-hours primary care in Norway. Scand J Prim Health Care 2010;28:160–5.
[3] Mykletun A, Knudsen AK, Tangen T, Øverland S. General practitioners' opinions on how to improve treatment of mental disorders in primary health care: Interviews with one hundred Norwegian general practitioners. BMC Health Serv Res 2010;10:35.
[4] Davidsen A. Experiences of carrying out talking therapy in general practice: A qualitative interview study. Patient Educ Couns 2008;72:268–75.
[5] Stanley MA, Wilson NL, Novy DM, Rhoades HM, Wagener PD, Greisinger AJ et al. Cognitive behavior therapy for generalized anxiety disorder among older adults in primary care: A randomized clinical trial. JAMA 2009;301:1460–7.
[6] Serfaty MA, Harworth D, Blanchard M, Buszewicz M, Murad S, King M. Clinical effectiveness of individual cognitive behavior therapy for depressed people in primary care: A randomized clinical trial. Arch Gen Psychiatry 2009;66:1332–40.
[7] Wiebe E, Greiver M. Using cognitive behavioural therapy in practice: Qualitative study of family physicians' experiences. Can Fam Physician 2005;51:992–3.
[8] Malterud K. Shared understanding of the qualitative research process: Guidelines for the qualitative researcher. Fam Pract 1993;10:201–6.
[9] Gask L, Dixon C, May C, Dowrick C. Qualitative study of an educational intervention for GPs in the assessment and management of depression. Br J Gen Pract 2005;55:854–9.
[10] Richards JC, Ryan P, McCabe MP, Groom G, Hickie IB. Barriers to the effective management of depression in general practice. Aust N Z J Psychiatry 2004;38:795–803.
[11] 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 Psychother 2009;37:571–83.
[12] Nasjonale retningslinjer for diagnostisering og behandling av voksne med depresjon i primær- og spesialisthelsetjenesten [National guidelines for diagnosing and treating adults with depression in the primary and specialist health services]. Oslo: Norwegian Directorate of Health; 2009.