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)
Overview

• Clinical assessment of mood and anxiety disorders
• Psychotherapy in general
• CBT
  • Indications
  • Overview of approach
  • Resources
Diagnostic challenge of symptoms vs syndromes

- Depression
  - Shame
  - Guilt
  - GI/cardiac/neuro sx’s
  - Sadness
  - Worry

- Mania
  - Irritability
  - Inattention
  - Suicidality
  - Elation
  - Racing thoughts
  - Increased motor activity

- Anxiety
  - Fatigue
  - Sadness
  - Worry
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

What a person HAS
What a person IS
What a person DOES
What a person ENCOUNTERS
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
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)
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
<table>
<thead>
<tr>
<th>Condition</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac Disease</td>
<td>17-27%</td>
</tr>
<tr>
<td>Diabetes (self-reported)</td>
<td>26%</td>
</tr>
<tr>
<td>Cancer</td>
<td>22-29%</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>5-20%</td>
</tr>
<tr>
<td>Chronic Pain</td>
<td>30-54%</td>
</tr>
<tr>
<td>Obesity</td>
<td>20-30%</td>
</tr>
</tbody>
</table>

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

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
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
Clinical risk factors for suicide

• Hopelessness
• History of prior attempts
• Lethality of plan and access to means
• Lack of social supports
• No established treatment relationship
Protective Factors for suicide

• Marriage
• Having dependent children
• Pregnancy and the first year of the child’s life
• Religious beliefs
• Relationships
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
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
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 $\geq 2$ months + 4 visits in a year
  • Psychotherapy: $\geq 8$ visits (with any provider lasting on average $\geq 30$ minutes) in a year

Percent of patients receiving minimally adequate treatment by provider type

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
(Some) Anxiety Disorders – DSM5

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

• Selective Mutism
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 evocative or directive (e.g., CBT)
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
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!)
Evidence base for CBT

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