CBT to Augment Psychopharmacology

Michael W. Otto, PhD
Department of Psychological and Brain Sciences
Boston University
The Approach Today
Adding a Few New Strategies to Your Practice

• An obsession with efficiency

• Repeated attention to emotional regulation/emotional intolerance

• Focus on additions to Current Practice
  – A few core principles for change
  – A few core strategies, complete with metaphors
What I am not talking about

Moderate Exercise is a terrific augmentation strategy.
Exercise:

- Improves mood
- Treats depression
- Treats anxiety and anxiety disorders
- Improves cognition
- Enhances sleep

- In short, prescribing exercise is a wonderful way to achieve a range of beneficial outcomes...with the side effect of living longer
The good news... combination treatment works!

- Enhances outcome for anxiety disorders (panic, GAD)
- Enhances outcome for chronically, more-severely depressed patients
- Enhances maintenance of treatment gains (with medication discontinuation if desired)
- Enhances outcome for bipolar disorder
- Enhances medication adherence
- A great strategy for medication non-responders (failing medication does not predict failure in CBT, depending on the disorder)
The bad news...combination treatment is less than we desire

- Modest gains for combination for many disorders
  - Anxiety and mood disorders in particular

- There are potential interference effects of medications on CBT:
  - Context effects, maintenance of treatment gains
  - Cortisol or other central learning effects

NONETHELESS:
- Except CBT almost always appears to have strengths in maintenance of treatment gains
- Strengths in non-responders

.......so......
• A weekly, 50-minute session accounts for less than 1% of a patient’s waking lives

• How do we get the 1% to have an influence over the 99%
Four Organizing Concepts

• We learn maladaptive responses over time
• Learning new responses to old cues is part of how therapy helps people
• Extinction learning is new learning
• New learning has to jump the gap between the session and the relevant moments in our patients’ lives (new learning has to compete successfully with old learning)
A Few Standard Strategies to Jump the Gap

- Co-therapist on the case
- Patient workbook (hear it, see it, read it)
- Programmed home practice (homework)
- Practice in relevant contexts in session
  - Role playing
  - High emotion
- Practice across contexts
  - Relapse Prevention - Over-rehearsal
- Vivid and/or emotional examples

Addressing Medication Context Effects

CBT can work well within contexts, and across programmed changes in context:

• Need to attend to attribution of treatment effects (add CBT during stable doses)
• If medication use changes, CBT may need to be reapplied
• Use a renewal course of CBT across medication discontinuation
Cotherapist on the Case
Session 1 - Establishing a Cotherapist on the Case

To help the patient be an active cotherapist in treatment, provide a:

• Model of the disorder (break the cascade of thoughts and emotions into elements)
• Model of the change process
• Information on the role of the patient
End of Treatment

• Patient has skills to act as his or her own therapist
• Patient focuses on well-being
• Therapist contact fades
10 Minute CBT: Cognitive Interventions

• Goal: Help patients take a step back from treating thoughts as truth. Learn to treat thoughts as guesses about the world.
• Classic Tools: Information, Socratic questioning, self-monitoring, behavioral experiments
• Styles of the Masters: Beck, Ellis, Meichenbaum
• 10 Minute CBT:
  ➢ CEO Thinking (mindfulness)
  ➢ Marveling
  ➢ Echoing
  ➢ Metaphors
What is the evidence that the automatic thought is true? Not true?

Is there an alternative explanation?

What is the worst that could happen? Would I live through it?

What’s the best that could happen?

What’s the most realistic outcome?
What is the effect of my believing the automatic thought?
What is the cognitive error?
If a friend was in this situation and had this thought, what would I tell him/her?
10 Minute CBT: Cognitive Interventions

- Anxiety (what if...)
  - Over-estimating the probability of negative outcomes
  - Assuming the consequence will be unmanageable

- Depression (look at me...)
  - The comparator (depression about depression)
  - Negative view of self, world, future

- Sleep
  - Cost of low sleep
10 Minute CBT: Exposure Interventions

- Goal: Step by step relearning of safety and comfort around feared situations (or feelings)
- Classic Tools: In vivo, imaginal, interoceptive
- Cognitive vs. Non-cognitive perspectives
- 10 Minute CBT:
  - Information
  - Emotional Acceptance (what are you doing in response to your anxiety)
  - Exposure Self-Care (what will I feel, how will I coach myself)
  - Goal for the situation
  - Safety behaviors
10 Minute CBT: Activity Interventions

• Goal: Return patients to rewarding and enjoyable activity
• Classic Tools: Monitor and Assign (values work)
• 10 Minute CBT:
  - Troubleshooting
  - The “feel” of getting better
  - Exercise
Behavioral Activation (BA) Treatment

• A nice reminder that “doing” in therapy is important

• Primary treatment strategies
  – Self-monitoring of daily activities and mood
  – Week-by-week scheduling of activities that bring patients a sense of pleasure or mastery
  – Identifying and reducing avoidance behaviors that increase depressive symptoms.
Emotional Intolerance

• Predicts all sorts of maladaptive behavior
  – Exercise avoidance
  – Emotional eating
  – Smoking for coping motives, early lapse
  – Drinking for coping motives
  – Dropout of drug treatment
  – Lack of persistence toward goals (when negative affect is present)
  – Disability from dyspnea

• Elevated in most disorders
• Anxiety Sensitivity Index is a great measure

• A range of ways to treat:
  – Exposure
  – Mindfulness
Uh oh!

What if:
  • This gets worse?
    • I lose control?
    • This is a stroke?

I have to control this!

Panic Cycle

Relative Comfort

• Notice the sensation
• Do nothing to control it.
• Relax WITH the sensation
Common Interoceptive Exposure Procedures

• Headrolling – 30 seconds - dizziness, disorientation

• Hyperventilation – 1 minute - produces dizziness lightheadedness, numbness, tingling, hot flushes, visual distortion

• Stair running – a few flights – produces breathlessness, a pounding heart, heavy legs, trembling

• Full body tension – 1 minute – produces trembling, heavy muscles, numbness

• Chair spinning – several times around – produces strong dizziness, disorientation

• Mirror (or hand) staring – 1 minute – produces derealization
Exposure Interventions

• Provide rationale for confronting feared situations
• Establish a hierarchy of feared situations
• Provide accurate expectations
• Repeat exposure until fear diminishes
• Attend to the disconfirmation of fears (“What was learned from the exposure?”)
Situational Exposure Guidelines

• Prior to completing in-vivo exposures, create a fear hierarchy identifying feared and avoided situations

• Identify safety behaviors- actions taken to avoid, prevent, or manage a potential threat
  – Avoidance
  – Checking (pulse, exits, hospitals)
  – Carrying aids (rescue medications, cellular phones)
Safety Behaviors

- What are safety behaviors?
  - Actions taken to avoid, prevent, or manage a potential threat
- Examples
  - Avoidance
  - Checking (pulse, exits, hospitals)
  - Carrying aids (rescue medications, cellular phones)
- Effective in short-term
- Maladaptive in long-term because people may fail to learn that they are safe (stuck with conditional safety)
A few core citations