



CBT for the Primary Care Clinician, Part 2: When to recommend CBT for your patients

-Sara Brewer, MD

In Part 1 of this two-part series, I introduced Cognitive Behavioral Therapy (CBT), a treatment for childhood psychiatric disorders. In that article, I discussed the aims and typical content of this type of treatment to help primary care physicians determine whether their patients are receiving CBT. In this article, Part 2 of the series, I will review the types of patients best suited for CBT based on the research literature.

The strongest evidence supporting the use of CBT is for obsessive compulsive disorder. In a summary of recent multisite, randomized, controlled trials funded by NIMH, Benedetto Vitiello, a child psychiatrist at the National Institute of Mental Health, concluded “optimal treatment of children and adolescents with obsessive-compulsive disorder requires CBT.” He adds that while outcomes are enhanced when pharmacotherapy is combined with CBT, CBT alone is more efficacious than pharmacotherapy alone.¹ An average of about 75 percent of children with OCD will respond to CBT. This response rate is similar to the response of school-age children with ADHD to stimulant medications.²

The evidence for CBT in treating other anxiety disorders is nearly as robust. In

their 2003 review of the evidence for CBT in anxiety disorders, Compton and colleagues reviewed 21 randomized, controlled studies of CBT for various anxiety disorders, including separation anxiety, social phobia, generalized anxiety/overanxious disorder of childhood, panic disorder, agoraphobia, and simple phobia.³ Most of the studies reviewed enrolled between 50-100 patients, and the average number needed to treat across all studies in order to show benefit was two children. This number is roughly the same as the number of patients who need to take oral sumatriptan to prevent one migraine.⁴ One limitation of this data is that most studies compared CBT to a waitlist control. The absence of a comparison treatment, such as supportive psychotherapy or play therapy, makes it difficult to differentiate between various types of treatment. However, based on the available evidence, it appears that CBT should be a first-line treatment for all types of anxiety disorders, including OCD. There is some data to suggest that, when anxiety disorders are severe and for older teens, a combination of CBT and medication is better than either treatment alone.⁵

CBT has been evaluated in several other types of childhood psychiatric disorders with mixed findings. First, there are fewer studies looking at CBT for depression than

for anxiety disorders. Second, available studies generally show that CBT is as effective for depression as a variety of other types of treatment, including interpersonal psychotherapy, supportive psychotherapy, and relaxation training, all of which have shown efficacy over waitlist control conditions. At the same time, in a recent review of randomized, controlled trials of CBT for depression, several studies found CBT to be superior to other active treatment, and none found CBT to be inferior.⁶ A set of recent publications on adolescent depression known as the Treatment for Adolescents with Depression Study (TADS) have shown that when compared to pharmacotherapy alone, CBT plus pharmacotherapy is superior for adolescent depression in the first 18 weeks of treatment.⁷ Interesting to note, all active treatments in the study, pharmacotherapy alone, CBT alone, and combined treatment were each superior to placebo. Still, once the controlled phase of the study was complete, most patients ultimately chose combination treatment. The study also found that patients who achieved remission with CBT alone had a slightly higher rate of recovery than treatments including pharmacotherapy (64 percent for CBT alone compared with 55 percent for fluoxetine alone and 60 percent for combination therapy). It seems reasonable to conclude from this body of literature that CBT is effective for pediatric depression but not exclusively so.

There is a smaller but growing body of literature supporting the use of an adaptation of CBT called "Trauma Focused CBT" (TF-CBT) for post traumatic stress disorder (PTSD). TF-CBT has shown efficacy for children with single incident traumas, such as car accidents and experiencing or

witnessing interpersonal violence.⁸ TF-CBT has been found effective as compared to both supportive therapy and to a waitlist control for children with PTSD who have experienced sexual abuse from multiple perpetrators.⁹ One relatively large, multisite study in which 89 children received TF-CBT found remission rates were overall of 80 percent.¹⁰ Interestingly, one published study compared TF-CBT plus sertraline to CBT alone and found minimal benefit with the addition of the medication.¹¹ Because PTSD is often considered as part of the spectrum of anxiety disorders, it may be a similarly good match for CBT treatments.

Bulimia nervosa is a disorder that, in adults, has shown benefit from CBT. The child literature in this area is more limited. However, one recent randomized, controlled trial compared individual CBT for bulimia with family-based treatment and found similar symptom reduction rates for both treatments at 12 months.¹² Of note, the main hypothesis for this study was that family-based treatment would be superior, but in fact, they found the CBT treatment to show slightly greater efficacy in reducing binge eating at six months. Adult remission rates with treatment are only about 50 percent; the data are too limited at this time to estimate recovery rates for teens with bulimia. In contrast to the bulimia literature, there is little evidence to support the use of CBT for teens with anorexia nervosa. With this illness, family-based treatments have shown the greatest efficacy.

In contrast to the emerging evidence outlined above supporting the use of CBT for internalizing disorders in child psychiatry, there is little evidence to

support this type of treatment for most externalizing disorders. For example, one published study that included adolescents with both major depression and conduct disorder found that CBT was effective for the depressive symptoms but not the conduct disorder symptoms.¹³ There is also no data to support the use of CBT for attention hyperactivity disorder, although some more purely behavioral treatments involving parents and teachers are recommended as adjunctive treatments to medications.¹⁴ No evidence supports the use of CBT for oppositional defiant disorder which, while difficult to treat, shows some responsiveness to parent management training and family therapy.¹⁵

In conclusion, there is strong evidence for the use of CBT for anxiety disorders in children, particularly for OCD. For these disorders, CBT should be considered a first-line treatment. There is also data supporting the use of CBT for depression, PTSD, and bulimia nervosa. For these conditions, CBT should be on your list of types of effective treatments. For externalizing disorders, there is less evidence to support the use of CBT and more evidence for medications in ADHD in particular, as well as parent management and family-based treatments for ADHD and other behavior disorders.

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¹Practice Parameter for the Assessment and Treatment of Children and Adolescents With Oppositional Defiant Disorder
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² Practice Parameter for the Assessment and Treatment of Children and Adolescents With Attention-Deficit/Hyperactivity Disorder
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³ Cognitive-Behavioral Psychotherapy for Anxiety and Depressive Disorders in Children and Adolescents: An Evidence-Based Medicine Review
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Journal of the American Academy of Child & Adolescent Psychiatry; August 2004 (Vol. 43, Issue 8, Pages 930-959)

⁴ What is a NNT? Moore, A. and McQuay, H.J. 2009, Hayward Medical Communications. Available online at <http://www.medicines.org.uk/bandolier/painres/download/whatisNNT.pdf>

⁵ Practice Parameter for the Assessment and Treatment of Children and Adolescents With Anxiety Disorders
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⁶ Cognitive-Behavioral Psychotherapy for Anxiety and Depressive Disorders in Children and Adolescents: An Evidence-Based Medicine Review
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