Off label CBT: a promising therapy or an adjunctive pluralistic therapeutic ingredient?

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It is a truth universally acknowledged that any treatment developed in psychiatry for a specific target condition will be progressively judged as having therapeutic propensities above its station, whether it be a medication tested “off label” or a psychotherapy developed for specific scenarios and repositioned as having broader if not universal application.

Such a diffusion effect is neither to be disparaged nor commended – resolution should weight empirical evaluation. Astute clinical observations of such “secondary” targets leading to formal efficacy studies can provide breakthrough therapeutic advances. A simple exemplar is the progressive extension of use of the atypical antipsychotic drugs for managing schizophrenia to their use as augmenting antidepressant medications and in managing bipolar disorders.

Thase et al (1) detail such a diffusion effect for cognitive behavior therapy (CBT), with their title raising some questions for pondering. Are we simply observing CBT expansionism? Is CBT *truly* of value in managing “severe mental disorders” and what does “severe” mean? If of value, does CBT have a primary role or only an adjunctive one? Does it offer substantive or skimpy add-on benefits? What mechanisms are involved – a specific or non-specific therapeutic effect? And does the word “promise” in the title imply potential or a distillation of empirical evidence? Importantly, their paper answers many of these first-phase questions.

But not the issue of expansionism. Beck wrote (2) that he first commenced to formulate CBT in the fifties for the management of depression. His theory weighted a “cognitive triad” –

with depressed patients viewing themselves, their future and their experiences negatively – and thus provided a therapeutic paradigm (i.e., redress the faulty dysfunctional attitudes held by those with depressive disorders). What remained unclear from that 1967 monograph (2) was whether such cognitive distortions were antecedent causal factors and/or “state” consequences of a depressed mood. If causal, then their correction did offer a logical therapeutic paradigm for those possessing a predisposing personality style, and might therefore not only be salient to acute management but of prophylactic benefit in averting future episodes by modulating the causal factor. If cognitive distortions were simply an epiphenomenon of a depressed mood, CBT would appear to lack a logic. For example, if an individual evidenced depressive cognitive distortions solely during an episode of melancholic depression and with both the depression and faulty attributions lifting after two weeks of receiving antidepressant medication, why might CBT be contemplated or initiated?

That exemplar suggests that CBT may be of no direct benefit when the psychiatric condition is quintessentially a “disease” with primary biological determinants and requiring a medication to address the biological perturbations – essentially the territory where Thase et al boldly choose to go in focusing on schizophrenia, related psychoses, bipolar disorder and severe, protracted and treatment-resistant depressive disorders.

But, while Beck focused on depressive disorders, he also articulated a broader “cognitive model”, quoting Epictetus: “Men are disturbed not by things but by the views which they take of them” (2). Patients seeking clinical assistance not only have a disease or a disorder but psychological perturbations and distress accompanying that condition, its concomitants

and its consequences. As Montgomery observed (3), “patients want to know what is wrong, if it’s serious, how long it will last, whether it will alter their life plans”. Even if they have a primary psychiatric disease responsive to medication, such non-disease concomitants have the potential to benefit from the therapist’s interpersonal interactions – whether provided informally or as a formal psychotherapy – disallowing any parsimonious view that diseases require physical treatments only.

We recently demonstrated (4) superiority of antidepressant medication to CBT in a 12-week study of patients with melancholia – a putative depressive “disease”. However, while we quantified absolutely no benefit from CBT over the first four weeks, we did observe some improvement over the next eight weeks. This perplexing pattern was clarified by several subjects stating (5) that, while CBT did nothing for their depressive condition, it progressively assisted in dealing with illness concomitants (e.g., anxiety) and in addressing depressive meta-cognitions – such as despair and demoralization about having such a condition. In essence, CBT was seemingly ineffective as a treatment for melancholia but it did assist people with such a disease to adjust to it and its consequences – an adjunctive but nevertheless important therapeutic component.

It is known that psychotherapy benefits accrue from both the specific technical nuances integral to its theoretical model (e.g., CBT can redress dysfunctional attitudes) and from non-specific therapeutic ingredients (including empathy, a clear rationale, a therapeutic relationship), and with the specific ingredients seemingly making the minority contribution. For example, Lambert’s review of empirical studies (6) quantified that only 15% of improvement during psychotherapy was attributable to specific techniques – as against 30% to the therapeutic relationship, 15% to

expectancy effects and 40% to client and extra-therapy factors. Such non-specific (but potentially beneficial) factors are likely to be equally salient for those with the conditions considered by Thase et al, and again argue for a pluralistic therapeutic paradigm.

In their review, Thase et al provide a rich set of studies quantifying the benefits of CBT for psychotic and other “severe” mental disorders, but clearly position it as having an adjunctive role and avoid proselytizing. Several secondary questions can now be put. Are such benefits unique to CBT as against any other psychotherapy, or is that CBT is the “in vogue” psychotherapy or did it out-punch the other psychotherapies simply by having an evidence base? Does adjunctive CBT have specific (as against non-specific) benefits in such disease groups, and if so, where

does it provide an impact? Is adjunctive CBT superior to non-drug adjunctive options (e.g., exercise, counselling, mindfulness)? If CBT is provided, when: as a combination package, or as a sequencing model after the impact of medication has been determined?

In the paper, as would be anticipated of these authors, understated wisdom weaves data about efficacy with the nuances of “real world” effectiveness. The authors’ balanced appraisal allows us to conclude that findings, though promising, do not position adjunctive CBT as a therapeutic panacea to be mandated in a formulaic way.

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CBT for severe mental disorder: a good product that is in danger of being over-extended

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There often comes a time in the history of every successful treatment in psychiatry when the notion of diagnosis seems to evaporate and the treatment seems to be a universal panacea. This happened in the past when, in the heady days after the introduction of antidepressants, these drugs were not only alleged to be effective in the treatment of depression, anxiety and somatic disorders, but also in “depressio sine depressione”. Cognitive behavior therapy (CBT) is getting closer to this dangerous milestone, dangerous because it can lead to disillusion, so it is worth examining this in the new treatment areas described in the paper by Thase et al (1).

Improvement in schizophrenia may be only a consequence of improvement in depression, anxiety and related symptoms. When training medical stu-

dents I advise them that, if they are stuck when asked for a named treatment for any psychiatric disorder, they should reply “CBT”. When asked for the rationale for this, I suggest they reply: “because mood, symptoms, behavior and thinking are all closely inter-related and in (X) disorder mood and all other symptoms are made worse by cognitive distortion”. This comment is relevant to the use of psychological treatments in schizophrenia. Although some of the trials of CBT in schizophrenia have been carried out without antipsychotic drugs being included, most, as Thase et al indicate, have used the psychological therapy as an adjunctive one. This is not ideal, as schizophrenia is a heterogeneous condition associated with considerable mood disturbance. There is also evidence that those who have relatively “pure” schizophrenia have a much better outcome than those who have comorbid mood or substance use disorders (2). Anxiety in particular is a

very prominent symptom in schizophrenia (3). It is therefore quite possible that the benefits of CBT in schizophrenia are dependent entirely on the mood component, and although target symptoms of schizophrenia such as command hallucinations may be improved, this is not necessarily an anti-schizophrenic effect, as it could be secondary to the effects of treatment on mood. It is perhaps worth reminding ourselves that a similar adjunctive therapy for schizophrenia proposed 35 years ago, beta-blockade in the form of propranolol, was similarly found to be effective as an adjunctive treatment to antipsychotic drugs (4), but not when compared directly with chlorpromazine (5), and we know now that beta-blocking drugs have very little role to play in the treatment of schizophrenia apart from their possible value in treating abnormal movements.

A collaborative relationship may be therapeutic and independent of CBT. In chronic schizophrenia, where