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Meet Our Board Members

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Biography



Dr. de Oliveira received his medical degree from the Federal University of Bahia in Brazil in 1978, and in 1979, he joined the Department of Pharmacology as an assistant professor. From 1983 through 1988, he trained in psychiatry at the University of Paris V, in France. Upon returning to Brazil, he resumed his activities at the Department of Pharmacology, where he remained until 1996. In 1995, he received his Ph.D. in psychopharmacology, and in 2000, became full professor at the Department of Psychiatry. Currently, Dr. de Oliveira performs both teaching and research functions in two doctorate programs at the Federal University of Bahia.

Dr. de Oliveira is the author of 130 articles and chapters, and more than 300 presentations and abstracts. He has also edited three books encompassing psychopharmacology, obsessive-compulsive disorder, and cognitive behavioral therapy (CBT). He serves as section editor of *BMC Psychology* and is on the editorial boards of *Brazilian Journal of Psychiatry*, *Clinics*, *CNS Spectrums*, *Journal of Clinical Pharmacy and Therapeutics*, and *RBP Psychiatry*.

Brief History of Professional Interests

My experience in conducting psychopharmacological studies led both by the university and the pharmaceutical industry started 20 years ago, when the decade of the brain started. The SSRIs (e.g., fluoxetine) and atypical antipsychotics (e.g., risperidone) were new and promising, and were opening novel perspectives in psychiatric treatment. Upon returning to Brazil in 1988, after living 4 years in France, I began teaching and conducting research activities at the Federal University of Bahia. Since then I have maintained a clinical trial center where my team and I conducted several studies on antipsychotics and antidepressants. Unfortunately, although safer than the old ones, the drugs put onto the market since then did not completely fulfill their initial promises, and psychiatric drug treatment has remained an unmet need.

In the late 1990s, after receiving a PhD in psychopharmacology, I also received a cognitive therapy (CT) certification by the Beck Institute of Philadelphia, and became a (founding) fellow of the Academy of Cognitive Therapy. Therefore, I gradually shifted my clinical practice and research interests from an exclusively biological and psychopharmacological focus to an integrative focus linking psychopharmacology and psychotherapy. I was integrating (1) my practice as a psychiatrist and psychopharmacologist, (2) my experience in conducting clinical trials, and (3) my competence in psychotherapy in my field of research. A multicenter randomized clinical trial (RCT) of topiramate and CBT in the treatment of binge-eating disorder was the first result of this shift in focus.[1]

Studies Conducted in Cognitive Behavioral Therapy, Trial-Based Therapy, and Social Anxiety Disorder

Additionally, my experience in CBT allowed me to develop a new psychotherapy model, which was founded in CBT and also in the work of the surreal writer Franz Kafka, and which I called trial-based therapy (TBT).[2] This name was inspired by Kafka's most famous novel, *The Trial*. My idea was to introduce a psychotherapy format that intended to be a case-formulation, evidence-based approach that might be more easily learned by new therapists and patients alike, because of its very structured presentation format and easy-to-remember techniques.

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I have recently published two studies to test the efficacy of TBT.[3,4] One[3] involved 36 patients with social anxiety disorder (SAD), in which the experimental group was treated with TBT and the contrast group received conventional CBT. Although both treatments significantly reduced the scores of the Liebowitz social anxiety scale, the fear of negative evaluation scale, the social avoidance and distress scale, and the Beck anxiety inventory, TBT was significantly more effective than the contrast group in reducing the fear of negative evaluation and social avoidance and distress. The data on quality of life[5] were also significantly better at post-treatment (bodily pain, social functioning, and emotional role) and at follow-up (emotional role) relative to the contrast group. A significant treatment effect on the emotional role domain at 12-month follow-up denoted a sustained effect of TBT relative to conventional CBT, suggesting that this study provided preliminary evidence that TBT was at least as effective as conventional CBT.

In the second study,[4] 166 patients were submitted to TBT—more specifically, to one technique. This technique, which simulated a courtroom trial, addressed and restructured negative core beliefs (NCBs) and corresponding emotions, and was conducted in one session. Significant reductions ($p < 0.001$) existed in percent values in the adherence of the patients to the NCB (81% to 20%), and in the intensity of the corresponding emotions (84% to 19%). The sample size of this study was recently extended to 259 patients, confirming its findings regarding NCBs and emotion change.[6]

The studies to be concluded in the next 3 years by my team are RCTs comparing TBT and (1) conventional CBT in SAD, (2) exposure in post-traumatic stress disorder, and (3) treatment as usual (normally pharmacological and support psychotherapy) in patients who have made a suicide attempt.

I have witnessed advances in my fields of research in the last 2 decades, namely the development of safer antidepressants (e.g., SSRIs and SNRIs) and antipsychotics (e.g., atypical antipsychotics) in psychopharmacology, and the development of the so-called third-wave evidence-based approaches [e.g., dialectic behavior therapy (DBT), acceptance and commitment therapy (ACT), compassion-focused therapy (CFT)] in CBT. It is my opinion that the next step will be a growing interest in studying the combined use of such approaches with psychopharmacology in different psychiatric disorders. My personal challenge is to conduct studies combining TBT and medication in different psychiatric conditions.

Continuing Developments in Brazil and Mexico

Although we are in a time of global crisis, the economy is improving in some Latin-American countries, particularly in Brazil and Mexico. However, despite the consequent availability of better public health systems, and free access to newer and better drugs, low-income people are still without access to effective, evidence-based psychosocial treatments such as CBT. As a personal contribution, I hope that the development of TBT will facilitate access to psychotherapy, because of its highly structured format and short-duration of training, as well as its transdiagnostic feature.

Brazilian scientific output has increased more than 4-fold in the last 3 decades due to the stability of the investment in research and development activities and to policy changes in the main funding agencies. Among all areas of knowledge, the most productive are health and biological sciences, and psychiatry presented a 191% increment, equaling some European countries.[7] The Brazilian scientific production in psychiatry has shown a quantitatively and qualitatively sustained rise over the last 10 years.[8] If the Brazilian government maintains this investment, I foresee even more growth in the years to come.

Finally, in the last few decades, perhaps as a reaction to a long-lasting hegemony of psychoanalysis, there has been a decline of the attention given by psychiatrists to psychotherapy and a great increase of psychopharmacology dominance, stimulated by the discoveries in biological psychiatry and psychopharmacology, and the influence of the pharmaceutical industry. As we have observed a plateau or even a decrease in the development of new drugs in the last few years, there has been a rediscovery of the power of psychotherapy in psychiatry, particularly those in the CBT umbrella, such as CT, ACT, and DBT. I would strongly advise a balanced interest in competencies including psychopharmacology and evidence-based psychotherapies in the education of young psychiatrists.

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