Two of our extramural supervisors have been working with therapists from the Veterans Association since May of this year, teaching them to do cognitive therapy with their depressed patients. The supervisors listen to at least two therapy tapes a week, then hold weekly one and a half hour group supervision sessions by phone.

The supervisors report that the therapists are quite motivated and, despite having little or no previous experience in cognitive therapy, have learned the model and practice well, are receptive to feedback and are very appreciative of this opportunity. Initially, supervisors focused on helping therapists structure sessions (for example, setting agendas), conceptualize patients according to the cognitive model, and engage in activity scheduling and problem-solving. The therapists have improved in their ability to effectively plan treatment within and across sessions and to collaboratively set up homework assignments that patients are able to accomplish.

One therapist may have saved a patient’s life. David (not his real name), a 35 year old veteran, was taken to the emergency room by his brother who had found him holding a gun to his head. He was hospitalized briefly, then discharged. A trigger for his suicidality had been the threat of divorce. David had recently had two physical

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altercations with his 15 year old son. His wife had thrown him out of the house. He moved in with his brother, who was living in a small apartment. David became quite depressed, spending virtually all of his time on the sofa, watching television, rarely leaving the apartment.

David’s therapist did safety planning with him and helped him respond to his hopeless thinking (“Things will never change. I’ll always feel miserable. What’s the use of even trying? I’m nothing without my wife and son,”) and encouraged him to do small experiments to see whether scheduling activities would have a positive effect on his mood. They also did problem-solving and role-playing so David could learn how to talk to his wife and son.

David almost immediately noticed that his mood was better when he took control, got out of the apartment, set small tasks for himself, got together with his buddies, and played basketball. His therapist is currently working with him on continuing to build a life for himself, now that his wife is filing for divorce. He is feeling stronger and has only intermittent, brief suicidal ideation. His prognosis is good.

We are pleased that the Beck Institute is playing a small part in helping our country’s soldiers and veterans through our training programs. Scholarship information is available by visiting www.cbtforsoldiers.org.

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have already been stabilized on medication or, for some reason, are not taking medication. We found that some of the high-functioning cases respond quite well to some of the standard cognitive therapy techniques used with nonpsychotic patients. For example, delusional patients, after substantial training, could review their delusional interpretations and reflect and come up with alternative explanations for their misinterpretations. One of my mentees in Canada, for example, reported a patient who became quite disturbed at the lettering on a bus as it passed by. He read the letters “G,” “O,” “T,” but could not see the rest of the letters. His first thought was that this was a signal from God: “G-O” to go some place; “T-,” but since he did not see the rest of the letters, he was distressed that he could not decipher where God wanted him to go. When he returned to his room and started to fill out one of the forms we use, he puzzled whether there could be an alternative explanation for this lettering, and, as he pictured the bus once again and thought of what the lettering on the bus might indicate, he realized that the letters actually stood for “Greater Ontario Transit System.” He was, thus, very much relieved that it was not a signal from God.

We have done considerable work with patients who are totally socially isolated, withdrawn, or, at least, are functioning at a lower level than previously. We find that we need to tailor our interventions to the specific level at which the patients are operating. For example, one patient operating at a low level (poor attention span, poor reasoning ability) had great problems in determining whether she was depressed or happy. The therapist drew several figures of happy, sad, and neutral faces. The patient was then able to select which face matched her own mood. At a later date, the therapist was trying to demonstrate the difference between feelings and thoughts. Eventually they hit upon the formula: feelings are generally one word, and thoughts are several words. She thus was able to make some discrimination between these two, and ultimately see that her thoughts influenced her feelings.
Dr. Judith Beck writes: There was an interesting discussion recently on the www.academyofct.org website about cross-cultural issues in the diagnosis and treatment of patients with psychiatric disorders. I asked Emel Stroup, Ph.D., who has an excellent cognitive therapy training program in Istanbul, Turkey, to write an article expressing her ideas.

I agree that there is a real danger in assuming that models of mental health, as well as of therapeutic approaches, developed in the United States can be applied elsewhere. However, in my experience in a broad range of individualistic and collectivistic cultures, the main way this problem presents itself (at least, for a cognitive therapist) is in diagnosis.

One example of this is a therapist who once briefed a case about a patient from a collectivist culture whom she diagnosed with dependency disorder. If the patient had been from the therapist's culture, the symptoms uncovered would have accurately pointed to that diagnosis. However, in the culture the patient came from, and in which he was still embedded, the "symptoms" the therapist detected in truth reflected a normal, healthy process.

Another example, looking at the symptoms issue from the other direction, is that most (virtually all) DSM diagnoses are valid around the world, but the diagnostic cues vary. This is a big subject, and it is a key reason why discussing it in settings like this is so important.

I have to argue, though, that cognitive therapy as developed by Dr. Aaron Beck is not a part of the problem our current topic addresses.

It is not an example of an American or Western approach to mental health that cannot properly be used outside of its home culture. In fact, it turns out most definitely to be part of the solution to the concerns expressed in this discussion. This may be almost entirely coincidental, but the fact of the matter unquestionably turns out to be that CT's patient focus, and its involvement of the patient as a meaningful and active collaborator in the therapeutic process, serve as an antidote to the danger seen in other therapeutic approaches.

Many if not most of these other approaches rely strongly, if not entirely, on the therapist as the active actor in therapy, using his or her knowledge, experience, and (as it turns out) cultural assumptions about what is "normal" to drive the therapy process. This is a crucial difference between these other approaches and cognitive therapy, and, as it happens, a key reason why cognitive therapy so effectively escapes the cultural bias trap.

In CT, the therapist focuses carefully on the patient and on the cues the patient offers regarding what is, in fact, normal and healthy in the patient's life and experience. The therapist doesn't assume that he or she knows what the symptoms or explanations offered by the patient mean; rather, the therapist carefully and thoroughly questions the patient, not only about what the symptoms are, but what they mean to the patient, why they mean that, and why that is a problem for the patient. Thus, the therapist is learning not only about the patient's culture, but also about the individual patient's problematic relationship to that culture.

Therapists must also discipline themselves to exercise the core elements of what makes cognitive therapy work with a patient. The problem is that instead of doing this, many therapists instead surrender to what seem to be overwhelming cultural habits. Here's one example that is very common in the collectivist culture where I currently practice: A new patient will often walk into the therapy room accompanied by a large contingent of extended family members and friends, or even workplace colleagues. This whole group will then calmly sit down, and everyone, including the patient, will simply wait as a group for the patient's therapy to begin. People from these groups will call the therapist before or after therapy, try to arrange private visits in order to "inform" the therapist about what's "really" going on with the patient, or try to find out how the patient is doing -- in particular, to learn what the patient is saying about them.

Some therapists will simply go along with this. It is important to note, by the way, that therapists who do this are not just those who are foreign to the culture, but even more commonly those that are part of the culture themselves. But this is very unhelpful. It is essential to the proper and effective practice of cognitive therapy that a trustworthy and confidential working alliance be established between the cognitive therapist and the patient.

It is true that this will often cause amazement on the part of the family and friends, and even some resentment or anger. This, actually, is a good example of a cultural aspect that does need to be carefully considered by a therapist. A cognitive therapist must learn to manage the establishment of the therapist/patient confidential relationship in a way that doesn't cause the therapy to be later undermined by family and friends. This can be caused by resentful family dynamics set in

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motion when the therapist fails to introduce, when necessary, the nature of the patient’s therapy to the whole family/group. This is a manageable issue, however. Families almost always come to understand and comply with the confidentiality measures necessary to good therapy. For their part, the patients, who are also usually surprised and amazed at my insistence on this, come very quickly to appreciate it. They develop a real and important sense of personal safety which helps them devote themselves with confidence and hope to the therapeutic relationship and the therapy.

The patients, unsurprisingly, quickly come to express themselves much more freely than otherwise. Diagnoses then tend to be more thoroughly grounded and reliable. In fact, I have found that patients from this culture, which is not naturally inclined to use the unique CT and Western private, confidential therapeutic relationship, become some of the most motivated and effective patient collaborators in cognitive therapy that I have seen anywhere.

I would like to suggest that we should be very careful about uncritically accepting the idea (which does seem to have a superficial plausibility) that we need to create a different form of CT for every cultural group, whether geographic, ethnic, or national. As cognitive therapists, we work with individuals. We do this by exercising the discipline to bring the patient into the center of the process, and by being alert to the contribution which that makes to the therapy.

Cognitive therapy distinguishes itself from other approaches in its central assumption that the patient is not only capable of understanding his or her disorder, but also of being a helpful, indeed an essential, participant in the healing process. Cognitive therapists use their knowledge and experience to help guide their patients through this process, not (as we must acknowledge is a legitimate cross-cultural concern with other approaches) to dismiss the patient’s concerns or needs by imposing a directive approach.

Of course it is helpful for cognitive therapists to be familiar with the local cultures they may encounter, and how these may influence diagnosis and the therapeutic process. Drs. Kuyken, Padesky, and Dudley have recently written, for example, on how important such an understanding is to effective case conceptualization (as their book title, Collaborative Case Conceptualization, makes clear). However, I think that in the case of cognitive therapy, when we find an apparent conflict between its practice in the West and in other cultures, we should examine that conflict carefully, instead of rushing to the conclusion that it is CT itself that is at fault. I don’t see how we can possibly be effective proponents or practitioners of cognitive therapy if we find ourselves looking for reasons to declare it imperfect before we have looked for ways that we ourselves might more effectively practice it for the benefit of our patients around the world.
Alla Kholmogorova and Natalia Garanyan, from the Moscow Research Institute of Psychiatry, trained with us here at the Beck Institute in the 1990s. We recently asked them about the state of mental health treatment and CBT in Russia. Here is what Drs. Kholmogorova and Garanyan wrote:

“The 1990’s were a very complicated period in Russian History, with changes occurring rapidly, not only in political life and in terms of the economy, but also in science, including psychiatry. The Center of Mental Health (Russian Academy of Medical Sciences) was one of the biggest psychiatric settings during the Soviet Era. We worked at this Center for more than ten years (1983-1996), until we transitioned to the Institute affiliated with the Ministry of Public Health, which we represent today.

Research and treatment approaches in Russian psychiatry during the Soviet Era traditionally focused on biological factors, while the importance of psychosocial variables were underestimated. Mainstream psychiatry during this period dealt primarily with linear biological models of causality. And research mainly focused on schizophrenia which was diagnosed at higher rates in Russia than in the United States and western European countries such as Germany, France and Spain. Using current criteria, many of the schizophrenia cases diagnosed at that time might have been diagnosed as depressive, anxiety, somatoform or personality disorders. Instead, "slowly progressive" schizophrenia was diagnosed in many cases. While therapeutic resistance to medication has been considered one of the most important criteria of this illness, psychotherapeutic interventions had minimal value since biological factors were viewed as the causal role in the origin and maintenance of mental disorders. Application of psychotherapeutic interventions for schizophrenic patients was seen as futile and virtually no one practiced them.

In the case of neurotic conditions and chemical addictions, behavioral methods based on reciprocal inhibition and the Pavlovian model of conditioned response had gained acceptance. A Russian variation of aversive techniques (known as "coding techniques") has been widely used in the treatment of alcoholism. And the most common treatment approaches have been hypnosis and relaxation. In 1912 the book, "Rational Psychotherapy" by French psychiatrist, P. Dubois, was translated into Russian. It has had a wide resonance within the professional community in Russia. Correction of a patient's irrational and maladaptive beliefs, namely, beliefs concerning their illnesses, was seen as an important psychotherapeutic tool. During the Soviet Era, theoretical concepts of psychoanalysis were considered ideologically wrong and never applied in practice. We did not have the slightest knowledge of cognitive, systemic and humanistic therapies.

Much has changed in the field during the Perestroika era. Psychoanalysis has become the only therapy to receive privileged support at the governmental level. Boris Yeltsin passed a decree to restore and develop psychoanalysis in Russia. Since then, several Institutes for Psychoanalysis have been established. Unfortunately, the qualification level of the Institutes’ graduates is far from perfect. The same can be said about training in other modalities, where standards often do not correspond to international norms.

In the 1990s, the first "consulting room for neurotic disorders" was opened in a primary care setting. It was the first service to be separated from psychiatric hospitals. Natalia and I were both offered positions as clinical psychologists in this service. We were quite surprised by the high rates of chronic forms of disorders. In some instances, patients with severe and chronic forms of depression and anxiety disorders, for example, had gone undetected and untreated for more than ten years. Some patients were afraid to see a psychiatrist in official out-patient psychoneurological clinics. Some initially decided to seek help, when they saw the sign "consulting room for neurosis disease;" others were treated by doctors of internal medicine with no result. Cardiologists, neurologists, endocrinologists and other internists clearly lacked the skills necessary to recognize and treat mental disorders. Their attempts to cure depression or anxiety often led to iatrogenic complications that worsened the patient's condition. Psychiatrists had traditionally referred many patients suffering from schizophrenia to our services.

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As Natalia and I searched for effective methods to help these clients, the discovery of Prof. Beck’s book seemed like a miracle. It really helped us recognize our patients’ disease patterns. We felt that, finally, we found what we were looking for. Natalia Garanian has been the first to translate parts of these Cognitive Therapy books into Russian. We were invited to participate in the extramural program at Beck Institute after we sent Prof. Beck our published article in a special issue of *Moscow Psychotherapeutic Journal* devoted to Cognitive Therapy.

Thanks to our western colleagues, we were given a broad view of psychotherapy methods in the 1990s. Hanna Wiener, former IFTA President, came to Moscow, at the time, with her husband, the head of the first Russian McDonalds services.

Wiener trained us in systemic family therapy. Greta Leutz, a German fellow and friend of J. Moreno, came to Moscow and trained us in psychodrama. With all this training, we truly felt the integrative power of Cognitive Therapy, which has been stressed by A. T. Beck for so long. Cognitive Therapy was a central construct, which provided a vision for integrating other approaches.

Psychotherapy in Russia is currently undergoing a process of intensive growth and formation. Interest in its practice is strong but the qualification level of professionals, the lack of clear ethical norms and legislation are serious impediments to its success and development. Still, more and more professionals are looking for evidence-based effective psychotherapeutic methods and are studying CBT.”

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October 19, 2010 – Manitoba, Canada – Grace Hospital. Speaker: Leslie Sokol, Ph.D. Workshop: Cognitive Therapy for Personality Disorders.

October 27, 2010 – Perry Point, MD – Chesapeake Health Education Program, Inc. (CHEP). Speaker: Leslie Sokol, Ph.D. Workshop: Cognitive Behavior Therapy for Anxiety Disorders, Underscoring PTSD. Website: www.chepinc.org


November 1-5, 2010 – Hong Kong – Hong Kong Hospital Authority. Speaker: Leslie Sokol, Ph.D. Workshop: Intensive 5-Day Cognitive Therapy Training. Website: www.ha.org.hk


February 21-25, 2011 – Stanton, MI – Montcalm Center for Behavioral Health. Speaker: Leslie Sokol, Ph.D. Workshop: Cognitive Behavioral Therapy Training with a Special Emphasis on Trauma. Website: CBTISTANBUL Workshops


May 7-8, 2011 Tokyo, Japan – Kyoto University Graduate School of Medicine / School of Public Health Speaker: Judith S. Beck, Ph.D. Workshop: Introduction to Cognitive Therapy. Website: http://tsudahall.com/THHP2/mainindex.htm. Contact: Toshiaki A. Furukawa, MD, PhD - furukawa@kuhp.kyoto-u.ac.jp


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