ADVANCES IN COGNITIVE THERAPY

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ADVANCES IN COGNITIVE THERAPY SM

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USING COGNITIVE THERAPY ON OURSELVES

One of the advantages of cognitive therapy is that we can actually use it on our own thoughts and feelings about patients and how therapy is going. This is a real advantage that we have over the psychodynamic approach to the counter-transference and transference. We can use these techniques immediately.

Here is a typical example: You have been seeing a patient for three months, suggesting self-help homework that the patient agrees to do, but the patient almost never does it. The patient is intermittently critical of you because he is not getting better. Furthermore, a past therapist, no longer available, understood him more—and helped him more. The patient tells you that cognitive therapy is superficial and doesn't really deal with the deeper issues.

There are a lot of responses that you might have to this situation. One of them might be to feel angry. Another might be that you feel anxious. Or, you might even feel curious and challenged and view this as an opportunity to understand this patient's interpersonal dynamics outside of therapy (Leahy, 2001, 2003).

But let's say you are like almost all of us and you feel angry. This is a great opportunity to write out your automatic thoughts. Perhaps they are the following: "He doesn't do anything to help himself," "He's unfair," "I can't stand people like this," "Why should I help someone who won't help himself?", "He'll probably quit," "This is another failure on my part," "Someone else would have succeeded with him," and "I'm a lousy therapist."

Try the following exercise: Write out your automatic thoughts and emotions about patients where you feel stuck. Pay attention to those with whom you feel angry or anxious. Is there a pattern to your thoughts? The patterns are probably related to your own core beliefs about being a therapist—and about yourself.

Some of the most common underlying core beliefs or schemas are focused on the following: "I must cure all my patients" (Demanding Standards), "I should do everything that I can to help them" (Self-Sacrifice), and "My patients will leave me and my practice will fall apart" (Abandonment; Incompetence). Not surprisingly, when I give workshops on the therapeutic relationship and resistance to change the most common core belief is about Demanding Standards. People who take workshops are often seeking perfection.

You can address your automatic thoughts using standard cognitive therapy techniques. For example, you might start monitoring and recording these thoughts---what triggers them? Do you have these thoughts when patients are frustrated, angry, indifferent, late, or miss sessions? Are you engaged in personalizing and mind-reading ("The patient is late because he thinks this isn't working"), or catastrophizing ("It's terrible when patients are angry with me"), or labeling ("He's a narcissist")? You can examine the costs and benefits of your thoughts—for example, the costs may be that you get angry, withdraw, retaliate, or you are hesitant to assert yourself. The benefits might be that you hope to be on guard, not surprised, and highly defended. You might examine the evidence for and against your thoughts---for example, if the patient is late, perhaps the patient is late for everyone. Or, if the patient is not doing the homework, it might be because he feels incompetent or ashamed.

> ***You can use these impasses as a window into the patient's interpersonal world***

You can use these impasses as a window into the patient's interpersonal world (Leahy, 2007). Perhaps the patient tends to

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Weight Loss and Cognitive Therapy

It is astonishing that obesity and being overweight have become such serious public health problems among adults, children and adolescents, despite the proliferation of public education programs, weight loss plans, diet foods, medication, and surgery. Not only do most people have difficulty losing weight, but nearly everyone who does lose weight gains some or all of it back within 5 years (and many within the first few months). Why are weight loss and maintenance so hard to achieve? One important factor is dieters' dysfunctional cognitions. In *The Beck Diet Solution*, I've outlined key eating-related beliefs, elicited from unsuccessful dieters.

Beliefs about hunger: Unsuccessful dieters generally believe that people should not feel hungry and, in fact, should avoid hunger. In addition to having low tolerance for hunger, many actually fear it. Interestingly, they usually do not initially recognize this fear. Fear of hunger becomes apparent, however, when they are asked to experiment with skipping meals in order to assess and learn to tolerate their hunger.

Beliefs about food: Unsuccessful dieters usually categorize food as either "good" or "bad." When they eat "bad" food, they often display self-deluded, thinking: "Since I've cheated, I may as well keep on eating ["bad" food] for the rest of the day and start my diet again tomorrow."

Beliefs about perfectionism: Unsuccessful dieters often believe that they should, and need to be, perfect in their endeavor to lose weight. They tend to label themselves as either "good" when they've been completely faithful to their diet or "bad" when they have not.

Beliefs about dieting: Perhaps fueled by the media, most dieters believe that dieting should be easy and fast. When they inevitably find that dieting is slow and at times difficult, they tend to over-generalize. They often characterize their whole dieting week as difficult instead of realizing that they struggled for just a few hours during the week. They also catastrophize, worrying that dieting will always be painful and challenging and doubting their ability to keep going.

Beliefs about "normal" weight people: Unsuccessful dieters tend to believe that people of normal weight rarely restrict their eating and rarely get hungry.

Beliefs about unfairness: Many unsuccessful dieters have ideas about unfairness that lead to demoralization and a reduction in motivation. They believe that it just isn't right that they should have to restrict themselves and expend a significant amount of time and energy to lose weight (when others, they mistakenly believe, do not).

Unsuccessful dieters generally believe that people should not feel hungry and, in fact, should avoid hunger.

Beliefs about self-efficacy: Unsuccessful dieters often view themselves as being either "in control" or "out of control." When they deviate from their diets, they begin to view themselves as helpless and become convinced that they will never be able to sustain the behavioral change needed to lose weight or keep it off.

Beliefs about weight gain: Unsuccessful dieters believe that they should lose weight every week (and, in fact, that they should be able to continue losing weight at the same rate as they did during the first week of their diet). When they fail to lose weight or when they actually gain weight one week (a normal and frequent occurrence, even if they've kept their calorie count and exercise constant), they believe that they have done something wrong or that their diet isn't working. They frequently conclude that it's just not worth trying to stick to a diet.

Beliefs about maintenance: Unsuccessful weight maintainers often believe that they should not have to institute lifetime changes in their eating behavior. They also tend to believe that they should be able to maintain the lowest weight they have achieved, a goal that is unrealistic for most people.

Beliefs about entitlement: Unsuccessful dieters often believe that they are not entitled to inconvenience or disturb anyone else in their quest to lose weight. They believe it is not right to take time to fulfill crucial dieting tasks (planning their meals, shopping, preparing food, eating meals slowly, exercising) if doing so means disrupting others, especially family members. They often believe that they should not make requests, such as keeping highly tempting foods out of the home. On the other hand, they often have entitled beliefs that lead them to eat in maladaptive ways, for example, "I'm entitled to abandon my diet if I'm celebrating, if I'm upset, or if other people are eating food I'm not supposed to eat."

These are just a few of the dysfunctional beliefs of those who struggle to lose weight. Incorporating a strong focus on identifying, monitoring, and continually responding to dieters' maladaptive ideas, in addition to behavioral change, can lead to more effective weight loss programs.

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Reference:

J. Beck (2007). The Beck Diet Solution. Birmingham, AL: Oxmoor House. www.beckdietsolution.com

NEWSLETTER SUBMISSIONS

Submissions to *Advances in Cognitive Therapy / Cognitive Therapy* are accepted on an ongoing basis. Topic areas include clinical issues, research updates, conference and training information, and summaries of CBT-related activities around the world. We are particularly interested in submissions from practitioners and researchers outside of the U.S. Submissions should be 350-700 words and sent in Word format with no more than five references.

Send submissions to:
Dr. Lynn McFarr

L.McFarr@ucla.edu

Important Announcement of Change in Our Official IACP Journal and Publisher

The International Association for Cognitive Psychotherapy (IACP) is delighted to announce the launching of its new official journal, *International Journal of Cognitive Therapy*, in early 2008. The new journal, which will move from Springer's Journal of Cognitive Therapy, will be the true IACP journal and will be published by the leading CBT publisher in the world. Focusing on theory, research, and therapy, the *International Journal of Cognitive Therapy* is dedicated to keeping clinicians and researchers up to date on the latest state-of-the-art developments and research by leading clinicians and researchers. Associate Editors for the new IACP journal will include Clive Robins (Duke University Medical School), Robert Leahy (American Institute of Cognitive Therapy), Paul Gilbert (University of Derby, England), Judy Beck (Beck Institute), and Stefan Hofmann (Boston University). The Editor of the *International Journal of Cognitive Therapy* will be announced in the fall. The journal particularly favors manuscripts in these areas: 1. Empirical studies of cognitive therapy and process; 2. Novel theoretical formulations or developments; 3. Review articles of literature related to cognitive-behavioral treatment; 4. Case studies, especially those that illustrate novel application of techniques, or that contribute to current knowledge; 5. Special issues that advance understanding of the field. We are very excited because the publisher that the IACP has chosen for the new IACP journal has a long track record of promoting cognitive therapy and distributing its journal publications and will provide on-line access to the journal to all subscribers. Although we wish Springer Publishing all success in continuing to publish the Journal of Cognitive Psychotherapy, it will not be the true IACP journal as of January 2008.

AWARDS

Congratulations to ACT member award winners! **Aaron T. Beck**, M.D. received the **Lasker Award for Clinical Medical Research** "for the development of cognitive therapy, which has transformed the understanding and treatment of many psychiatric conditions, including depression." **Paul Salkovskis** (2006) and **David Barlow** (2005) received the **Aaron T. Beck Award** which is presented each year at the ABCT Annual Conference to an individual who has made significant and enduring contributions to the field of cognitive therapy. Finally, a much belated congratulations to **Frank Datillio** for **ABCT's**

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CBT in Psychiatric Nursing

Cognitive behavior therapy (CBT) has migrated into the disciplines of social work, counseling, psychiatry and advanced practice nursing (APN) to name a few (Freeman, 2006). Disciplines such as nursing (Freeman & Roy, 2005) that sub-specialize in mental health practices have recognized the effectiveness and utility of techniques and interventions that meet the scientific standards of empirical testing, such as CBT. In APN practices the approaches become more complicated as psychiatric medication, physical complications, and psychological conditions interplay (Beck & Reilly, 2006). The end result is that APNs are employing psychological and pharmacological interventions simultaneously.

APNs are trained to recognize the nuances inherent in most medical conditions that coexist with psychiatric conditions. The APN is therefore in an ideal position to rule out conditions that would confound the psychiatric diagnosis. The psychiatric APN can rule out and treat hypothyroidism for example with simple blood tests on site without breaking stride with psychotherapy. Medical conditions such as chronic pain disorders have proven efficacy with combined pharmacotherapy and CBT approach which would be the ideal purview of the psychiatric APN trained in CBT (Thomas, 2005).

Case Example: Use of CBT by APN: *Woman with Breast Cancer*

Amy is a 41-year-old single woman diagnosed with breast cancer. Amy has undergone two sequences of an 8 sequence series of chemotherapy treatments following a mastectomy without reconstruction. Amy makes an appointment with her APN, Ginger, for evaluation of depression. She reports difficulty falling asleep, early morning awakening at 4:00 a.m., tearfulness, anergia, amotivation, hopelessness, and helplessness.

Amy has negative self views *("I am so ugly now")* and her future *("I don't believe I will ever have a normal life again")*. Ginger completes a medical evaluation for hypothyroidism and anemia, and finds that serum levels are normal. Amy is experiencing several side-effects from the chemotherapy including thrush and neuropathy. Ginger is anxious that the chemotherapy may have to be discontinued. Ginger evaluates her for suicidal ideation which is negative.

Ginger: *"You said that your life will never be normal again. What do you mean by normal?"* (Evaluating idiosyncratic meaning)

Amy: *"I am so deformed and I don't have any energy and I don't care about anything anymore!"*

Ginger: *"Which is more troubling - feeling deformed, no energy, or not caring about anything?"* (Note: Ginger is helping Amy focus on one problem/issue at a time, making change more reasonable than a "scattergun" approach).

Amy: *"If I have to choose, I would say feeling deformed."*

Ginger: *"Okay. Let's start there. Tell me more about feeling deformed."*

Amy: *"I don't have a nipple; I have this huge scar across my chest! I feel like a freak!"*

Ginger: *"What choices have you discussed with your surgeon about replacing your nipple?"* (Examining alternatives)

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CBT IN PSYCHIATRIC NURSING

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Amy: *"He said I could have more surgeries to build one, or I could get a tattoo of a nipple."*
Ginger: *"Which option is more appealing?"* (Note: Ginger did not ask if one option was more appealing. She gave limited choices.)
Amy: *"I think a tattoo – no more surgeries!"*
Ginger: *"Would the tattoo make you feel more or less deformed?"* (Note: the answer seems obvious; however, it is important for Amy to start the momentum.)
Amy: "*A lot less deformed – more normal again."*
Ginger: *"What have you investigated about tattoos?"*
Amy: *"Nothing."*
Ginger: *"Where will you start?"* (Note: Ginger does not ask a question that allows for a non-start reply.) (homework)
Amy: *"Well, my girlfriend got a tattoo last month -- I can ask her where she went. She is going to laugh when I ask her about a tattoo parlor!"* (Amy is now laughing, which indicates a shift from negative to positive mindset.)
Ginger: *"You'll have to let me know how that goes!"* (Note: Again, Ginger states her response in the affirmative expectation that Amy will follow through as opposed to asking her if she will ask her girlfriend, which would allow for a negative response.)

Conclusion

There has been a rapid increase in the numbers of psychiatric nurses who obtain advanced degrees and develop independent practices. Their practices become more complicated as psychiatric medication, physical complications, and psychological conditions collide. CBT has been proven to integrate well into psychiatric APN practice and meets the scientific standard for effective techniques and interventions that are empirically based.

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Beck, J. S., & Reilly, C. (2006). Nurses Integrate Cognitive Therapy Treatment Into Primary Care: Description and Clinical Application of a Pilot Program [Electronic Version]. *Medscape Nursing*, 6. Retrieved 9/19/06 from http://www.medscape.com/viewarticle/544402.

Freeman, S. M. (2006). Cognitive Behavioral Therapy in Advanced Practice Nursing: An Overview [Electronic Version]. *Medscape Nursing*, Topics in Advanced Practice Nursing eJournal. Retrieved 10/19/06 from http://www.medscape.com/viewarticle/545336.

Freeman, S. M., & Roy, S. C. (2005). Cognitive Behavior Therapy and the Roy Adaptation Model: Integrating CBT into Nursing Practice. In S. M. Freeman & A. Freeman (Eds.), *Cognitive Behavior Therapy in Nursing Practice* (pp. 3-28). New York, N.Y.: Springer Publishers.

Thomas, V. J. (2005). Cognitive behavioural therapy in the management of chronic pain. In S. M. Freeman & A. Freeman (Eds.), *Cognitive Behavior Therapy in Nursing Practice* (pp. 145-166). New York, N.Y.: Springer Publishers.

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depend on other people and then blame them for not solving their problems. Or perhaps the patient feels that his problems are unsolvable and all he wants is to ventilate and get validation. Perhaps the patient is stuck in the victim role and thinks that someone else causes his problems so he shouldn't have to change.

Whatever you are experiencing with the patient is probably similar to what others experience with him. In order to use the impasse constructively, you could elicit the patient's automatic thoughts about homework and about being frustrated with therapy. These might be thoughts like, "I can't do anything right," or "Everyone lets me down." Or they might be thoughts about a magical cure, "I thought this therapy worked immediately and I still have problems."

You might address the issue of how the patient expresses his frustration with other people: "Are there people and situations in your life that you feel frustrated with? What are your expectations? What thoughts do you have about them when they 'let you down'?" These automatic thoughts and assumptions can then be addressed by examining alternative interpretations, encouraging the patient to be skillful in assertion, utilizing mutual problem solving, helping the patient learn how to ask for help in a more constructive and less "game-playing" fashion, and setting up behavioral experiments in which the patient must do self-help before blaming or depending on someone else. Part of the self-help could be listing all the reasons why self-help won't work and then examining the evidence for and against the self-help and committing to incompleteness and imperfection as successful goals.

We find that patterns reflecting interpersonal schemas begin to emerge through the exploration of frustration in sessions. Non-compliance with homework, withdrawing from or criticizing the therapist, and even no-shows in therapy can become opportunities for deepening the therapeutic experience. Therapists with high drop-out rates are often missing these valuable opportunities, which further adds to their own frustration and anger. Imagine, if you could, that non-compliance could be viewed as an inevitable part of therapy from which you derive the most meaningful information and opportunities for your own growth. By re-framing "non-compliance" as "collecting new information about the real-world for this patient" you will help reduce your own frustration and anger.

Robert L. Leahy, Ph.D., ACT
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Leahy, R.L. (2001) Overcoming Resistance in Cognitive Therapy. New York: Guilford.

Leahy, R.L. (2003) Roadblocks in Cognitive-Behavioral Therapy: Transforming Challenges into Opportunities for Change. New York: Guilford.

Leahy, R.L. Schematic mismatch in the therapeutic relationship: A social-cognitive model (pp.229-254). In Gilbert, Paul and Leahy, R.L. (2007) (Editors), The Therapeutic Relationship in the Cognitive Behavioral Psychotherapies. Routledge, London.

Book Review: Treating Survivors of Childhood Abuse

Cloitre, M., Cohen, L.R., Koenan, C.K. (2006). ***Treating Survivors of Childhood Abuse: Psychotherapy for the Interrupted Life.*** **New York: Guilford Press.**

The treatment of individuals with histories of abuse in childhood is frequent in all mental health settings, particularly in public and community clinics. As mental health centers look for evidence-based practices that are also informed by input from the individuals in treatment, this new book is particularly welcome. The authors have looked at the empirical evidence for treatment models targeting the symptom clusters they have identified and have listened to the women they have treated over the last ten years, incorporating their feedback into the treatment model. The resulting treatment model, a brief psychotherapy targeted to this population, is explained in this combined workbook and text.

This well thought out and reasoned volume is a strong addition to our understanding and treatment of adults, particularly women, disabled as a result of abuse they suffered in childhood. The authors begin by grounding the text in a thorough delineation of a "resource loss" model of childhood abuse trauma. Drawing on a large body of research in child abuse, attachment, and PTSD, the authors effectively lay the groundwork for their therapeutic model. This model has two phases: "Skills Training in Affective and Interpersonal Regulation" (STAIR) and "Narrative Story Telling" (NST). These phases address three general symptom areas: symptoms of PTSD, problems with emotion regulation, and interpersonal problems.

After an extensive review of theoretical underpinnings, pertinent literature review, and rationale for the chosen treatment approach in the first nine chapters, the authors detail each of the 16 sessions in a separate chapter. There are guidelines about how to assess individuals from the first telephone contact, how to know when to move to the next phase, and how to treat those with common comorbidities. Some of the instructions are quite specific but there are also suggestions made for flexibility points in the therapy. Several difficult areas are also addressed. For instance, the authors wade into the controversy of continuous versus recovered memories, specifying that one inclusion criterion for this therapy is that the individual have at least one continuous memory of abuse. Suggestions about how to address someone appropriate for the therapy who also meets criteria for Borderline Personality Disorder are also given. Some chapters include reproducible handouts and worksheets for use in the therapy as adjuncts and homework assignments.

In the first phase Skills Training in Affective and Interpersonal Regulation (STAIR), which consists of eight sessions, the target symptoms of poor emotion regulation and interpersonal problems are addressed by working to gain skills in emotional awareness, regulation, and increased engagement. The client is helped to identify personal schemas and to test hypotheses about these schemas in and out of the sessions. This initial phase allows for the development of a strong therapeutic rapport and improved emotion regulation skills before moving to the second phase for the final eight sessions.

In the second phase, Narrative Story Telling (NST), all three symptom groupings are addressed. With the rapport built and the emotion regulation skills learned, the stated goal of the narrative work is to help the individual resolve PTSD symptoms, organize traumatic memories, and develop an integrated life story by narrating the memories of trauma in sessions and learning to experience them with depth and control. These final eight sessions are audio taped so the individual may listen to the session daily to increase habituation.

This detailed treatment manual integrates the treatment of interpersonal, cognitive, and emotional regulation problems into a phased, short-term treatment. It does this in a structured way which should lend itself to outcome research and application in a wide variety of settings. It deserves consideration from clinicians at all levels of experience.

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What do we know about effective dissemination & training approaches?

In the past 10 years, there has been a significant expansion of evidence based practices (EBPs) for severe psychiatric disorders (schizophrenia, bipolar disorder, severe recurrent depression, etc.). Although, effective practices have been established in principle, actual clinical practice at the community mental health level has lagged significantly behind. There is a substantial disconnect between what has been found to be effective dissemination and training strategies based on research and what actually happens in practice.

Fixsen et al (2005) in their comprehensive monograph reviewing effectiveness of dissemination practices draw the following conclusions: "Although these [information dissemination and training] have been two of the most widely used methods for attempting implementation of policies, programs, and practices, they repeatedly have been shown to be ineffective in human services, education, health, business, and manufacturing." (page 70)

In general, standard training approaches presenting didactic material in workshop lecture formats are highly ineffective in promoting sustainable changes in actual clinician behaviors. Enhancing the traditional approach with an emphasis on continuing coaching and specific feedback in small group case presentations and use of ongoing small group supervision utilizing tape recorded therapy sessions appears to provide important additional support for helping clinicians make and sustain changes in practice.

Our study describes results of a two-year project funded by The Health Trust of San Jose, California involving dissemination of evidence based practices (EBP) to clinicians working primarily with young adults in community mental health outpatient clinics in Santa Clara county. Changes in attitudes and preferences toward EBPs were assessed in a highly culturally diverse group of providers as a function of their exposure to, and participation in, training in EBPs. Cognitive-behavioral therapy (CBT) was empha-

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Cultural Competencey in Cognitive Therapy

Over the past several decades, global streams of immigration have changed the face of most societies, requiring therapists to become more sensitive to the role of culture and context in the therapy relationship. Many of us regularly find ourselves sitting across the room from a client who does not share our background. Regardless of whether those differences are cultural, racial, ethnic, or socioeconomic, it is important to acknowledge those differences by carefully attending to cues that our own beliefs, values, and assumptions may not be shared equally by our clients. In this article, suggestions for successful application of CBT to culturally diverse populations will be provided, with examples focusing on treating Asian American and African American clients.

One of the key advantages of cognitive-behavioral therapy in working cross-culturally is that the theoretical assumptions of the approach are made explicit early on in the therapy. During the initial socialization phase and over the course of treatment, however, it is important to engage the client in a dialogue to assess how their own understanding of their problem, including its cause and cure, compares to that of the cognitive model. The discussion can help to clarify expectations and reduce ambiguity regarding the process of therapy and the roles and responsibilities of the therapist and client.

For example, recent reviews of the research on treating Asian Americans suggest that Asian-American clients' preference for structured and directive approaches in therapy make them particularly amenable to CBT (Leong, Chang, & Lee, 2006; Lin, 2001). However, the cultural emphasis on respect and deference to authority may make it difficult for them to challenge the therapist or express disagreement, often resulting in premature dropout from treatment (Chen & Davenport, 2005). A similar dynamic has been observed in individuals with low levels of income or education. As a result, it is important to actively solicit both verbal and written feedback from the client over time, assessing their comfort with the therapy process, and showing interest in their unique experience of their problem and treatment.

As the therapy progresses, particular beliefs held by the client may be identified as underlying maladaptive behaviors. However, when those beliefs are linked to core cultural values that have been passed down from generation to generation, the client may resist applying a rational approach to evaluating their validity. Among individuals who come from collectivistic cultures such as Asian and Hispanic/Latino cultures, this reluctance may stem from a belief that by examining and challenging these beliefs, one is being disrespectful to one's elders. Indeed, they may feel like they have a responsibility to honor their parents and respected family members by upholding sacred family values, even if they are no longer adaptive.

Chen and Davenport (2005) cautioned that in working with Asian Americans in particular, the emphasis on filial piety and the hierarchical family structure may produce resistance to confronting beliefs considered important to maintaining family harmony. For example, one of my Chinese American patients was reluctant to challenge her belief that one can only trust people within the family, a belief inherited from her parents, both survivors of the Cultural Revolution.

In such cases, it may be helpful to acknowledge that these beliefs may have been adaptive during certain periods in one's family history, but may no longer be applicable today. In my client's case, it was helpful to acknowledge the origin of her parents' beliefs and their desire to protect her from the traumas that they experienced first-hand. This helped her to recognize that she could hold different beliefs that were more valid given her own life circumstances, without labeling her parents' worldview as inherently "irrational" or "dysfunctional".

In a similar vein, clients who are members of oppressed minority groups, whether in their home or chosen countries, may have adopted a mistrustful stance that may appear irrational to an outsider. However, it is important to consider the possible adaptive function that such vigilance may serve, as well as the potential psychological and interpersonal costs to the individual. Some African American researchers for example, have suggested that some degree of mistrust towards the larger White society, termed "healthy cultural paranoia" is protective against racially-based assaults on the self esteem of Black Americans (Ridley, 1984). From this perspective, cultural paranoia may be conceptualized as a type of cultural coping response in African Americans. Under these circumstances, therapists are cautioned to acknowledge the social and contextual factors that may contribute to the development of clients' core beliefs, even if they do not mirror the therapists' own experiences and worldviews.

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References

Chen, S.W., & Davenport, D.S. (2005). Cognitive-behavioral therapy with Chinese American clients: Cautions and modifications. Psychotherapy: Theory, Research, Practice, Training, 42(1), 101-110.

Leong, F., Chang, D.F., & Lee, S-H. (2006). Counseling and Psychotherapy with Asian Americans: Process and Outcome. In F. Leong, A. Inman, A. Ebreo, L. Yang, L. Kinoshita, & M. Fu (Eds.), Handbook of Asian American Psychology (pp. 429-447). Thousand Oaks, CA: Sage.

Lin, Y-N. (2001). The application of cognitive-behavioral therapy to counseling Chinese. American Journal of Psychotherapy, 55(4), 46-58.

Ridley, C.R. (1984). Clinical treatment of the nondisclosing Black client: A therapeutic paradox. American Psychologist, 39, 1234-1244.

AWARDS

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Outstanding Clinician Award (2005) for significant international service in the field of Cognitive Behavioral Therapy. The award is only given every three years. So our congratulations arrive only shortly before the award is given again!

What do we know about effective dissemination & training approaches?

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sized including training in both basic and more advanced application of CBT theory and practices to young adult clients with serious mental illnesses including schizophrenia, bipolar disorder, severe recurrent depression and PTSD.

Attitudes towards innovation act as antecedents to the decision to try new approaches, making clinician attitudes, preferences and behavior key determinants in facilitating the dissemination and implementation of EBPs (Aarons, 2004; Baumann, Kolko, Collins & Herschell, 2006). Much prior research on empirically supported interventions has focused on doctoral level psychologists and the use of manual–based treatments (Addis & Krasnow, 2000). However, in most community mental health clinics, mental health services are provided by master's level clinicians. While there is growing interest and debate about the dissemination and adoption of empirically supported treatments in real world mental health delivery systems, little is known about effective strategies for directly influencing clinician attitudes and behaviors in such settings. The aim of the current study was to determine if provider attitudes towards EBPs in a highly diverse group of practitioners was related to the amount of specific training received in EBPs. It was hypothesized that number hours of training attended would be correlated with positive attitude towards, and preference for using, EBPs in actual clinical work.

Sixty-six mental health clinicians representing 24 agencies in the Santa Clara County mental health system participated in the training program. In order to address the problem of translating knowledge into practice, the researchers developed a three tiered training model. Each of these training components was delivered on a weekly basis:

1) A first tier of training on the "basics" of CBT involving presentation of information in a didactic lecture format supplemented with videotaped examples of live interventions with a group of 20-25 clinicians.

2) A second tier of training which focused on coaching clinical staff in providing interventions through the use of role-playing and feedback, rehearsal of skills, etc.; and

3) A third tier of training in a small group format (8-10 clinicians maximum) where clinicians were required to audiotape sessions which were reviewed by Academy of Cognitive Therapy-certified clinical psychologists with a focus on assisting clinicians in providing specific types of interventions consistent with evidence-based practices.

The program also included 80 hours of intensive one to three day workshops focusing on the application of CBT to multi-problem, chronically mentally ill clients with content experts including David Kingdon, David Fowler, Leslie Sokol, Lynn McFarr, Robyn Walser, David Mee-Lee and Jennifer Gregg. At the end of the training program, clinicians completed a survey that was distributed through multiple channels including the internet, telephone and email.

The survey included demographic and background information, the Evidence-Based Practice Attitudes Scale (EBPAS, Aarons, 2004), and a series of five-point Likert scale items regarding participants' satisfaction with the training program. The EBPAS was developed by Dr. Greg Aarons to explore mental health provider attitudes towards evidence-based practices in community settings. The scale includes four dimensions of attitudes towards the acceptance of evidence-based practice with subscales including Appeal, Requirements, Openness and Divergence factors. Appeal is defined as interest in EBPs. Requirements measures the likelihood of utilizing EBPs given the means to do so. Openness measures the degree of receptiveness to new practices. Divergence (negatively correlated to other subscales) measures the perceived disparity between usual practice and research based treatments.

Forty clinicians completed the survey out of a total group of 66 who participated in the two year period – a 60% response rate. A majority of the respondents were female (70.5%) and over the age of 30 (77%). Clinicians were highly ethnically diverse and broadly representative of the population in this area of California: 35% were Caucasian, 30% were Hispanic/ Latino, 20% were Asian/Pacific Islander, 7.5% were African American, 5% indicated multiracial or other ethnicity, and the 2.5% declined to specify ethnicity. A majority of the clinicians had a Masters degree (87.5%), 60% were licensed practitioners at the masters' level, and 80% were front line clinicians (versus case managers or supervisors).

Our analyses indicated that hours in training were significantly correlated with both the Appeal subscale ($r = .52$, $p<.01$) and the Openness subscale ($r = .47$, $p< .01$) of the EBPAS. In addition, clinician's licensure status was positively correlated with the Divergence subscale ($r=.36$, $p<05$). This is consistent with prior research that indicates that interns are more open to innovative practices then licensed clinicians (Garland, Kruse & Aarons, 2003). No relationship was found between education, previous training or experience. Prior research reported that these characteristics are related to attitudes towards EBPs (Ball, Bachrach, DeCarlo, Farentinos, Keen et al, 2002).

These results suggest that increasing amounts of exposure to evidence-based practices in didactic and small group consultation–based training (but not workshops!) correlates with clinician acceptance of evidence-based practices. Limitations of the study include the voluntary nature of participation in training, clinician's ability to drop out of training at any time and the lack of a comparison group of untrained clinicians.

Much of the research on attitudes towards treatment has focused on doctoral level psychologists and use of empirically supported interventions or manual-based interventions (Addis & Krasnow, 2000). Dissemination of EBPs within a broader mental healthcare delivery system mainly to masters' level practitioners raises an interesting question about the diverging agendas between credentialing and dissemination efforts. Credentialing has the goal of stringently limiting accreditation to "experts" who practice a highly uniform type of therapy readily distinguishable from any other type of practice (i.e. the Academy) thereby increasing internal validity, consistency, and fidelity to the model. Realistically, credentialing 100% of master' level practitioners is not a feasible use of resources. Yet, master' level clinicians (and unlicensed interns) tend to provide the bulk of care to the most seriously ill clients especially in public mental health systems. The objective of dissemination is to help clinicians apply new practices in real world settings with difficult multi-problem clients. Given that we have a massively underserved population that could never be appropriately served solely by highly credentialed ACT experts, the goal of dissemination is not to transform clinicians into highly credentialed experts, but to give them sufficient basic skills that can be applied in their settings in order to reach

(Continued on page 8)

DISSEMINATION

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and impact as many clients as possible.

This is consistent with a "stepped care" model where initial care for less serious and persistent problems is delivered by a generalist mental health practitioner. If a problem becomes more severe, the next step is a referral to a first level specialist. A model of this type of "stepped care" is provided by the National Institute for Health and Clinical Excellence (NICE) in several of its clinical guidelines.

We hope that this discussion will stimulate further thinking about the kinds of training models we will need to select in the future in order to be effective in large-scale dissemination of EBPs in community settings.

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Aarons, G. A. (2004). Mental health provider attitudes toward adoption of evidence-based practice: The Evidence-Based Practice Attitude Scale (EBPAS). *Mental Health Services Research*, *6*(2), pp. 61-74.

Baumann, B. L. Kolko, D. J. & Collins, K. Understanding practitioners' characteristics and perspectives prior to the dissemination of an evidence-based intervention. *Child Abuse & Neglect, 30*(7), pp. 771-787.

Addis, M. E. & Krasnow, A. D. (2000). A national survey of practicing psychologists' attitudes toward psychotherapy treatment manuals. *Journal of Consulting and Clinical Psychology, 68*(2), pp. 331-339.

Fixsen, D., Naoom, S., Blase, K., Friedman, & Wallace,F. (2005). Implementation reseach: a synthesis of the literature. http://nirn.fmhi.usf.edu/resources/publications/Monograph/.

CALL FOR PAPERS

We are now calling for papers for the first volume of the *International Journal of Cognitive Therapy.* The Editor of the new journal will be formally announced in August. **If you would like to submit a manuscript, or discuss ideas for a submission or for special issues, please feel free to contact the Temporary Publications Chair, Robert L. Leahy, at Leahy@CognitiveTherapyNYC.com, or at American Institute for Cognitive Therapy, 136 E. 57th Street, #1101, New York, New York 10022 USA.**

Associate Editors for the new IACP journal will include Clive Robins (Duke University Medical School), Robert Leahy (American Institute of Cognitive Therapy), Paul Gilbert (University of Derby, England), Judy Beck (Beck Institute), and Stefan Hofmann (Boston University). The journal particularly favors manuscripts of the highest quality in these areas: 1. Empirical studies of cognitive therapy and process; 2. Novel theoretical formulations or developments; 3. Review articles of literature related to cognitive-behavioral treatment; 4. Case studies, especially those that illustrate novel application of techniques, or that contribute to current knowledge; 5. Special issues that advance understanding of the field. The IACP staff is very excited because the publisher that it has chosen for the new journal has a long track record of promoting cognitive therapy and distributing its journal publications and will provide on-line access to the journal to all subscribers. We wish Springer Publishing continuing success in publishing the *Journal of Cognitive Psychotherapy*, but it will not be the true IACP journal as of January 2008.

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