Evidence-Based Psychotherapies

Combining Cognitive-Behavioural Therapy and Pharmacotherapy in the Treatment of Anxiety Disorders

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Rapid growth in cognitive science has led to improved psychological treatments for anxiety disorders. There are now cognitive models of posttraumatic stress disorder (PTSD) (1,2), obsessive–compulsive disorder (OCD) (3), generalized anxiety disorder (GAD) (4,5), panic disorder (PD) (6), social anxiety disorder (SAD) (7,8) and specific phobias. These models have led to empirically validated treatment approaches for anxiety. Cognitive-behavioural therapy (CBT) is a time-limited, present-oriented approach to psychotherapy that teaches patients the cognitive and behavioural competencies needed to function adaptively (9). Reports of nonresponders and considerable relapse rates after either pharmacologic (10–12) or cognitive-behavioural treatments have led to a search to maximize the benefit of these treatment modalities.

The relative efficacy of CBT and medication alone or of the two in combination is now being studied. This research trend is particularly relevant to clinicians treating patients with anxiety disorders. Some important questions to consider are as follows: Is it best to start a medication first to promote quicker entry into feared situations? Should CBT be administered sequentially to medication to decrease relapse rate? Might CBT interventions be used most effectively to augment gains in partial responders to pharmacotherapy? These commonly encountered questions are the impetus for this article, which describes an empirically proven cognitive-behavioural approach to anxiety disorders and then reviews recent literature that has begun to examine some of the advantages and disadvantages of combining medication and CBT.

A comprehensive review of CBT is beyond the scope of this article. Simply put, however, most variations of CBT for anxiety disorders include as central components exposure and exploration of thoughts about feared situations. Exposure techniques are designed to help patients face the situations they fear and yet stay psychologically engaged, so that the natural conditioning processes involved in fear reduction (for example, habituation and extinction) can occur. As a first step, patient and therapist develop a rank-ordered list of anxiety-provoking situations. To keep anxiety within a tolerable range, the patient begins by facing the least-feared situation; as mastery of the lesser situations is achieved, the patient approaches increasingly more difficult situations. It is also important for patients to examine their thoughts about feared situations and the beliefs that may underlie them. In cognitive restructuring, individuals are taught to 1) identify negative thoughts that occur before, during or after anxiety-provoking situations; 2) evaluate the accuracy of their thoughts in light of data derived from Socratic questioning or as a result of so-called behavioural experiments; and 3) derive rational alternative thoughts based on acquired information.

Cognitive restructuring techniques contain a significant exposure component; however, exposure in this context focuses on collecting information that will allow patients to revise their judgements about the degree of risk to which they are exposed in feared situations. The essence of both exposure and behavioural experiments is to engineer fear-arousing situations in which the patient is expecting unrealistically that something bad will happen but in which the negative consequences do not occur.

To date, only 26 randomized clinical studies involving CBT and medication treatment of either OCD, SAD, GAD, PD or other anxiety disorders have been reported. Methodological limitations in some of these studies excluded them from a recent meta-analysis undertaken by Foa (13). After setting stringent inclusion criteria, this author reviewed 10 studies and calculated within-subject effect sizes to compare treatment conditions within and across studies. The results suggest that combining CBT and medication may have differing effects across anxiety disorders. Combined medication and CBT were found to be no more effective than CBT alone for OCD, SAD and GAD (13). Interestingly, a multisite study found group CBT and phenelzine treatment of SAD to be comparable (14), yet relapse was lower in those who received group CBT alone (15).

A more complex picture emerges from the few studies allowing a direct comparison of combined treatment and...
pharmacotherapy alone. Franklin and others have reported preliminary data showing that CBT in combination with medication is better than medication alone for the treatment of OCD (16). Similarly, preliminary results by Connor and others suggest that adding CBT to sertraline substantially improved a modest response in PTSD patients (17). In contrast, a recent one-year follow-up of SAD patients treated with placebo, exposure, exposure plus sertraline or sertraline alone found that only those treated with exposure alone or placebo alone did not deteriorate after the completion of treatment (18). This suggests that there may be a negative effect of simultaneously combining medication and CBT for the treatment of SAD. A negative benefit of combined treatment has been more clearly shown with PD. Two studies of combined treatment of PD showed that the addition of medication interfered with long-term maintenance of gains arising from CBT (19,20). A plausible explanation for these findings is found in the cognitive model of panic. It is postulated that panic patients are hypersensitive to anxiety-related physiological responses such as tachycardia or dizziness. Moreover, these physiological responses are interpreted as potentially dangerous; that is, as signs of impending heart attack or seizure. For PD, CBT is designed to elicit such responses, with the absence of the anticipated disaster providing corrective information about their safety. Medication diminishes anxiety responses and thus may interfere with CBT exercises aimed at allowing patients to understand their erroneous beliefs about these responses.

Several methodological limitations bear mentioning. First, many studies of combined treatment define combined as simultaneous treatment; however, sequential treatment may be more optimal and better reflect clinical reality. Further, studying the interaction between medication and CBT is daunting because there is little a priori reason to assume that all medications combine with CBT in the same way. A reasonable hypothesis is that medications exerting their therapeutic effects with the fewest obvious side effects may be less likely to interfere with patients’ abilities to learn new skills and to believe that they can apply them. Medications with more intrusive side effects may lead the person to attribute positive changes to the medication (21) and to be more vulnerable to relapse. Similarly, we cannot automatically assume that different CBT protocols and different medication classifications. A cautious reading of current findings is that combined medication and CBT is no more effective than CBT alone for OCD and GAD, while simultaneous addition of medication may detract from CBT treatment of SAD and PD. The finding that the addition of CBT to medication decreases relapse in SAD is important and parallels reports of decreased relapse after CBT for depression (22,23).

These studies of combined CBT and medication raise several therapeutic points. First and foremost, it is important for clinicians to be aware of empirically proven treatments to provide a rationale to anxiety patients for choosing CBT, medication or both. Second, the addition of CBT has never been found harmful and may likely decrease relapse. Further, the benefit of adding basic principles of CBT to the pharmacologic treatment of anxiety requires further exploration. Little formal CBT training is required to 1) carefully explore the extent of avoidance and beliefs underlying patients’ fears; 2) share a cognitive model of anxiety, with its emphasis on facing fear gradually by breaking the tasks into small steps; 3) guide patients through the growing array of self-help booklets and Internet resources; and 4) explore the meaning of taking medication (that is, do patients attribute their improvement to the medication or to acquired skills on their part?). Finally, until more definitive results from studies of combined CBT and medication of anxiety disorders are available, patients remain our most valuable resource as we adopt a basic tenet of CBT and enlist them in a collaborative examination of their treatment’s effect, whether the treatment be medication, CBT or a combination.

References


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