COGNITIVE BEHAVIOR THERAPY FOR MOOD DISORDERS

Outline

- Introduction
- Cognitive theory of depression
- Methodology
- Uses
- CBT for major depressive disorder
- CBT for bipolar disorder
- Advantages and limitations
- Comparison with other psychotherapies
- Conclusion

Introduction

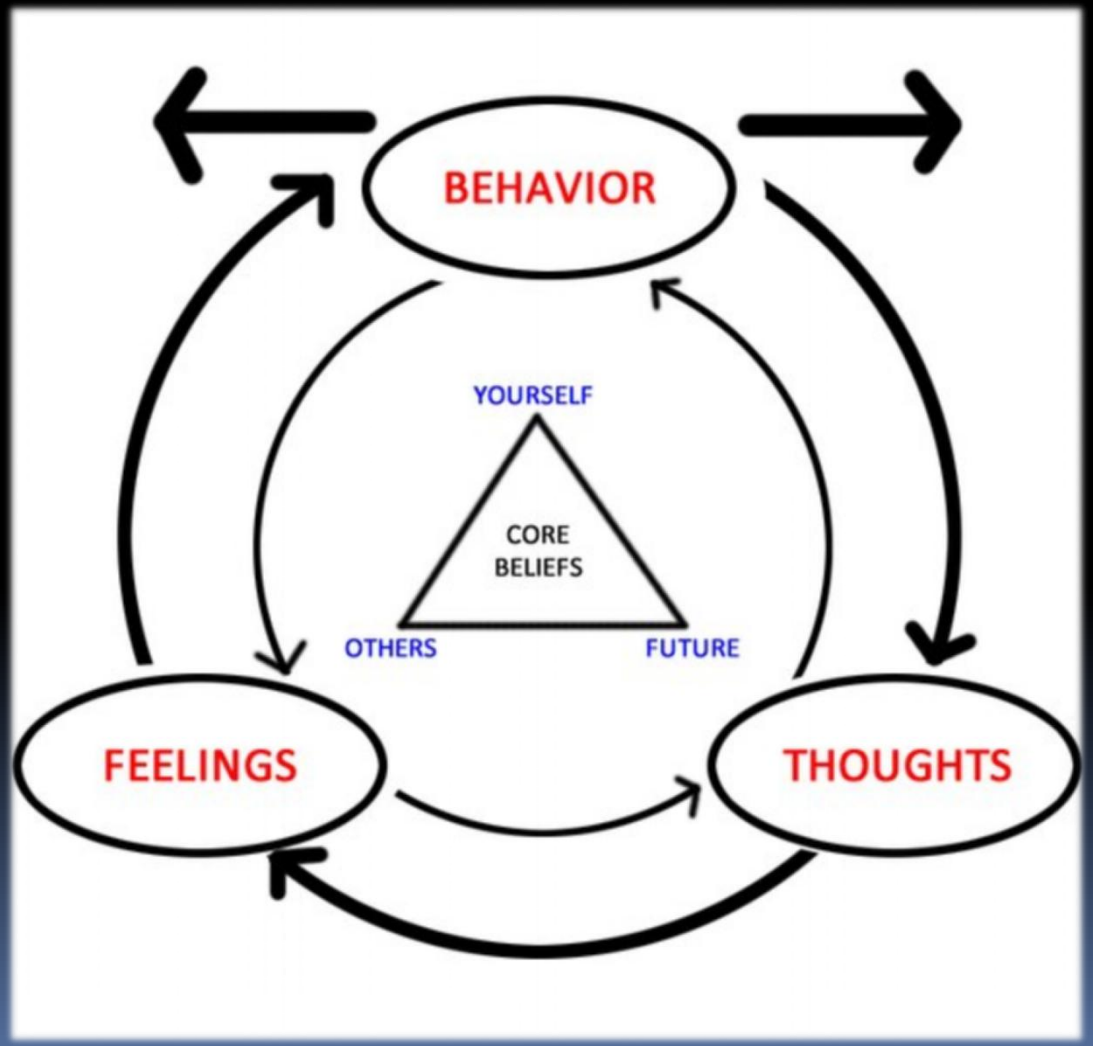
- Cognitive therapy - short-term, structured therapy that uses active collaboration between patient and therapist to achieve its therapeutic goals, which are oriented toward current problems and their resolution
- Individual basis; group methods sometimes helpful
- Perception and experiencing are active processes which involve inspective and introspective data
- Cognitions represent synthesis of internal and external stimuli

Introduction

- Constitute their stream of consciousness, which reflects their configuration of themselves, their world, their past and future.
- Alterations in the content of their underlying cognitive structures affect their affective state and behavioural pattern.
- CBT - patients can become aware of their cognitive distortions
- Correction of faulty dysfunctional constructs can lead to clinical improvement.

Cognitive Theory of Depression

- Aaron Beck - psychoanalytic theory did not sufficiently explain dreams of depressed pts.
- Developed theory of depression based on educating the patient about his/her negative thinking (cognitions)



Levels of Cognition

- Aaron & Judith Beck: division of cognition into 3 levels
  1. **Automatic Thoughts:** most accessible, labeled; represent conscious response to stimuli
  2. **Intermediate Beliefs:** assumptions about self, world and future – led to automatic thought occurring in response to stimulus
  3. **Cognitive Schema:** content and its organization – determines which stimuli will be noticed and encoded in memory, linked and associated and most easily recalled

Strategies and Techniques

- Duration – 15-25 weeks, once weekly meetings
- Reevaluate diagnosis if pt. doesn't improve
- Maintenance therapy continues over years
- Therapist – exude warmth, understand life experience, be genuine and honest with themselves and their pts.
- Agenda set at start of each session, homework assigned during sessions, teach new skills

Components of CBT

1. Didactic aspects
2. Cognitive techniques
3. Behavioral techniques

Didactic Aspects

- Explaining cognitive triad, schemas, and faulty logic
- Therapists inform clients that they will formulate hypotheses together and test them over the course of the treatment
- Full explanation of relationship b/w depression and thinking, affect, and behaviour, rationale behind all aspects of treatment

Cognitive Techniques

4 processes:

1. **Eliciting Automatic Thoughts** - cognitions that intervene b/w external events and person's emotional reaction to the event
2. **Testing Automatic Thoughts** - test validity of automatic thoughts; encourage pt. to reject inaccurate/exaggerated automatic thoughts
3. **Identifying Maladaptive Assumptions** - rules or maladaptive general assumptions that guide a patient's life
4. **Testing the Validity of Maladaptive Assumptions** – pt. asked to defend the validity of their assumptions

Behavioral Techniques

- Test and change maladaptive and inaccurate cognitions
- Help patients understand inaccuracy of their cognitive assumptions and learn new strategies and ways of dealing with issues

Behavioral Technique	Description
Scheduling activities	Keep records of activities, review them with therapist
Mastery and pleasure	Pts. asked to rate the amount of mastery and pleasure their activities bring them
Graded task assignments	Break tasks into subtasks to simplify situation and allow mini accomplishments
Cognitive rehearsal	Imagine and rehearse various steps in meeting and mastering a challenge
Self-reliance training	By doing simple things
Role-playing	Elicit automatic thoughts and learn new behaviour
Diversion techniques	Difficult times; physical activity, social contact, work, play, visual imagery

Uses of CBT

- Depression
- Bipolar disorder
- Anxiety disorder
- Obsessive compulsive disorder (OCD)
- Borderline personality disorder
- Eating disorders
- Panic disorder
- Phobias
- Post-traumatic stress disorder (PTSD)

CBT FOR MAJOR DEPRESSIVE DISORDER

Initial Assessment

- Accurate assessment and diagnosis
- Standardized measures: SCID, HAM-D, BDI
- Assess SOF: interpersonal relationships, work and achievement, health and recreation
- Formulation: case conceptualization + cognitive + behavioral coping strategies

Course of Therapy

1. Orienting pt. to treatment approach
2. Establishing rapport
3. Identifying problems and treatment targets
4. Assessing current symptoms and problem severity
5. Providing initial symptom relief
6. Initial homework assignment

Course of Therapy

- Agenda set forth & agreed on by therapist and patient every session
- Pt. oriented and trained in thought tracking and activity tracking
- Thoughts/behaviors to be targeted – based on specific needs
- Pt. asked to give evidence to support negative belief - reduces negative feeling
- Thought challenging by developing behavioral experiments to test the belief

Course of Therapy

- Point out recurring themes and help pt. identify and challenge core beliefs
- Generate alternative core beliefs and help pt. identify behaviors and cognitions consistent with new beliefs
- Reviewing progress, identifying potential future challenges and learning to administer interventions independently
- Identify improvements, learned skills and potential challenges which may arise in the future

Cognitive Errors

	Assumption	Intervention
Overgeneralizing	If it's true in one case, it applies to any case that is even slightly similar.	Exposure of faulty logic. Establish criteria of which cases are similar to what degree.
Selective abstraction	The only events that matter are failures, deprivation, etc. Should measure self by errors, weaknesses, etc.	Use log to identify successes patient forgot.
Excessive responsibility	I am responsible for all bad things, failures, etc.	Disattribution technique
Assuming temporal causality	If it has been true in the past, it's always going to be true.	Expose faulty logic. Specify factors that could influence outcome other than past events.
Self-references	I am the centre of everyone's attention, especially my bad performances. I am the cause of misfortunes.	Establish criteria to determine when patient is the focus of attention and also the probable facts that cause bad experiences.
Catastrophizing	Always think of the worst. It's almost likely to happen to you.	Calculate real probabilities. Focus on evidence that the worst did not happen.
Dichotomous thinking	Everything is either one extreme or another (black or white, good or bad).	Demonstrate that events may be evaluated on a continuum.

CBT FOR BIPOLAR DISORDER

Bipolar Disorder - Mania

- Pts view themselves in an inflated, expansive manner
- Hyperpositive core beliefs
- Impulsive, minimize potential threats and take risks.
- Euthymic state – need for compensation from depressed state – overextend and overstimulate themselves – poor sleep - hypomania

CBT for Bipolar Disorder

1. Education about disorder
2. Learning to track symptoms and warning signs of relapse
3. Improving adherence to pharmacotherapy
4. Identifying thoughts and beliefs which may exacerbate symptoms or increase risk of relapse

Initial Assessment

- Accurate assessment and symptoms
- Assess SOF: level of activity, stability of routine, supportive social networks
- Identify pts' beliefs regarding bipolar disorder

Course of Therapy

- Adjunctive to pharmacotherapy

1. Orienting pt. to treatment approach
2. Establishing rapport
3. Identifying problems and treatment targets
4. Assessing current symptoms and problem severity
5. Assessing knowledge about bipolar disorder
6. Provide education to expand on understanding and correct misconceptions

Course of Therapy

- Pharmacotherapy + Psychotherapy – easier, but inadequate time/expertise to provide psychotherapy
- Separate providers for pharmaco- and psychotherapy – frequent contact and coordination with each other
- Focus on:
  - Tracking symptoms and functioning
  - Identifying/modifying cognitions which may exacerbate symptoms/impair functioning
  - Behavioral interventions – increase rewarding activities without manic activation

Course of Therapy

- Enlist family members to provide feedback:
  - Educate them about disorder and its warning signs
  - Work with pt. and support person to agree on how the support person will inform the pt. about concerns and how the pt. will respond
- Implementing skills practice
- Provide support and encouragement
- Challenging core beliefs which may add to risk of relapse

War g Signs

	Depressed	Warning Sign	Normal	Warning Sign	Manic
Sleep	>10 hrs.	Trouble waking up, >9 hrs.	8 hrs.	>7 hrs.	No sleep, energized
Energy	Cannot get out of bed	Tired in the evening	Up at alarm clock, able to work whole day	Waking up early and energetic	"Superman" mode
Spending	Isolating – not buying necessities	An effort to get food	Normal	Start buying treats for friends	Giving away all money to charity
Mood	Crying easily	Pessimistic	"OK"	Optimistic	Euphoric
Guilt	Thoughts about failure	Sensitive to criticism	"OK"	Flippant, not concerned about others	"I am special in God's eyes"
Religion	Abandoned by God	Feeling cynical and doubting	Comfortable with faith	Wanting to share the good news	"I am God's messenger" – seeking out people to convert
Suicide	Start planning to kill self	Thoughts of being dead	None	None	None ("I will live forever")

Psycho v/s Pharmacotherapy - Indications

	Psychotherapy	Pharmacotherapy
Depressed mood	Mild to moderate situational or characterological depressed mood	Marked vegetative signs; extreme or uncontrolled mood
Decreased interest	Apathy, decreased enjoyment; diminished sexual desire or gratification	Anhedonia; loss of libido; impaired sexual function or performance
Weight loss/gain	Insignificant weight gain	Significant weight loss
Insomnia/Hypersomnia	Oversleeping, morbid dreams or nightmares	Early morning wakening
PMA	Restlessness or feelings of being slowed down	Hyperactivity or motor retardation
Fatigue/loss of energy	Lack of motivation or will	Depressive stupor
Feelings of worthlessness/guilt	Low self-esteem, inappropriate guilt feelings, self-reproach	Nihilistic or self-deprecatory delusions, self-berating auditory hallucinations

Psycho v/s Pharmacotherapy - Indications

	Psychotherapy	Pharmacotherapy
Decreased ability to think/concentrate	Distractibility, sluggish thinking or decision making; negative cognitions	Loss of control over thinking, obsessive rumination, inability to focus or act
Recurrent thoughts of death/suicide	Chronic feelings of hopelessness or helplessness	Acute, episodic, and uncontrolled suicidal acts or plans
Associated features	Social withdrawal or fears of rejection or failure; psychosomatic complaints or hypochondriasis	Panic (anxiety) attacks or phobias; persecutory delusions; pseudodementia; physical symptoms or somatic delusions
Family history	No genetic loading (dysthymic disorder)	Genetic loading (bipolar disorder or depressive disorder)
Predisposing factors	Psychosocial stressors	Other mental disorders
Personality disorders	Dependent, inadequate, masochistic	Borderline, histrionic, obsessive-compulsive

Advantages & Limitations

	Advantages	Limitations
Theory	Cognitive-behavioral orientation is tangible and objective	Cognitive-behavioral emphasis may neglect whole person, especially affective component; symptom-oriented perspective overlooks past history, complex problem areas, and hidden conflicts
Goals	Primary goal of symptom relief is expedient in itself and is first stage in changing cognitive style	Symptom reduction may be insufficient, superficial, or temporary; focus on current problems can preclude enduring modification of personality or prophylactic function of treatment
Structure	Brief or fixed duration is cost-effective and can foster results in short period, may heighten expectation of rapid change and encourage optimism	Short or predetermined duration may be insufficient or inflexible
Therapist Role	Active therapist can directly intervene to interrupt depressive schemata and suggest alternatives to faulty thinking	Active suggestion and direction can undermine patient responsibility and self-esteem by imposing therapist point of view or values

Advantages & Limitations

	Advantages	Limitations
Techniques	Specific approach is directly tailored to depressed population and aims at particular target symptoms; identification of depressogenic assumptions and homework to test new thinking foster cognitive modification	Emphasis on specific cognitive schemata may bias toward certain preconceived themes; overt simplicity of techniques may lead to underestimation of technical skill required
Research Status	Operational manual allows for replication of treatment and training and empirical establishment of efficacy	Research-oriented operationalized approach may become oversimplified formula for complex clinical phenomena
Relation to Other Modalities	Competition with pharmacotherapy encourages research on relative efficacy, especially instances when cognitive therapy alone is most effective	Competition with pharmacotherapy fosters polarization of approaches and partisan resistance to integration with drug treatment
Patient Population	Logical thinking ensures maximal potential to deal with and change depressogenic assumptions and thought patterns	Cognitively impaired population may not benefit; sophisticated, introspective patients may find approach too simple-minded or superficial

Psychotherapeutic Approaches

Feature	Cognitive Approach	Psychodynamic Approach	Interpersonal Approach
Major theorists	Plato, Adler, Beck, Rush	Freud, Abraham, Jacobson, Kohut	Meyer, Sullivan, Klerman, Weissman
Concepts	Distorted thinking: dysphoria due to learned negative views of self, others, and the world	Ego regression: damaged self-esteem and unresolved conflict due to childhood object loss and disappointment	Impaired interpersonal relations: absent or unsatisfactory significant social bonds
Goals & mechanisms	To provide symptomatic relief through alteration of target thoughts; to identify self-destructive cognitions; to modify specific erroneous assumptions; to promote self-control over thinking patterns	To promote personality change through understanding of past conflicts; to achieve insight into defenses, ego distortions, and superego defects; to provide a role model; to permit cathartic release of aggression	To provide symptomatic relief through solution of current interpersonal problems; to reduce stress involving family or work; to improve interpersonal communication skills

Psychotherapeutic Approaches

Feature	Cognitive Approach	Psychodynamic Approach	Interpersonal Approach
Techniques	Behavioral-cognitive: recording and monitoring cognitions; correcting distorted themes with logic and experimental testing; providing alternative thought content; homework	Expressive-empathic: fully or partially analyzing transference and resistance; confronting defenses; clarifying ego and superego distortions	Communicative-environmental: clarifying and managing maladaptive relationships and learning new ones through communication and social skills training; providing information on illness
Therapist role	Educator-shaper: positive relationship instead of transference; collaborative empiricism as basis for joint scientific (logical) task	Interpreter-reflector: establishment and exploration of transference; therapeutic alliance for benign dependence and empathic understanding	Explorer-prescriber: positive relationship-transference without interpretation; active therapist role for influence and advocacy
Family role	Use of spouse as objective reporter; couples therapy for disturbed cognitions sustained in marital relationship	Full individual confidentiality; exclusion of significant others except in life-threatening situations	Integral role of spouse in treatment; examination of spouse's role in patient's predisposition to depression and effects of illness on marriage

Nonselective Patient Variables

- Feelings of hopelessness and helplessness
- Apathy, decreased enjoyment, diminished desire or gratification
- Too high ego ideals and expectations
- Oversleeping, morbid dreams or nightmares
- Feelings of restlessness or being slowed down
- Lack of motivation or will
- Low self-esteem, inappropriate or excessive guilt and self-reproach
- Distractibility, sluggish thinking or decision making
- Wish or intention to be dead
- Social withdrawal, fear of rejection or failure
- Psychosomatic complaints, hypochondriasis

Selective Patient Variables (CBT)

- Obvious distorted thoughts about self, world, and future
- Pragmatic (logical) thinking
- Real inadequacies (including poor response to other psychotherapies)
- Moderate to high need for direction and guidance
- Responsiveness to behavioral training and self-help (high degree of self-control)

Efficacy

- Effective in treatment of major depressive disorder
- CBT = pharmacotherapy; fewer side effects and better follow-up
- Mixed results: Combination of CBT & pharmacotherapy more efficacious than either therapy alone
- NIMH Treatment of Depression Collaborative Research Program – pharmacotherapy alone or with psychotherapy – treatment of choice for severe depressive episodes

Conclusion

- Problem focused, action-oriented
- CBT - thought distortions and maladaptive behaviors play a role in the development and maintenance of psychological disorders
- Symptoms and associated distress can be reduced by teaching new information-processing skills and coping mechanisms
- Good efficacy
- Multiple uses, expanded beyond depression and anxiety

References

- Sadock BJ, Sadock VA. Kaplan and Sadock's synopsis of psychiatry: Behavioral sciences/clinical psychiatry. Lippincott Williams & Wilkins; 2011 Dec 26.
- Kaplan HI. Kaplan & Sadock's Comprehensive Textbook of Psychiatry, (2 Volume Set, 2017).
- Whitfield G, Davidson A. Cognitive behavioural therapy explained. CRC Press; 2018 Oct 8.
- Lambert MJ. Bergin and Garfield's handbook of psychotherapy and behavior change. John Wiley & Sons; 2013 Jan 14.

THANK YOU


So the HAPPY MEAL DIDN'T WORK.
CARTOONSTOCK
Glenn McCoy
Search ID: ggm071203
©Glenn and Gary McCoy/Distributed by Universal Uclick via CartoonStock.com