Editorial

Introducing the In Debate Series

Joel Paris, MD

In this issue, the Canadian Journal of Psychiatry initiates a new series, entitled In Debate. There is no lack of debatable issues in psychiatry. In fact, one might ask which major question in our field is not up for discussion. The series, which will appear a few times each year, will focus on clinically relevant areas that are the subject of passionate disagreement.

We have borrowed the format (as well as the title) from the British Journal of Psychiatry, which has been running a similar series for several years. We have invited 2 experts to take 2 sides of an issue. Each is allowed about 1500 words and 10 references to make his or her case. The lines of debate will be drawn, but a final answer will not be provided. (We have only chosen questions to which there is no definitive answer.)

The first topic, to be presented in this issue, concerns the important question of whether individuals suffering from alcoholism can return to social drinking. While this is an old debate, it has never been settled to everyone’s satisfaction. Our readers are invited to come to their own conclusions.

Guest Editorial

Cognitive-Behavioural Therapy for Severe Mental Disorders

Neil A Rector, PhD

Over 4 decades, ago Aaron T Beck presented the basic theoretical and treatment approach of cognitive-behavioural therapy (CBT). Since then, hundreds of randomized controlled clinical trials (RCTs) have demonstrated the efficacy of CBT for the broad range of psychiatric conditions, including severe mental disorders such as bipolar disorder, refractory obsessive–compulsive disorder (OCD), substance abuse, suicide, personality disorders, and schizophrenia.

Increasingly, we see the integration of CBT with biological psychiatry resulting in optimized treatment outcomes. This may be no better illustrated than in the recent efforts to develop and test cognitive and behavioural interventions for patients experiencing persistent symptoms of psychosis with only partial response to pharmacologic interventions. Although it has been noted that, as late as the 1980s, schizophrenia was the “forgotten child of behaviour therapy” (1), significant developments in the use of CBT for medication-resistant symptoms in schizophrenia have occurred over the past 15 years.

The CBT treatment approach to schizophrenia has been detailed in several step-by-step treatment manuals. Typically, it includes the following therapeutic goals: 1) the establishment of a solid therapeutic alliance; 2) psychoeducation, within a biopsychosocial model, about the nature of psychosis; 3) reducing stigma and normalizing the symptoms of psychosis; 4) delivering cognitive and behavioural interventions...
Dr Corrine Cather, a leading expert in the CBT treatment of schizophrenia at Harvard Medical School, outlines a novel cognitive-behavioural approach to remediating social functioning deficits (10). In contrast to the prevailing view that the symptoms of psychosis should be targeted first to remove putative barriers to improved social and vocational performance, she outlines a new treatment approach wherein the primary treatment target is to harness patients’ motivation to help them identify, pursue, and achieve important life goals in the face of residual psychotic symptoms. The benefits of helping individuals to develop concrete and achievable goals are nicely illustrated in clinical vignettes.

Taken together, these papers highlight the potential for CBT to contribute not only to reducing personally painful experiences associated with distorted reality perception but also to reducing negative symptoms and to helping the person with schizophrenia become emotionally reengaged with personally relevant life goals.

References


1. Psychologist, Centre for Addiction and Mental Health, Toronto, Ontario; Associate Professor, Department of Psychiatry, University of Toronto, Toronto, Ontario.