

Cognitive-behavioral therapy in the treatment of mental disorders

A terapia cognitivo- comportamental no tratamento dos transtornos mentais

The cognitive-behavioral model has appeared in the end of the 1950's with the works of Albert Ellis, and more especially cognitive therapy (CT) in the beginning of the 1960's with Aaron T. Beck. Since then, it has been exerting a strong impact both on the formulation of new etiological models for mental disorders and on their treatment.

Beck, a psychiatrist with a psychoanalytical training, while doing research with depressed patients, having as his reference the psychoanalytical model for depression, had his attention turned to the fact that in this disorder, patients have a distorted and negative appraisals of themselves, of their surrounding world and of the future. He then formulated the hypothesis that such a negative cognitive triad would stem from negative, rigid and non realistic cognitive schemas, formed during childhood due to the interactions with the environment, that would be the critical elements for the development, maintenance and recurrence of depression.¹ Coherently with this theoretical model, he developed a set of techniques aiming at correcting these distorted beliefs and, therefore, relieving the depressive symptoms. CT has thus appeared as a new explanatory model for the origins and maintenance of depressive symptoms and their treatment. Controlled clinical trials have subsequently found that CT had a similar efficacy of that observed with the use of antidepressants in the treatment of depression.^{2,3}

Explanatory hypotheses based on the more general cognitive model have been suggested for anxiety disorders, such as obsessive-compulsive disorder, generalized anxiety, panic disorder and social anxiety, chemical dependency, eating and personality disorders. The explanatory models of all these disorders propose a role for the errors in the processing of information as predisposing factors for a cognitive vulnerability, which, associated with genetic, neurobiological and environmental factors interact in the development and maintenance of symptoms. Currently, cognitive models are being investigated for other disorders, such as schizophrenia and bipolar disorders, among others, aiming to integrate them with the recent breakthroughs on molecular neurobiology, neuropsychology and genetics. Neuroimaging studies have demonstrated the neurobiological correlates of the action of CT in the brain.⁴

The more comprehensive term "cognitive-behavioral therapy" (CBT) is the most usual nowadays, as it simultaneously uses the typical interventions of the cognitive model, such as the techniques for the correction of dysfunctional beliefs and thoughts and incorporates behavioral techniques of the behavioral therapy, such as exposure and the use of reinforcers, among others. The great acceptance of the cognitive and cognitive behavioral model is due to several factors: 1) the proposition of models with high heuristic value, which enable a more comprehensive vision of the psychopathology of mental disorders, as they incorporate, to the traditional etiological models, the role of dysfunctional thoughts and beliefs, besides erroneous learning; 2) the proposition of models and hypotheses which are

testable through psychotherapeutic interventions, often brief ones, whose efficacy may be easily checked; 3) the short duration of treatments for Axis I disorders, which allows a better cost-benefit ratio as compared to the traditional treatments; 4) the elaboration of protocols and manuals which enable their standardization and reproducibility by different researchers; 5) the development of scales and tools to check the outcomes and the short duration of treatments allowing a better control of the intervening variables, a better follow-up of outcomes – which are barriers that, up to now, have not been surpassed by the long-duration treatments, allowing a great expansion of research on CBT.

The clinical efficacy of CBT has been well established in controlled studies, in the treatment of unipolar depressive disorders,^{2,3,5} both for adults and children, in panic disorder with and without agoraphobia,^{5,6} in social phobia,⁵ in post-traumatic stress disorder (PTSD),⁵ and obsessive-compulsive disorder (OCD),^{7,8} Non-controlled studies of CBT for schizophrenia and bulimia nervosa are in course in this moment.^{5,9} CBT is being tested in a series of other psychiatric conditions, such as chemical dependency, especially in the prevention of relapses, in personality disorders, in delusional disorder, in bipolar disorder, in attention-deficit hyperactivity disorder, in impulse disorders, in the treatment of marital problems, and in medical problems such as chronic pain, among others.⁵

The editors of the *Revista Brasileira de Psiquiatria* have decided, in a very appropriate moment, to provide their readers with a supplement in which are described the fundamentals and applications of CBT on those disorders whose efficacy has been consistently established and the clinical use has been consecrated by its effectiveness. The authors are academic professors, mostly linked to universities post-graduate courses, who have dedicated themselves since long time ago to the practice and teaching of CBT, besides having performed researches with worldwide quality.

Paulo Knapp and Aaron Beck report the history of the origins and theoretical foundations of the different models of CBT, and point to the similarities and differences between them. The review article describes some procedures and techniques, which are characteristic of CT, and presents data from the literature showing evidences of CT's efficacy on different disorders.

The first application of CT was in the treatment of depression. Vânia Powell et al. write about the fundamentals of CBT in the treatment of depression and perform a review on evidence of short- and long-term efficacy of the therapy alone or associated with medications. CBT has also shown to be especially efficacious in the treatment of anxiety disorders. Manfro et al. describe the use of CBT in the treatment of the symptoms of panic disorder and Ito et al. describe the use in social phobia, pointing to the evidence of efficacy. CBT has shown to be particularly effective in the treatment of OCD symptoms. Aristides V. Cordioli presents a brief history of exposure and response prevention therapy as well as CBT for OCD, their fundamentals, the techniques used, showing the evidences of efficacy in this disorder. Of note, brief group

approach in social phobia, in OCD and panic disorder has shown to be equally efficacious, enhancing the possibilities for the use of this approach in public or even private institutions with a great demand of patients, providing a better cost-benefit relationship. The scarce space of a supplement prevents the description of the use in other anxiety disorders, such as in post-traumatic stress disorder (PTSD), in generalized anxiety (GAD) and in specific phobias, in which the approach is well established due to its high effectiveness, alone (in phobias) or in combination with medications (PTSD, GAD, bulimia nervosa).

CBT has been successfully used in the treatment of addiction problems, especially in the prevention of relapses. In their article, Bernard Rangé and Alan Marlatt review the cognitive models of addiction and relapse prevention, and the theory of stages of change on which is based the motivational interview. They describe the techniques used in the treatment of this serious health public problem.

Fortunately, medical residencies in psychiatry and training courses, as well as psychology courses, have been inserting cognitive and behavioral theory in their curricula and disciplines, and also the practical training in CBT. But at this moment, there are still few medical professionals who use this approach in their daily practice.

The decision of RBP's editors to release a supplement aiming to divulge CBT among the journal's readers is the result of the concern in presenting these breakthroughs and situating them in their connection to the state-of-the-art in CBT and within the context of the other approaches of psychiatric disorders. A comprehensive list of bibliographic references will allow interested readers to enhance their knowledge.

Surely, this supplement will allow a first contact for readers with a lower familiarity to CBT - especially in the treatment of those disorders to which its efficacy has been solidly established and whose effectiveness has been consecrated by the clinical use - and will be also a stimulus for them to become interested in this treatment modality.

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Note: UFRGS = Universidade Federal do Rio Grande do Sul.

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