Cognitive Behavior Therapy for Depression and Anxiety

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Disclosures and Objectives

- Disclosures: None
- Objectives:
  1. Describe the symptoms of major depression and (some) anxiety disorders
  2. List nonspecific benefits of all psychotherapies
  3. List the principles of cognitive behavior therapy (CBT)

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Overview

- Clinical assessment of mood and anxiety disorders
- Psychotherapy in general
- CBT
  - Indications
  - Overview of approach
  - Resources

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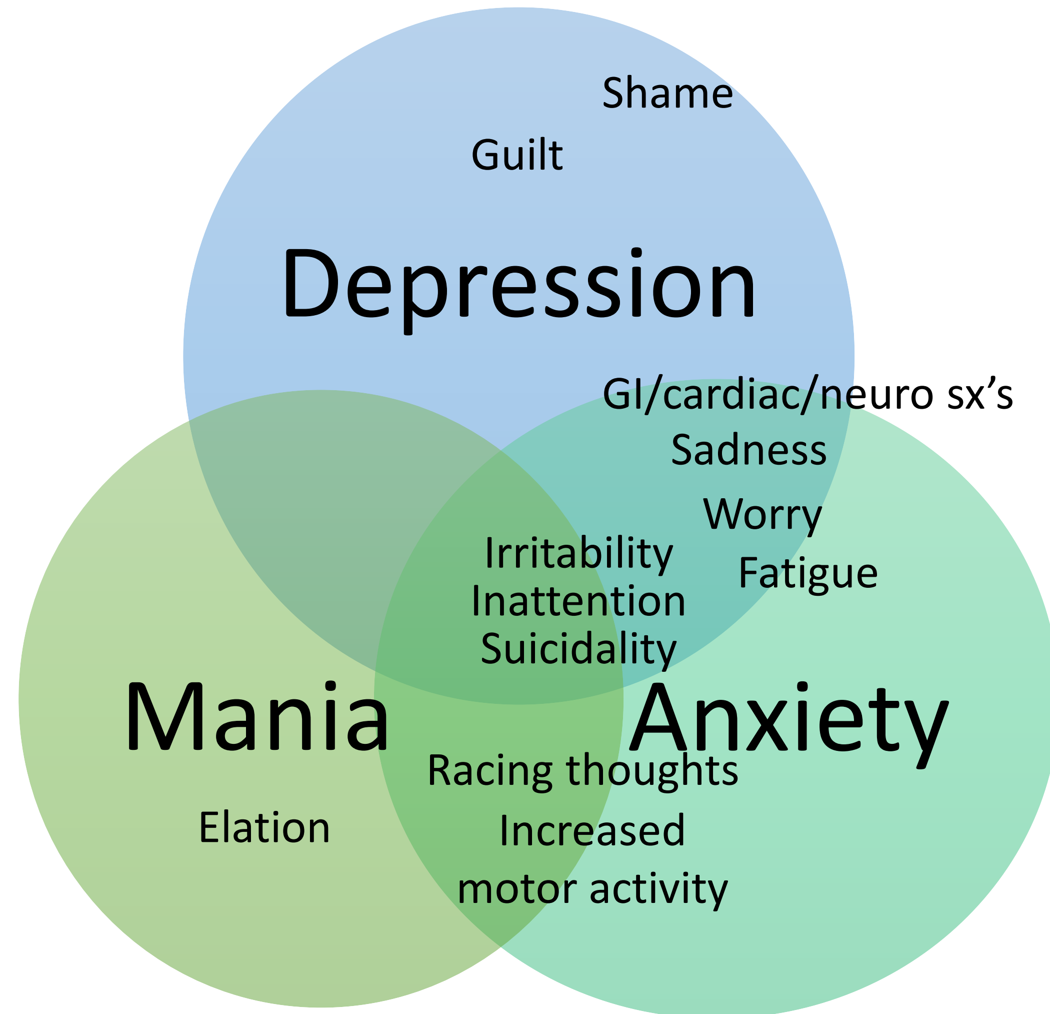
Diagnostic challenge of symptoms vs syndromes



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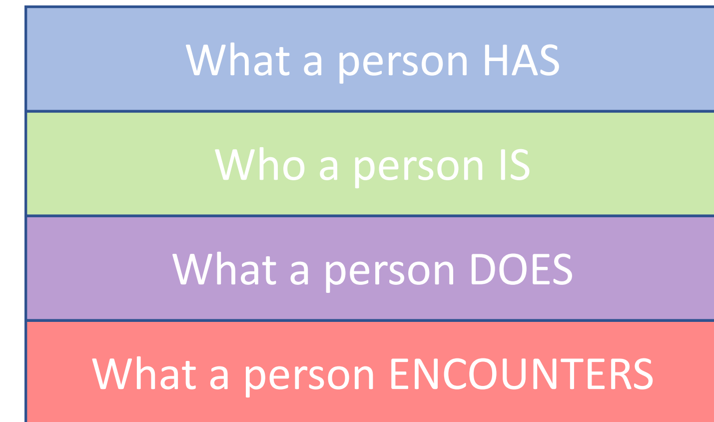
Differential diagnosis and the perspectives of psychiatry

- Major Depression
- Anxiety disorder
- Bipolar Disorder
- Bereavement/grief
- Adjustment disorder/demoralization
- Substance abuse disorder
- Eating disorder
- Personality disorder



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Challenges of MDD case definition

- Major Depressive Disorder is a clinical diagnosis
- No diagnostic blood test or brain scan
- Insight needed for optimal self-report
- Optimal assessment involves skilled clinical assessment and information from an outside informant

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Major Depression (DSM-5)

- Five or more of the depressive symptoms present during the same two week period
- The symptoms cause clinically significant distress or impairment in functioning
- The symptoms are not due to the effects of alcohol or other substances or a medical condition (but comorbidity common)
- Depressive episodes only, no manic, mixed, or hypomanic episodes
- Symptoms not better accounted for by bereavement (but not an exclusion)

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Epidemiology of Major Depression

- Lifetime prevalence rates
  - Women 10% – 25%
  - Men 5% – 12%
- Rates equal for pre-pubertal boys and girls
- Rates in women twice those of men following menarche

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Prevalence of Depression in Patients with Comorbid Medical Illnesses

Cardiac Disease	17-27%
Diabetes (self-reported)	26%
Cancer	22-29%
HIV/AIDS	5-20%
Chronic Pain	30-54%
Obesity	20-30%

Rudisch & Nemeroff 2003; Anderson et al. 2001; Raison & Miller 2003; Cruess et al. 2003; Campbell et al. 2003; Stunkard et al. 2003

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Prevalence of Major Depression in Patients with Neurologic Disorders

• Parkinson’s Disease	40 – 50 %
• Multiple Sclerosis	35 %
• Migraine Headaches	40 %
• Alzheimer’s disease	30 – 50 %
• Amyotrophic Lateral Sclerosis	no increase

Mayeux R, *Handbook of Parkinson’s Disease*, 1992; Sadovnick et al., *Neurology*, 1996; Breslau et al., *Neurology*, 2000; Rabkin, et al., *Psychosomatic Medicine* 2000; 62:271-9

Suicide and Psychiatric Illness

- 90% of completed suicides have a diagnosed psychiatric disorder
- Depressive disorders most common ~ 80%
- Comorbid Alcohol abuse common
- Patients with depressive disorders and schizophrenia often commit suicide early in the course of their illnesses

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Suicide risk following hospitalization

- Increased risk in the period following discharge
- >33% of depressed patients who commit suicide were hospitalized within the past 6 months
- Highest risk of a second attempt is in the three months following the first attempt

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Clinical risk factors for suicide

- Hopelessness
- History of prior attempts
- Lethality of plan and <u>access</u> to means
- Lack of social supports
- No established treatment relationship

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Protective Factors for suicide

- Marriage
- Having dependent children
- Pregnancy and the first year of the child's life
- Religious beliefs
- Relationships

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Initial Assessment

- Comprehensive history
  - Medical causes of mood symptoms
  - History of previous, milder episodes
  - Assessment for hypomanic, manic and mixed symptoms
- Mental Status
  - Careful assessment of suicidal thoughts
- Outside informants
- Discussion of Diagnosis, Treatment Recommendations, and Emergency Plan

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Treatment of Mood Disorders

- Medications
- Individual psychotherapy
- Education and support
- Family involvement and/or family therapy
- Control of behaviors (alcohol abuse, substance abuse, eating disorders, and cutting)
- Other treatments
  - Electro-convulsive therapy (ECT)
  - Bright Light Therapy

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National Comorbidity Survey Replication (NCS-R)

- Survey of 9,282 adults
- Diagnosis of mood, anxiety, and substance abuse disorders
- Assessment of psychiatric treatment in past 12 months with all providers
- Minimally adequate treatment
  - Medication for ≥ 2 months + 4 visits in a year
  - Psychotherapy: ≥ 8 visits (with any provider lasting on average ≥ 30 minutes) in a year

Wang PS et al. *Archives of General Psychiatry* 2005;62:629-640

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Percent of patients receiving minimally adequate treatment by provider type

General Medical
Psychiatrist

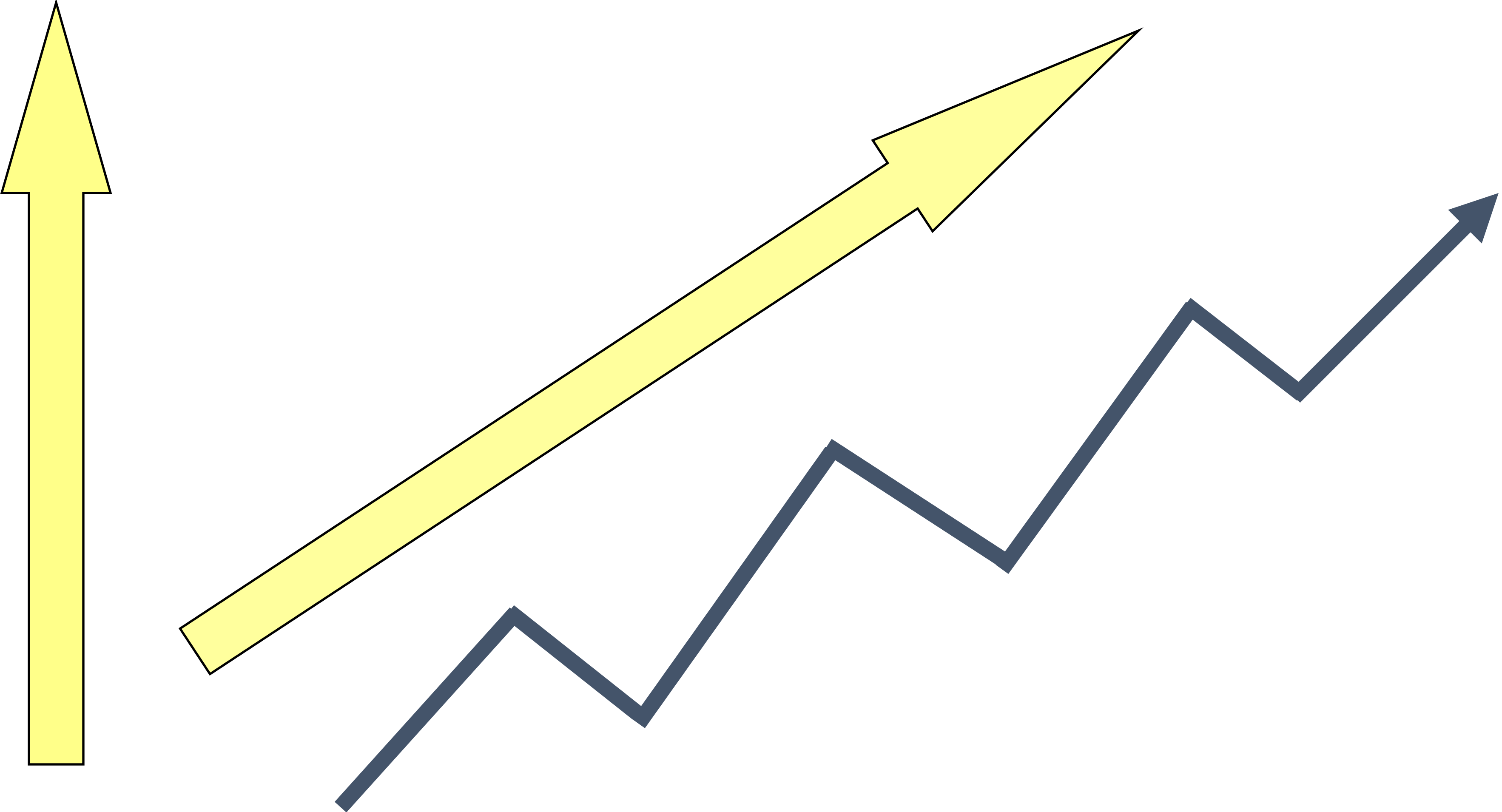
Percent with Minimal Tx

70
60
50
40
30
20
10
0

MDD
Bipolar
GAD
Panic

Wang PS et al. *Archives of General Psychiatry* 2005;62:629-640

Course of Recovery from Major Depression



Anxiety symptoms

- Psychic anxiety – mental manifestations of anxiety
  - Worries, fears
- Somatic anxiety – bodily manifestations of anxiety
  - Palpitations, tachycardia, tachypnea, dyspnea, nausea, diarrhea, etc.

- Patients may exhibit either or both
- “Free-floating” or triggered by specific stimuli

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(Some) Anxiety Disorders – DSM5

- Separation Anxiety Disorder
- Social Anxiety Disorder
- Generalized Anxiety Disorder
- Specific Phobia
- Panic Disorder
- Agoraphobia

- Selective Mutism

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Psychotherapy – nonspecific ingredients

- Occurs in the "assumptive world"
- The problem: demoralization or loss of hope

- All psychotherapies consist of:
  - Relationship
  - Setting
  - Rationale
  - Procedure

- Individual psychotherapies are <u>evocative</u> or <u>directive</u> (e.g., CBT)

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Frank & Frank, Persuasion and Healing, 3ed.

Which of these are psychotherapy?

- Yearly checkup
- Acute visit for knee pain
- Writing a prescription for an antihypertensive
- Discussing loss of a spouse with your doctor

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When to use psychotherapy

- Incomplete response to medication
- Patient is reluctant to use medications
- Medication regimen is complex and drug-drug interactions may be too problematic
- Failure to respond to medication trials
- When the patient is not too ill (CBT requires some energy/motivation; safety first!)

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Evidence base for CBT

- Mild-moderate MDD
  - Comorbid MDD and substance abuse
  - Comorbid MDD and PTSD
- OCD
- Eating disorders
- Insomnia
- Pediatric migraine

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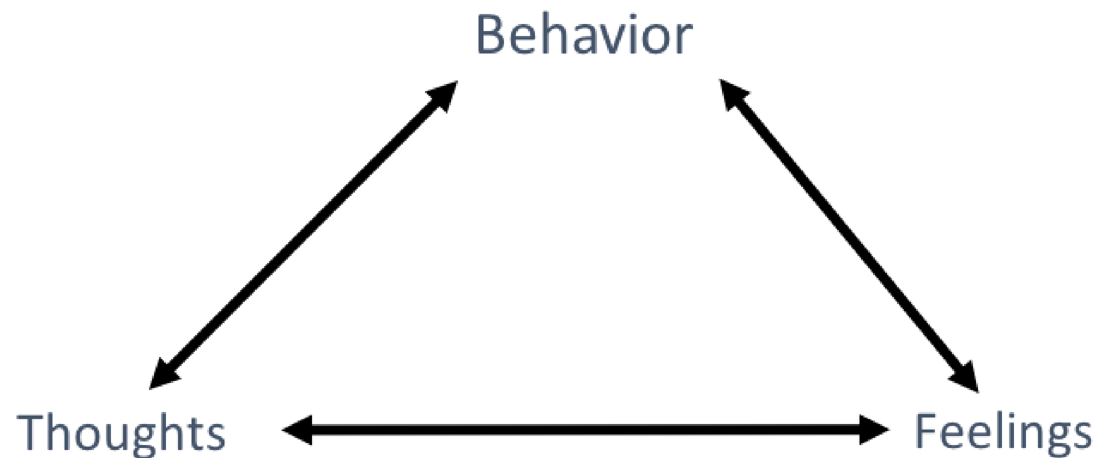
CBT – the general idea

- Learned, automatic thoughts develop over a lifetime
- Unhelpful thoughts cause distress or drive unhealthy behaviors
- Learning to ”unthink and undo” these unhealthy thoughts and behaviors helps patients feel better



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CBT – the general idea

- Patients are taught to identify sequences of Situations->Automatic Thoughts->Reactions (feelings, behaviors, physiological reactions)
- Thoughts are examined and beliefs challenged until they are not held as strongly
- Homework is key

u notice your mood getting worse, ask yourself, "What's going through my mind right now?" and as soon as possible jot down the thought or mental
tic Thought column.

Situation	Automatic thought(s)	Emotion(s)	Adaptive response	Outcome
1. What actual event or stream of thoughts, or daydreams or recollection led to the unpleasant emotion? 2. What (if any) distressing physical sensations did you have?	1. What thought(s) and/or image(s) went through your mind? 2. How much did you believe each one at the time?	1. What emotion(s) (sad/anxious/angry/etc.) did you feel at the time? 2. How intense (0–100%) was the emotion?	1. (optional) What cognitive distortion did you make? 2. Use questions at bottom to compose a response to the automatic thought(s). 3. How much do you believe each response?	1. How much do you now believe each automatic thought? 2. What emotion(s) do you feel now? How intense (0–100%) is the emotion? 3. What will you do (or did you do)?
Talking on the phone with Donna.	She must not like me any more. 90%	Sad 80%		
Studying for my exam.	I'll never learn this. 100%	Sad 95%		

CBT – outline of treatment sessions

1. Role induction, education about CBT, goal setting, homework
2. Check on mood, bridge from previous session, set the agenda, review homework, discuss agenda items, set new homework
3. …

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CBT – identifying cognitive distortions

- All or nothing thinking
- Catastrophizing
- Disqualifying the positive
- Emotional reasoning
- Labeling
- Magnifying/minimizing
- Selective abstraction
- Mind reading
- Overgeneralization
- Personalization
- “Should” and “must”
- Tunnel vision

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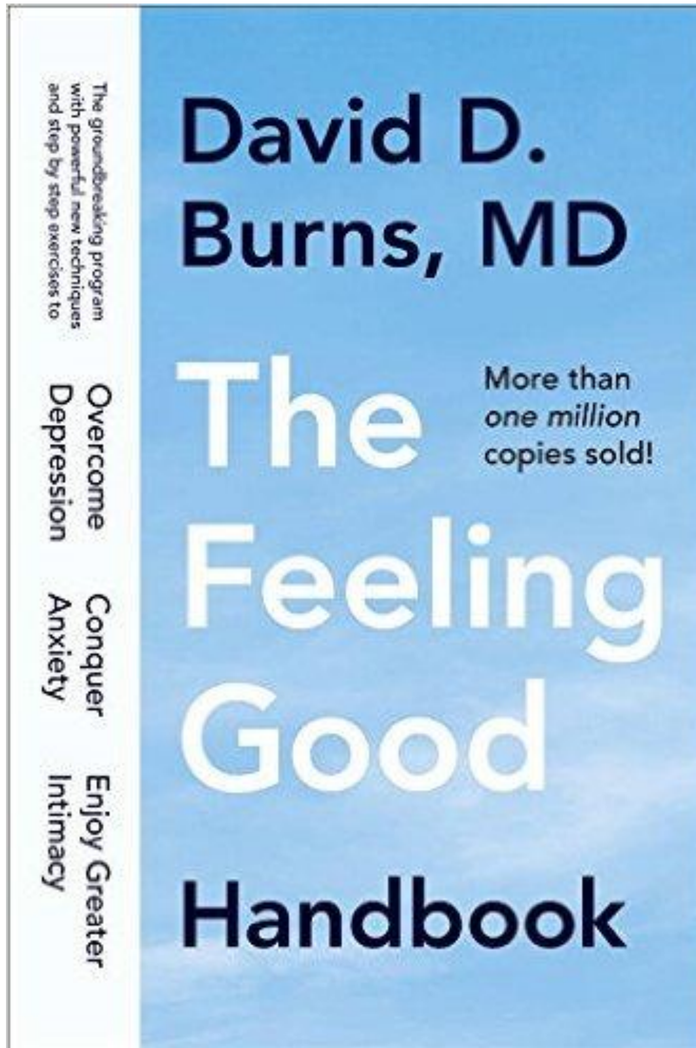

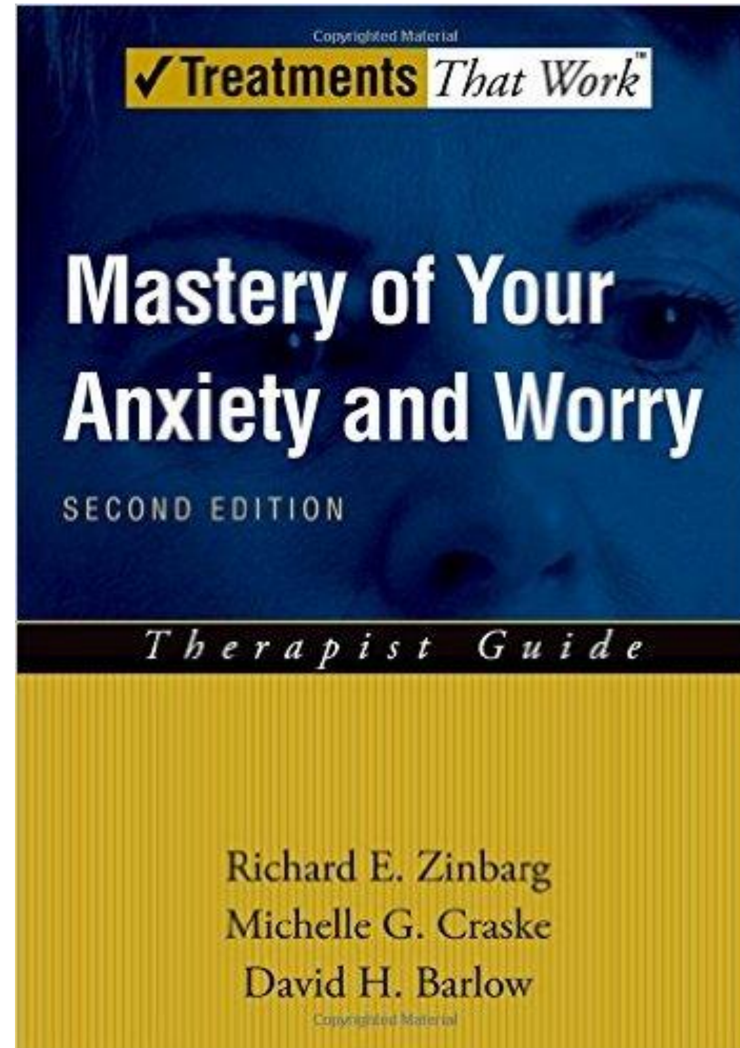

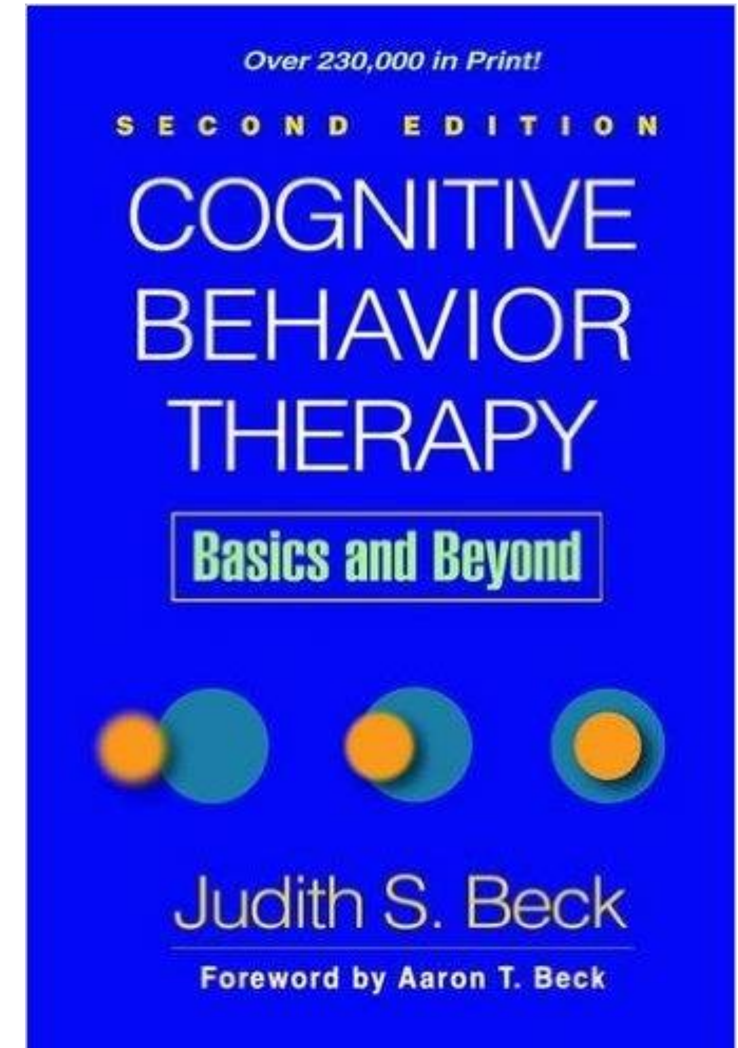

Conclusions

- Mood and anxiety disorders are common, treatable diseases
- Psychotherapy builds hope
  - Like much in psychiatry, we know that it works but not how it works
- CBT can be an effective treatment for mood and anxiety disorders

- Acknowledgements to Karen Swartz, MD!

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