

THE CARLAT REPORT

PSYCHIATRY

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Daniel Carlat, MD
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Learning Objectives

After reading these articles, you should be able to:

1. Discuss the value of specific cognitive behavior therapy techniques to treat patients with common psychiatric disorders.
2. Identify the benefits of using cognitive behavior therapy for insomnia (CBT-I) in patients with sleep issues.
3. Summarize some of the current findings in the literature regarding psychiatric treatment.

Some Helpful CBT Techniques for Specific Disorders

Clifford Lazarus, PhD, clinical director, The Lazarus Institute, Skillman, NJ

Dr. Lazarus has disclosed that he has no relevant financial or other interests in any commercial companies pertaining to this educational activity

When we first set about planning this article, its working title was “The Most Evidence-Based Psychotherapies.” But as we scoured the literature, it became clear that there’s no scientific consensus about which techniques are best (one exception to this being techniques for OCD—see page 3). In fact, the latest

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In Summary

- Behavioral activation therapy techniques are a good depression treatment choice for practitioners with limited patient time.
- CBT techniques such as relabeling, breathing exercises, and exposure can help patients with panic disorder, OCD, and PTSD.
- In conjunction with medication treatment, specific CBT techniques can be helpful for patients with bipolar disorder.



Cognitive Behavior Therapy for Insomnia

Michael Perlis, PhD

Associate professor of psychiatry & nursing, University of Pennsylvania. Director, UPenn Behavioral Sleep Medicine Program

Dr. Perlis has disclosed that he has received funding for research on CBT-I and has received funds from the sales of materials related to the teaching of CBT-I techniques. Dr. Carlat has reviewed this interview and has found no evidence of bias in this educational activity.

TCPR: Dr. Perlis, you are one of the major researchers of cognitive behavior therapy for insomnia. Why are you so interested in the topic of insomnia?

Dr. Perlis: Because insomnia is so ubiquitous and misunderstood with respect to its health consequences and “treatability.” At the core of this is the widespread misconception that insomnia is primarily a symptom of other things. In fact, the sleep community bears some responsibility for this, as it has been long been a slogan (since the mid-1980s) that “insomnia is not a disorder; it is a symptom, like a cough or fever.”

TCPR: And how is insomnia not a symptom? Certainly in psychiatry we see insomnia listed in DSM-5 as a symptom of various disorders, like major depression, mania, and anxiety disorders.

Dr. Perlis: It has been true, and continues to be true, that insomnia is listed as a symptom (or feature) of up to 80% of Axis-I DSM disorders. This said, insomnia is also identified in DSM-5 as an independent disorder (780.52) which, when occurring with other DSM-5 disorders, is considered a comorbid disorder rather than a symptom. The research supporting this point of view suggests that insomnia occurs prior



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Some Helpful CBT Techniques for Specific Disorders Continued from page 1

official statement on the subject by the American Psychological Association concludes with two key points: “(1) most valid and structured psychotherapies are roughly equivalent in effectiveness and (2) patient and therapist characteristics, which are not usually captured by a patient’s diagnosis or by the therapist’s use of a specific psychotherapy, affect the results” (<http://www.apa.org/about/policy/resolution-psychotherapy.aspx>). In other words, all techniques are equally effective, and it’s likely that the skills of individual therapists are as important as the specific technique they choose.

This is all well and good, but meanwhile, in the real world, we need to make decisions about how to treat specific patients. If we wait for the definitive answers from research, we will be waiting for a very long time. Therefore, in this article, we will detail certain well-known techniques drawn from the broad umbrella of cognitive behavior therapy, or CBT. We choose these techniques because they have all been

widely researched and found to be more effective than receiving no therapy. Does this mean that you should prefer these techniques to others, such as supportive psychotherapy or psychodynamic therapy? Not at all. You should develop a repertoire of techniques that you find intriguing enough to pursue expertise in. And you should have a systematic way of gathering feedback from your patients on whether they are responding to therapy.

In past issues of our newsletters, we have focused on psychoanalytic techniques (*TCPR*, June 2016), dialectic behavior therapy (*CATR*, August 2016), and the general characteristics of good therapists (*TCPR*, April 2015). We are an equal opportunity therapy critic. This article covers certain techniques without implying that they are more—or less—effective than others.

Major depression

Behavioral activation therapy (BAT) is a subset of techniques derived from CBT for depression. CBT for depression is a more comprehensive approach requiring significant training and greater time commitment from patients—both of which limit the technique’s real-world usefulness. BAT is simpler to learn and is more easily integrated into the briefer sessions that most prescribers are likely to have with patients. A recent meta-analysis of 26 controlled studies found that BAT had a large effect size in comparison with control groups such as wait list and treatment as usual (Ekers D et al, *PLoS ONE* 2014;9(6):e100100. doi:10.1371/journal.pone.0100100).

BAT simply encourages depressed patients to engage in more general activity, physical movement, and social interaction. This counteracts the tendency of people with depression to withdraw, disconnect, and disengage from previously enjoyable involvements and outlets. Ask patients to describe their typical days and assess whether they are avoiding activity. Then teach them about the vicious cycle of depression, in which their lack of motivation and activity leads to withdrawal from potentially enjoyable experiences—thus inviting their depression to worsen.

Instead of a vicious cycle, BAT helps create a “virtuous circle” of becoming more engaged in life, resulting in more positive experiences and, theoretically, better mood.

Panic disorder

Many of us were taught in training that CBT is the most effective therapy for panic disorder. However, according to the latest Cochrane review, there is no good evidence that CBT is any more effective than psychodynamic therapy, and only marginal evidence that it has an advantage over supportive therapy (Pompoli A et al, *Cochrane Database of Systematic Reviews* 2016;(4):CD011004. doi:10.1002/14651858.CD011004.pub2).

As is true with CBT for other conditions, such as OCD and PTSD, CBT for panic entails some type of exposure to the source of anxiety. Since the idea of exposing oneself to an anxiety trigger frequently makes patients nervous, I will often help them buy into the treatment by using the analogy of how one treats an environmental allergy. I will explain that allergies are caused by an immune system that is overly sensitive to environmental triggers, or allergens. Instead of having little or no reaction when exposed to, say, pollen, an allergy sufferer’s immune system launches a dramatic response, resulting in the misery of an allergy attack.

In anxiety, the nervous system overreacts, rather than the immune system. Anxious people overreact to a “psychological allergen” (ie, a sense of risk, threat, or danger), and their nervous system’s response leads to the misery of an anxiety attack. Just as allergy sufferers can be successfully desensitized by exposure to gradually increasing doses of allergens, people who suffer from the psychological allergy of anxiety can be desensitized, too. This is accomplished by gradually exposing anxious patients to the very stimuli, situations, or events that evoke their anxiety. Over time, the anxious person’s nervous system calms down and, just as with allergy desensitization treatment, eventually stops overreacting to whatever used to set it off.

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Some Helpful CBT Techniques for Specific Disorders Continued from page 2

This allergy metaphor not only helps patients to accept the treatment, but also provides a preview for the different components of CBT. CBT for panic has three important elements: cognitive relabeling, corrective breathing, and exposure to the interoceptive feelings and sensations of panic itself.

Cognitive relabeling entails teaching the patient that the sensations of panic are not life-threatening, but instead are physiological responses to events that are falsely interpreted as catastrophic. Patients can learn to reinterpret actual life events as less threatening, typically by filling out automatic thought sheets after having a panic attack.

Corrective breathing consists of diaphragmatic breathing methods. One way to teach this is to say to your patient, “First, get as comfortable as possible within your current surroundings. Then, close your eyes and begin to breathe deeply through your nose or mouth, whichever feels better for you. Take in deep breaths, and during each exhalation, let yourself unwind; notice your muscles loosening and tension draining away. Now, see if you can notice your belly rising as you inhale and falling as you exhale. This ‘belly breathing’ is what is meant by ‘diaphragmatic breathing.’ By doing this for just a few minutes, your physiology can return to a more balanced state, helping your body relax and your mind grow calm.”

Finally, in the *interoceptive exposure phase*, you help the patient induce the feelings of having a panic attack. You can do this in various ways. The most common technique is to have a patient spin in a swivel chair for about 30 seconds while hyperventilating into a paper bag. This often produces some of the sensations of panic, such as dizziness and increased heart rate. Usually, demonstrating this method before having the patient do it is most beneficial (partly because watching the therapist deliberately induce generally unpleasant sensations causes a degree of anticipatory anxiety in the patient, thus “priming the pump”). I also find it helpful to model a few moments of diaphragmatic breathing after the interoceptive demonstration.

OCD

According to continued expert consensus, the most evidence-based method for treating OCD is a form of CBT that includes exposure and response (or ritual) prevention (ERP). (See, for example, Lack CW, *World J Psychiatry* 2012;2(6):86–90. doi:10.5498/wjp.v2.i6.86.) Other therapies might also be effective but have not yet been adequately tested in controlled trials.

ERP is based on the idea that OCD behaviors are counterproductive efforts to prevent anxiety. It’s helpful to break down the patient’s anxiety prevention efforts into three categories: avoidance, escape, and reassurance-seeking. Avoidance means simply not exposing oneself to the anxiety-producing situation (for example, not using public restrooms). Escape is performing a ritual, which is a behavior done to neutralize the anxiety, such as washing, checking, or arranging. Reassurance-seeking involves repeatedly asking questions to confirm that nothing bad has happened (for example, a patient calling his parents multiple times a day to make sure they are alive, due to his fear that he had left the stove on the last time he visited).

The ERP technique involves encouraging patients to expose themselves to the trigger, and to learn how to neutralize the anxiety without resorting to rituals. For example, if a patient has contamination fears, the therapist might first model desirable responses by touching something the patient avoids and then not washing (eg, a doorknob, toilet flusher, rim of a trash can, etc). After modeling the nonavoidant and nonritualistic behavior, the patient is encouraged to perform it. Once the patient reports feeling “contaminated” and the patient’s subjective distress is gauged (usually on a 10-point SUDS—subjective units of distress—scale), the therapist asks the patient to periodically reassess the SUDS score until the anxiety has significantly diminished or completely resolved.

Conducting this type of therapy well usually requires significant experience and expertise, meaning you will likely need to refer patients to therapists for this treatment. Two websites that can help you locate such therapists are the sites for the

Association for Behavioral and Cognitive Therapies (<http://ABCT.org>) and the International OCD Foundation (<https://iocdf.org>).

PTSD

According to the latest Cochrane review, the three most evidence-based therapies for PTSD are exposure therapy, eye movement desensitization and reprocessing therapy (EMDR), and cognitive processing therapy (Bisson JI et al, *Cochrane Database of Systematic Reviews* 2013;12(CD003388). doi:10.1002/14651858.CD003388.pub4).

Exposure therapy is the most well-established technique. You start by teaching patients some basic relaxation exercises, then you have them recount the traumatic experience out loud several times. Often, patients record the sessions so they can listen to the narrative later as homework. This repetition gradually extinguishes the fear response triggered by the memories. The technique is highly effective if patients can stick to it, but there’s a fairly high dropout rate since the process is emotionally painful and not everyone can tolerate it.

EMDR involves having patients move their eyes back and forth while recounting the traumatic event and repeating various functional or dysfunctional beliefs, images, sensations, and emotions. The theory is that eye movements (or hand taps or sounds in lieu of eye movements) activate and facilitate the brain’s information processing system. However, there’s controversy about whether the eye movements are a necessary part of the therapy.

In *cognitive reprocessing therapy*, you help patients identify how a traumatic event has affected their view of the world, and how this view may be negatively affecting their life. For example, patients may believe that the world is a dangerous place and therefore avoid work or other activities. Other patients may blame themselves for the trauma, leading to depression. The therapist helps patients evaluate these beliefs and replace them with more accurate and functional ones.

Insomnia

The best psychological treatment for

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to, and is a risk factor for, various psychiatric disorders—and that it makes those disorders harder to successfully treat.

TCPR: What are the implications of reconceptualizing insomnia as a separate disorder?

Dr. Perlis: It means insomnia should be treated, and aggressively so, whether with medication or CBT-I. This brings up another perspective issue. Up to the present, the model for medical treatment has been that insomnia is like chronic pain and hypnotics are like opiates. When sleeping pills are prescribed, patients are told, “Take this only when you need it, and take as low a dose as you can.” But what if this treatment perspective is not correct? What if insomnia is more like an infection and sleeping pills are like antibiotics? In this case, patients would be told, “Never miss a dose, and complete the full regimen.” Maybe this approach to the medical treatment of insomnia would yield more robust results and durable treatment gains.

TCPR: Your point is well taken. How effective is modern treatment for insomnia?

Dr. Perlis: Both CBT-I and hypnotics decrease insomnia by about 50%. After discontinuing CBT-I, 50%–70% of patients maintain their clinical gains. In sharp contrast, those treated with hypnotics show little to no retention of clinical gains when treatment is discontinued. It is for these reasons, and its more benign side effect profile, that CBT-I is now recommended as the treatment for chronic insomnia by the American College of Physicians (<https://tinyurl.com/gmzqdox>).

TCPR: A lot of the studies that I’ve seen on CBT-I have been focused on so-called “primary insomnia.” What does that mean, exactly? And would the treatments effective for primary insomnia also be effective for the kinds of insomnia psychiatrists see every day, which are concurrent with psychiatric disorders?

Dr. Perlis: Yes, a lot of the original CBT-I literature was in primary insomnia, in which they recruited rarified individuals with no medical or psychiatric comorbidity. Recently, we have seen much more real-world research of CBT-I with all kinds of patients, including those with psychiatric comorbidity, those with ongoing chronic pain, etc. It turns out the technique is just as effective in all these populations (Geiger-Brown JM, *Sleep Med Rev* 2015;23:54–67).

TCPR: So how does CBT-I actually work?

Dr. Perlis: CBT-I is typically a weekly, 50-minute therapy session for 8 weeks, though this can vary from as little as 2–4 sessions to as many as 12–16 sessions. Some sessions may be as short as 15 minutes or as long as 120 minutes. The first step is to have patients keep a sleep diary for a couple of weeks, which can be challenging because they’re not receiving treatment during this time. That said, such data are crucial for CBT-I because patients are rarely able to retrospectively report their sleep patterns accurately.

TCPR: What is in a typical sleep diary?

Dr. Perlis: Sleep diaries are typically a set of questions that the patient completes each and every morning. Generally, patients record various measures of sleep, such as when they went to bed, when they got up, how long it took them to fall asleep (so-called “sleep latency”), total sleep time, and other variables. Other relevant factors might include daytime sleepiness, whether they napped, amount and timing of caffeine and nicotine use, etc. [Ed. note: A free sleep diary can be downloaded at <https://sleepfoundation.org/sites/default/files/SleepDiaryv6.pdf>.]

TCPR: And how do you use sleep diary information?

Dr. Perlis: These data are used to create a plan for sleep restriction therapy (ie, a new sleep schedule) and to determine if and when that new sleep schedule should be changed, depending on a variable called sleep efficiency. We also use the data to monitor the other main aspect of CBT-I, which is stimulus control therapy.

TCPR: Let’s take those in order. What is sleep restriction?

Dr. Perlis: The purpose of sleep restriction is to correct the mismatch between sleep opportunity and sleep ability. Let’s say you have a patient who needs to wake up for work at 6 am and sets an alarm. He begins to feel sleepy around 10 pm and gets into bed, but then tosses and turns for an hour or so, falling asleep at about 11 pm. He wakes up a couple of times during the night and estimates that he is awake for another 30 minutes over those combined periods. His sleep opportunity was 8 hours (10 pm to 6 am) but his sleep ability was about 6.5 hours, and therefore the mismatch is about 90 minutes. If his 7- to 14-day sleep diary shows that this represents an average night, his therapist would prescribe a new sleep schedule as the first step in treatment.

TCPR: What would this new sleep schedule look like?

Dr. Perlis: It would be adjusted so there is a better match between sleep opportunity and sleep ability. In this example, the patient’s time in bed would be reduced from 8 hours to 6.5 hours. How the new schedule is set follows a specific protocol and requires a fair amount of explanation to garner patient compliance. After all, the patient comes in thinking more sleep is the answer, but the therapist is effectively recommending less sleep.

TCPR: So once the sleep period is compressed to 6.5 hours, what happens next?

Dr. Perlis: If the patient achieves a good match between sleep opportunity and sleep ability after a week or so on the prescribed sleep schedule, the sleep opportunity would be upwardly titrated by 15 minutes (eg, from 6.5 hours to 6 hours and 45 minutes) and the patient would be evaluated again in a week’s time for progress. This process occurs again and again over the treatment period. If treatment is successful, the patient will fall asleep earlier (reduced sleep latency) and will have less time awake during the night.

“Insomnia is so ubiquitous and misunderstood with respect to its health consequences and ‘treatability’ Insomnia should be treated, and aggressively so, whether with medication or CBT-I.”

Michael Perlis, PhD

Expert Interview
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TCPR: You had also mentioned stimulus control. What is that?

Dr. Perlis: Frankly, stimulus control is a ridiculously simple and yet complex thing. At its most basic, it is the natural complement of sleep restriction therapy. Sleep restriction sets a schedule that increases the likelihood of solid and efficient sleep, but it does not explicitly tell patients what to do when they wake up at night. This is where stimulus control comes in. If you're awake at night, don't spend that time in bed—go elsewhere and return to bed when “sleepy.” But there are other aspects to stimulus control, including suggestions such as “Don't do anything in the bedroom apart from sleep and sex,” “Keep a regular bedtime,” and regardless of how you sleep (a good or bad night), “Get out of bed the same time each and every day.” All of these things likely contribute to the efficacy of stimulus control, particularly as a component of CBT-I.

TCPR: So let's return to the nuts and bolts of the therapy sessions. How exactly does the therapy progress?

Dr. Perlis: The first couple of sessions are primarily assessment, using both questionnaires and sleep diaries to determine if the patient is a good and appropriate candidate for CBT-I. For example, we would assess what factors (eg, comorbidities and/or life circumstances) are likely to complicate the use of CBT-I. Central to this assessment is the documentation of coexisting medical disorders, psychiatric disorders, and other possible sleep disorders (eg, obstructive sleep apnea, restless leg syndrome, parasomnias, etc.).

TCPR: And if there is a comorbidity, what do you do? Do you proceed with CBT-I, or do you wait for the other condition to be treated?

Dr. Perlis: That depends on the nature of the comorbid condition. With most chronic and stable comorbidities, there is no reason to delay the use of CBT-I. In fact, the use of CBT-I may provide for better outcomes with some of the comorbid conditions; this appears to be especially true in the case of depression. At the end of the day, the decision to use CBT-I is related to a few key points: 1) Is the insomnia of sufficient severity and frequency to warrant treatment? 2) Is there something about the patient or the patient's comorbid condition(s) that would prevent the standard use of CBT-I (or its use at all)? 3) Is there something about CBT-I that may exacerbate the patient's comorbid condition(s) that poses an unacceptable risk, even in the short term? If the answers are “yes,” “no,” and “no,” CBT-I is indicated.

TCPR: Can you give an example of common difficulties patients have with the therapy?

Dr. Perlis: I could think of 10 right off the bat. But here's the one that is usually the first of the classic patient resistances. Regardless of how much you prepare patients, it still comes as something of a shock that they won't be going to bed when sleepy. Instead (in keeping with our earlier example), the bedtime will be delayed by an hour and a half. So instead of going to bed at 10 pm, the patient's new bedtime is 11:30 pm. At the moment this number is on the table, the patient invariably says, “I don't think I can stay awake until then,” to which the therapist replies, “That sounds like we're on the right track!” In truth, this moment is the first step of what some might call cognitive therapy—it represents the opportunity to reframe the patient's treatment expectations from “I need to get more sleep” to “I'd be happy with less sleep if I fell asleep quickly and stayed asleep for most of the night.”

TCPR: A lot of what you describe seems to overlap with “sleep hygiene.” Most psychiatrists know a bit about sleep hygiene, and we often talk to patients about it and hand them a sheet with tips. Is this effective?

Dr. Perlis: Giving patients a list of tips, like avoiding too much alcohol before bedtime or trying not to take naps during the day, can be helpful, but there's no clinical trial evidence that such recommendations alone improve sleep. In fact, sleep researchers often use sleep hygiene as a control condition for trials of CBT-I because it's considered to be ineffective on its own. What worries me most about such well-intended interventions is the patient's belief that sleep hygiene is CBT-I, and this may deter the patient from seeking out evidence-based CBT-I as delivered by an experienced clinician.

TCPR: I think one of the reasons sleep hygiene tips are popular is that it's hard for us to find qualified therapists in our areas who can provide CBT-I.

Dr. Perlis: That's fair. However, there are more CBT-I therapists today than ever before. If you are considering making a referral for CBT-I, there are several compendiums you can find by Googling “CBT-I provider directory.” Most states also have specialists who can provide treatment via telehealth. Finally, there are CBT-I packages on the internet, like Shut-I and Sleepio. Randomized controlled trials of these programs have shown them to be effective, though it is not clear that they are as effective as in-person treatment.

TCPR: How does one find out about CBT-I training?

Dr. Perlis: You can find a list of CE trainings at our website (http://www.med.upenn.edu/cbti/cont_ed.html). We are in the process of providing a full list of CE trainings (see <http://www.med.upenn.edu/cbti/> and click “Continuing Education: CBT-I and BSM” in the left bar menu). In addition to UPenn, there are also other universities that have such trainings, including VA, UMass, Ryerson University, and Oxford University. You can also purchase CBT-I products at PESI (<https://pesi.com>) and CBT-I Educational Products (<http://www.cbtieducationalproducts.com/>).

TCPR: Thank you for your time, Dr. Perlis.

Essentials of Cognitive Behavior Therapy for Insomnia

- Goal: Help patients fall asleep quickly and sleep through the night
- Indications: Chronic insomnia, including when comorbid with psychiatric disorders
- Format: Typically 8 weekly 50-minute sessions
- Key elements:
 1. Sleep diary: Have patients keep a sleep diary for the first couple weeks
 2. Sleep restriction therapy: Create a new sleep schedule based on sleep diary data
 3. Stimulus control: Help patients associate the bedroom with sleeping rather than waking activities

Research Updates IN PSYCHIATRY

ANTIDEPRESSANTS

High-Dose Citalopram and Escitalopram: Undeserved Bad Rap?

REVIEW OF: Ray WA et al, High-dose citalopram and escitalopram and the risk of out-of-hospital death. *J Clin Psychiatry* 2016. doi:10.4088/JCP.15m10324

STUDY TYPE: Retrospective cohort study

Selective serotonin reuptake inhibitors (SSRIs) are considered the first-line treatment for depression; however, our confidence in their safety took a hit when the FDA issued a warning in 2011 about doses of citalopram above 40 mg causing QTc prolongation. The FDA originally said that high-dose citalopram was “contraindicated,” but in 2012 softened its language to “not recommended.” However, even this gentler warning remains controversial, and the study examined here attempts to further pinpoint whether QTc prolongation is any more likely with high-dose citalopram than with other SSRIs.

The authors reviewed the records of Tennessee Medicaid enrollees who had prescriptions for high doses of SSRIs between 1998 and 2011. “High doses” were defined as > 40 mg of citalopram, paroxetine, or fluoxetine; > 20 mg of escitalopram; or > 150 mg of sertraline. The study endpoint was sudden unexpected deaths, which included sudden cardiac deaths, other

cardiovascular deaths, and unintentional medication overdose deaths in non-hospitalized patients. The authors believed that these deaths were more likely to be related to cardiac arrhythmias.

RESULTS

There were 54,220 persons with 557,510 prescriptions meeting criteria for high-dose SSRIs. There were 254 deaths during the study period, including 145 sudden unexpected deaths and 100 other deaths. In comparing deaths in patients taking the different SSRIs, the authors adjusted for various comorbidities, such as other risk factors for heart disease. The adjusted risk of sudden unexpected death was not significantly higher in citalopram-treated patients than in patients treated with any other SSRI. Here are the numbers for the hazard ratios for citalopram vs each of the SSRIs examined: citalopram vs escitalopram, 0.84 (95% confidence interval (CI), 0.4–1.75); citalopram vs fluoxetine, 1.24 (95% CI, 0.75–2.05); citalopram vs paroxetine, 0.75 (95% CI, 0.45–1.24); citalopram vs sertraline, 1.53 (95% CI, 0.91–2.55). For those rusty on their statistics, the hazard ratio represents the relative risk. The 95% CI means there’s a 95% chance that the actual risk is somewhere in the cited range. Thus, patients on citalopram were 1.53 times more likely than those on sertraline to have sudden death. That sounds damning for citalopram, but the 95% CI means that the actual risk could be as low as 0.91 (lower than sertraline’s risk) or as high as 2.55.

Because the lower range of the CI is below 1, the risk is considered non-significant.

When the authors zeroed in on the subset of patients who had particularly high cardiac risk factors, they still found no significant difference among the medications in the risk of sudden unexpected death.

TCPR’S TAKE

This was a retrospective chart review, and it’s hard to ascertain causes of death with certainty. However, the study size was quite large, meaning that it is likely to be generalizable to the larger patient population. There is still concern about QTc prolongation with citalopram, but at least in this study, the risk of sudden unexpected death was not significantly different with high-dose citalopram than with escitalopram, fluoxetine, paroxetine, or sertraline users. This finding is aligned with another recent study showing that when VA patients were taken off of citalopram after the FDA warning, they were at higher risk for depression and not at lower risk of arrhythmias (see *TCPR*, July/August 2016).

PRACTICE IMPLICATIONS

Research continues to chip away at the FDA citalopram warning. While it’s prudent to be aware that there is some concern about citalopram, don’t hesitate to prescribe it in high doses when you and your patient think the benefits outweigh the questionable risks.

Colleen Ryan, MD. Dr. Ryan has disclosed that she has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

Some Helpful CBT Techniques for Specific Disorders

Continued from page 3

insomnia is an approach called cognitive behavior therapy for insomnia, or CBT-I. See this month’s Q&A with one of CBT-I’s major innovators, Michael Perlis, for more information on this technique.

Bipolar disorder

Although medications are the mainstay of treatment for bipolar disorder,

a recent review found that several bipolar-specific therapies are helpful as an adjunct (Swartz HA and Swanson J, *Focus* (Am Psychiatr Publ) 2014 Summer;12(3):251–266. doi:10.1176/appi.focus.12.3.251). Psychoeducation, for example, is useful for any phase of the disorder. Talk to your patient about factors that tend to trigger an episode,

such as increased work stress, less sleep, arguments with family members, substance abuse, and so forth. Then, based on that discussion, come up with a relapse prevention plan, which should be put in writing.

Typical CBT can be very effective for treating depression in bipolar

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CME Post-Test

To earn CME or CE credit, you must read the articles and log on to www.TheCarlatReport.com to take the post-test. You must answer 75% of the questions correctly to earn credit. You will be given two attempts to pass the test. Tests must be taken by April 30, 2018. As a subscriber to *TCPR*, you already have a username and password to log onto www.TheCarlatReport.com. To obtain your username and password, please email info@thecarlatreport.com or call 978-499-0583.

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For those seeking ABPN Self-Assessment (MOC) credit, a pre- and post-test must be taken online at <http://thecarlatcmeinstitute.com/self-assessment/>

Below are the questions for this month's CME/CE post-test. This page is intended as a study guide. Please complete the test online at www.TheCarlatReport.com. Note: Learning Objectives are listed on page 1.

1. Exposure and response prevention (ERP) has been shown to be the most effective technique in helping patients with: (LO #1)
 a. Generalized anxiety disorder b. Panic disorder c. PTSD d. OCD
2. You have a patient who goes to bed at 11 pm, falls asleep at about midnight, and wakes up for work at 7:30 am. He also wakes up multiple times during the night for a total of about an hour. What is the mismatch between this patient's sleep opportunity and sleep ability? (LO #2)
 a. 30 minutes b. 90 minutes c. 120 minutes d. 160 minutes
3. According to studies, the three most evidence-based therapies for treating PTSD are: (LO #1)
 a. Exposure and response prevention, cognitive relabeling, and interpersonal and social rhythm therapy (IPSRT)
 b. Exposure therapy, cognitive reprocessing therapy, and eye movement desensitization and reprocessing therapy (EMDR)
 c. Cognitive relabeling, corrective breathing, and EMDR
 d. Exposure therapy, cognitive reprocessing therapy, and IPSRT
4. CBT-I is not as effective for patients with primary insomnia who also have psychiatric comorbidities. (LO #2)
 a. True b. False
5. According to a recent study, the adjusted risk of sudden unexpected death was not significantly higher in patients treated with high doses of citalopram than in patients treated with high doses of paroxetine or fluoxetine. What amounts defined "high dosage" in the patient records that the study examined? (LO #3)
 a. 30 mg of citalopram, paroxetine, and fluoxetine
 b. 30 mg of citalopram; 40 mg of paroxetine or fluoxetine
 c. 40 mg of citalopram; 30 mg of paroxetine or fluoxetine
 d. Greater than 40 mg of citalopram, paroxetine, and fluoxetine

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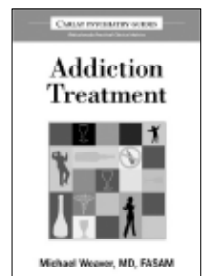
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This Month's Focus:
**Cognitive Behavior
Therapy Techniques**

Next month in *The Carlat Psychiatry Report*: Dementia

Some Helpful CBT Techniques for Specific Disorders

Continued from page 6

disorder. This involves behavioral activation (as described previously); activity scheduling and pleasure predicting; thought journaling; and reevaluation of irrational beliefs (eg, overgeneralizing, catastrophizing, all-or-none thinking, and so on.).

Another type of psychosocial treatment is interpersonal and social rhythm therapy (IPSRT). The premise is that recurrences of mood episodes are often triggered by changes in routines, changes that are frequently caused by interpersonal conflicts. These changes in routine (called "rhythm dysregulation") can then disrupt the sleep cycle, and sleep problems are often linked to mood issues. Your job as the therapist is to help patients identify connections between times when their days are thrown off kilter and mood episodes. Then, you coach your patients in how to manage their life in a somewhat regimented way to maintain a consistent sleep, meal, work, and exercise schedule.

Finding the right therapist for your patient

A helpful referral resource is the Association for Behavioral and Cognitive Therapies (ABCT); it has a useful "Find a CBT Therapist" function on its website (<http://ABCT.org>). Most of ABCT's members are trained and experienced cognitive behavior therapists, which can help in making reasonably confident referrals.

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