Cognitive Therapy Today

SPECIAL STUDENT SCHOLARSHIPS
See article below...

Dr. Aaron T. Beck and Dr. Judith S. Beck greeted participants at the Student Workshop in August 2010.

FROM THE PRESIDENT

Student and Faculty Scholarships: Second Annual Competition
Judith S. Beck, Ph.D.

Can you please help us spread the word?

We are pleased to be able to offer full tuition scholarships to our second annual student and faculty three-day cognitive behavior therapy workshop, to be held August 15-17, 2011, here in Philadelphia, but scholarship awardees may be able to attend a Level I workshop at another date (see beckinstitute.org).

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FROM THE PRESIDENT EMERITUS

Conceptualization of Emotion
Aaron T. Beck, M.D.

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The listserv of the Academy of Cognitive Therapy had a very interesting and important discussion recently on the difference between the clinical and scientific model. Here is my latest thinking: The clinical model is based on observable and introspective phenomena and it is adequate in terms of the administration of cognitive therapy. Specifically, the clinical model consists of situation/stimulus -> situation/stimulus.
meaning (belief) -> emotion/behavior. The meaning, of course, can be ascertained by the automatic thought, image, or reflections. The scientific/theoretical model goes like this: schema activation -> cognitive processing -> emotion. The cognitive processing operates at several levels, or perhaps on a continuum, from unconscious to conscious. Some recent research on depression¹ has shown the following: 1) Based on neural scans, depressed patients show insensitivity to masked positive stimuli and hypersensitivity to masked negative stimuli. This is represented by activation of the amygdala without conscious awareness. Biasing is reversed after antidepressant medication (the patients showed an increased sensitivity to a previously attenuated response to positive stimuli after the administration of antidepressant medication). Non-depressed subjects show only the enhanced positive bias. This enhancement of positive reactivity after medication preceded any emotional or behavior change.²

2) Another group³ showed an inability of depressed individuals to maintain activation of the reward system to positive stimuli. Putting it all together, the physiological findings parallel the psychological findings (i.e. the clinical model) and especially the observation that cognitive change precedes emotional change. I had previously described this theoretically in terms of activation of the depressive mode. Therapeutic application: One colleague has argued that since the processing is unconscious, a behavioral intervention would be the most effective approach. However, I believe that even though processing starts at a preconscious or unconscious level, it rapidly proceeds into conscious awareness. Specifically, the preconscious processing labels a particular event as good or bad, and focuses attention on the supposedly “bad” aspect of a particular stimulus (in depression). However, the complex conscious processing elaborates on this and will produce a thought such as “Since she did not respond to me with a smile, it means she doesn’t like me and therefore nobody likes me.” A cognitive intervention would then reframe this interpretation, and feeds back to reverse the negatively biased processing. It has been shown that this reframing involves an activation of a neural pathway from the cortical to the subcortical region (amygdala). The bottom-up automatic dysfunctional processing is modified by the top-down reflective processing. Cognitive therapy can be effective even when cognitive processing is largely unconscious.

“Even though processing starts at a preconscious or unconscious level, it rapidly proceeds into conscious awareness.”

References
The workshop will focus on the fundamentals of cognitive therapy and will include a conversation period with Dr. Aaron Beck, who will be celebrating his 90th birthday. The competition is open to graduate students, post-doctoral fellows, residents, and faculty in any mental health field, who study in any country.

Please answer the following questions, with no more than 200-500 words, in the body of an email and send it to beckinstitute@beckinstitute.org.

We regret that we will not be able to open attachments.

1. What is your exposure to and experience in CBT?
2. How do you intend to use CBT in the future?
3. What involvement, if any, have you had in CBT-related research?

The deadline for applications is March 1, 2011. Scholarship winners will be notified by email during the first week of April. Applicants from 2010 can re-apply.

Finally, we would appreciate your telling friends and colleagues about the scholarship competition. We look forward to reading the applications for 2011. Good luck!
Cognitive Therapy with Older People: A short review of treatment evidence and developments in theory.

Part One - Recent Evidence for CT with Older People

Ken Laidlaw, Ph.D.

Cognitive Therapy (CT) has always been a flexible treatment for the emotional disorders and it has been applied successfully in many settings with many treatment groups. This is as true for older people, as randomized controlled trials of CT largely generated in North America in the 1980s and 1990s testify. CT is now the most systematically evaluated of all the psychotherapies offered to older people. In 2009, Cuijpers and colleague’s meta-analysis demonstrated CT to be as efficacious with older people as with working age adults.

Two recently published RCTs in the UK demonstrate that CT works well with older people in primary care settings. Laidlaw and colleagues, where all participants met DSM-IV criteria for major depressive disorder criteria, is a very small study, but is one of very few psychotherapy studies in late life to show that CT alone is as efficacious as Treatment as Usual (TAU). In most cases, antidepressant medication managed by primary care physicians constituted TAU. At the end of treatment and at the six month follow-up, the CT alone group showed significant reductions in the Beck Hopelessness Scale in comparison to those who had continued to receive TAU. This demonstrates that CT provides clients with active coping strategies with a consequent impact on sense of optimism and pessimism.

Serfaty and colleagues examined CT plus treatment as usual (usually CT plus medication) in comparison to Treatment as Usual (TAU) alone (usually antidepressant medication), but in addition added a third treatment option by including a talking treatment condition (TC). TC appears to function as an attention control treatment, where therapists are warm and interested in clients but are essentially passive, offering no help with problems. One would expect CT to outperform this passive talking treatment, and it does. Indeed, CT participants on average achieved better treatment outcomes compared to TC and TAU. This is important because, as Serfaty and colleagues assert, their results show depressed older people are not simply lonely or in need of a listening ear because CT outperformed TC. It would appear that the active nature of CT treatment impacts positively upon treatment outcome. As most cognitive therapists avow and Serfaty’s study confirms, CT is more than a talking therapy and more accurately is a ‘doing’ therapy.

Treatment data for CT with older people is very good news and

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serves to emphasize what most clinical geropsychologists know already; that older people are good candidates for psychotherapy and CT in particular is especially effective with older people with emotional problems. In many respects we should not be surprised that CT works well with older people, as older people tend to value the core principles of this treatment approach because it is skills enhancing, present-oriented, problem-focused and straightforward to use, as well as effective. It also aims to be empowering of individuals, seeking to promote and encourage self-agency in the face of challenges, and adopts a non-pathologising stance in understanding a client’s problems.

References


Beck Institute sends speakers around the U.S. and the world to present half-day to full-week workshops for hospitals, professional associations, national/international conferences, managed care companies, primary care physician groups, and other related organizations. Lecturers and keynote speakers offer a wide range of cognitive therapy topics to meet the needs of your setting.

**SPEAKING ENGAGEMENTS**

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

- **March 4, 2011 – Vancouver, BC**
  Speaker: Judith S. Beck, Ph.D.
  *Cognitive Therapy for Personality Disorders*
  British Columbia Psychological Association

- **March 8, 2011 - New York, New York**
  Speaker: Judith S. Beck, Ph.D.
  *Cognitive Therapy for Personality Disorders*
  nyc-cbt.org

- **March 25, 2011 – New Orleans, LA**
  Speaker: Judith S. Beck, Ph.D.
  *Advances in Cognitive Therapy*
  American Counseling Association

- **June 2-5, 2011 - Istanbul, Turkey**
  Speaker: Judith S. Beck, Ph.D.
  *A CBT Program for Weight Loss and Maintenance; CBT for Personality Disorders*
  International Association for Cognitive Psychotherapy

- **June 27-30, 2011 - Copenhagen, Denmark**
  Speaker: Donna Sudak, M.D.
  *Differential Diagnoses*

- **July 14-16, 2011 – Seoul, Korea**
  Speaker: Judith S. Beck, Ph.D.
  *Beck Diet Solution*
  Asian Cognitive Behavioral Therapy Conference

- **November 4-5, 2011 - Mérida, Spain**
  Speaker: Leslie Sokol, Ph.D.
  *CBT for Difficult Cases*