

Cognitive Therapy Today®

Volume 13 Issue 2

Fall 2008

From the Director

Judith S. Beck, Ph.D.

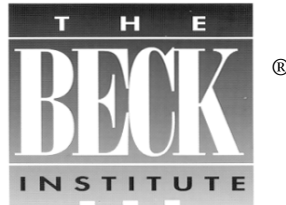
Dieting is about Food, Too

As you can tell from the last few newsletters, I've been occupied lately with developing a CT approach to weight loss and maintenance. After reading literally thousands of online postings and emails from people following the program in my first book and workbook, I realized there was an additional obstacle to permanent weight loss: People were choosing diets that were insufficiently healthy or sustainable. So I worked with a registered dietician to create an eating plan that people could follow for life. *The Complete Beck Diet for Life*, out in late December, contains both a cognitive behavioral program to teach dieters essential skills and a diet (along with a step-by-step process to gradually integrate it into one's eating).

What's wrong with many existing diets?
What mistakes do dieters make?

- ◆ They choose diets they can't sustain for life: fad diets; liquid diets; diets with pre-packaged foods; diets that are too complicated or inflexible for real life situations; diets that contain too few calories.
- ◆ They skimp on food during the day (even skipping breakfast or lunch), then spend too many calories after dinner.
- ◆ They eat whenever they feel like eating, instead of on a regular schedule.
- ◆ They choose too many simple carbohydrates and not enough lean protein and healthy fats.

(Continued on page 4)



For Cognitive Therapy
and Research

Inside This Issue:

New Initiatives. Page 1
Dieting is about Food, Too. Page 1
Obsessive Compulsive Disorder. Page 2
Cognitive Therapy for Couples. Page 3
Announcements. Page 6

Cognitive Therapy Workshops at Beck Institute

Upcoming Dates:

- February 23 - 25, 2009
- March 30 - April 1, 2009
- June 1 - 3, 2009
- July 13 - 15, 2009
- September 14 - 16, 2009
- November 9 - 11, 2009

* * *

Also Announcing:

**The Beck Diet Program
Special One-day Workshop for
Professionals and the Public —**

September 13, 2009

Email dietprogram@beckinstitute.org
for more information

* * *

*Additional information on training
opportunities is available on our website!*

Please visit www.beckinstitute.org

From the President

Aaron T. Beck, M.D.

New Initiatives

At the Psychopathology Research Unit at Penn, we are carrying out three major Cognitive Therapy projects: 1) training counselors in the community, 2) training medical specialists who work in Veterans Administration hospitals in CT, and 3) treating patients who suffer from schizophrenia in a controlled study.

We are training community counselors through a group called Community Behavioral Healthcare, the managed care entity of Philadelphia that works with various mental health centers to treat publicly funded mental health patients.

The agencies receiving training are:

1. four Community Mental Health Centers, including a substance abuse center
2. a mental health center for children and adolescents at a local high school
3. a center for seniors
4. the Transcultural Center that treats individuals with various gender and sexual orientation issues
5. a psychosis treatment center

We are also moving toward a contract with the city to train counselors who deal with parolees and possibly with counselors who work within the prison system.

One of the most serious issues among veterans is suicide. An attempt is typically discovered either in a primary care doctor's office or in an emergency

(Continued on page 4)

Be sure to tell your colleagues about our newsletter! To subscribe, visit www.beckinstitute.org, click on Newsletters.

Obsessive Compulsive Disorder: Signifying Nothing

Norman D. Cotterell, Ph.D., Clinical Coordinator

There is a fine line between entrenched obsessions and delusions. A patient might believe—or merely have the thought—that people are talking about her, or a ritual will prevent catastrophe, or her husband is an impostor. In each of these cases, her degree of belief in the problematic idea varies. Patients can move easily from skepticism to conviction and back again: “I don’t know if it’s true but it might be true. If it is true, why is it happening? I can’t be absolutely certain what’s going on. I need some proof or some indication that this isn’t true. But I’m still uncertain and I feel helpless to change. This seems crazy but on the other hand it feels true.”

The ability of patients to recognize that their obsessions are excessive or unreasonable can change from session to session. Clinically we find two useful distinctions when working with obsessions: (1) patients’ distress in having intrusive thoughts and (2) how they try to make the distress go away.

Words, words, words

Rachman & de Silva (1978) showed that even “ordinary” people can have excessive, unreasonable, intrusive (and even violent) thoughts from time to time. If we regard intrusive thoughts as fleeting and either amusing or harmless, they quickly vanish and do not plague us. When we *fear* them, though, they often turn into obsessions as we develop inaccurate beliefs about them and develop mental or behavioral rituals to counteract them. One kind of belief about intrusive thoughts involves a fear of internal events: “If I don’t control this thought, I’ll lose control, I may act on it, I’m weak, I’m out of control, I’m bad.” A second kind of belief involves a fear of external events: “If I don’t control this thought, it may come true, it may be an omen, something bad might happen, people will be harmed.” A third involves fear of having responsibility for a terrible

outcome: “I can’t take the risk, even the smallest chance is too large, I must do everything I can to prevent something bad from happening.”

John (not his real name) is unusual in that his rituals change from day to day, even hour to hour: “Touch this. Don’t touch that. Think only good thoughts.” What is absolutely consistent, though, is his belief that if he doesn’t follow these rules, something extremely bad will happen. He knows that if he decides to disobey the intrusive thought by not engaging in the compulsive behavior and something bad does happen (any time, any place), he will make the connection and feel an overwhelming, extraordinarily painful sense of guilt. With encouragement, he does a therapeutic experiment to hold off on the ritual for five minutes, even though he is thinking, “My fears will come true. This is very uncomfortable. I hate this. Something horrible really might happen and it will be my fault.”

These thoughts reflect a fear of internal events (feeling burdened, overwhelmed, out of control), external events (fear coming to fruition), and responsibility (“with great power comes great responsibility”).

In treatment, we examined the beliefs behind these thoughts and asked, “What’s the evidence that my beliefs about my obsessions are accurate? What’s another way to understand my obsessions? What are the advantages of continuing to believe this? What are the disadvantages of believing this? What are the benefits of change?” One crucial goal is for him to no longer fear these thoughts, through a combination of psychoeducation, examination, and acceptance.

Without Control

Even if people don’t fully believe their intrusive thoughts, they do have absolute, incontrovertible evidence that the rituals and compulsions prevent or reduce their

anxiety. John intellectually understood the importance of exposure and response prevention (ERP): exposing himself to the feared situation and preventing himself from engaging in rituals. He also knew that ERP would dramatically raise his anxiety. He listed the disadvantages of doing ERP:

1. It will be extremely uncomfortable.
2. Scared of bad things happening.
3. Difficult to do because the compulsions keep changing.
4. Could take a long time to fix the OCD.
5. It might not work.

He “knew” the rituals worked, both preventing bad things from happening and temporarily allaying his anxiety. He listed the benefits of avoiding ERP:

1. [Doing the rituals] feels effective.
2. I’m good at the rituals; it seems natural to do them.
3. The rituals might really prevent bad things from happening.

But he knew there was a cost of avoiding ERP. If the rituals were the ideal cure for obsessions, he would not have need of therapy in the first place. But rituals never work in the long run. In fact, he concluded, he would not wish them on his worst enemy. He listed the disadvantages of avoiding ERP and maintaining his rituals:

1. Interferes with productivity.
2. I only accomplish 10% of what I can.
3. It’s weird and makes me a social leper if people see it.
4. Makes me feel bad that I have to do them.
5. It’s like a 100-pound backpack.
6. Monetary cost for treatment.
7. It’s distracting if I drive.
8. I can break or drop things.
9. It’s not practical.

Finally, he identified the benefits of engaging in ERP so he could eliminate the rituals. This gave him something to focus on, aim toward, and look forward

(Continued on page 5)

Cognitive Therapy for Couples

Leslie Sokol, Ph.D., Director of Education

When treating couples, I often find that each partner's reported goals seem, at first, to be in opposition to the other's, and perhaps even predictive of failure. In the case of a married couple (no children) whose treatment I have just completed, both spouses entered therapy with the recognition that their marriage was in trouble. The wife, who had been previously married, reported that she was still in love with her husband and fully intended to grow old with him, but the husband reported that he was not sure that he was still in love, and was almost ready to pursue a divorce.

After many years of treating couples, I have found again and again that regardless of a couple's differences in their respective starting points and stated objectives, Cognitive Therapy can prove effective as long as both are willing to work toward a goal of discovering whether the relationship can be improved by, for example, running certain important experiments.

As with all couples, I began treatment with a thorough evaluation. One important question was, "On a scale of 1 to 10, where is your relationship?" This couple both rated it a 4. Although the husband's numbers would drop to as low as 2 within two months, he would eventually rate it a 9.5, and the wife would come to rate it a 10. Treatment was conducted weekly, with a few individual sessions in addition to the standard couple's sessions. When couples are willing to investigate whether the relationship can be improved, treatment often lasts two to four months and during this time, more often than not, the relationship is repaired.

As a cognitive therapist, I have certain tools that I utilize to bring about the desired result, such as assigning homework. In this case,

both spouses were invested in treatment and both did their homework. The wife was immediately compliant in doing her homework, and the husband, though he delayed a few weeks, eventually began to do his assignments as he came to believe that the treatment made sense and as he became more hopeful.

I told this couple (married more than twenty years) that their prognosis was good because they both recognized that they were in trouble and they both rated their relationship a 4, and not a 0. In addition, they had a history of being close friends and both reported that they loved and cared about each other.

I began treatment with both parties agreeing to try a course of therapy and to opening their minds to the possibility that the relationship might be able to be repaired. They agreed to do the work to see if this would be possible. One strategy I asked them to try was to do fewer activities apart from each other and more activities together. For example, for the time being at least, they were to refrain from going out with other people separately and they were to move back to one bedroom. I also asked them to socialize with other highly functioning couples, which would set a good example for them and also allow them to reunite and experience themselves as a couple again.

My clients agreed to try this experiment. They went out for dinner with other couples and then alone with each other. They ran errands together, did household chores together, and reconnected in both recreational and the more routine aspects of life. The husband, in particular, had previously been pursuing his leisure activities independently of his wife and now worked to find activities that he and his wife could do together.

~~~

A couple's communication causes a barrier in the relationship when both parties misinterpret what the other has said. In this couple's case, the husband interpreted his wife's communication as signifying that she did not respect him and did not value his opinion. His misinterpretations led to frustration, which caused him to respond to her in a hostile and aggressive way. When I helped him look at the data, however, he was able to see that his wife actually did respect him, which she demonstrated by routinely asking for his input and doing what he wanted.

The wife, in turn, misinterpreted her husband's hostile and aggressive communication, taking it to mean that he did not care about her. This caused her to become very upset and so she responded in a dysfunctional way, by shutting down and avoiding. Helping the husband recognize the negative message he was giving, and how at odds it was with the message he intended, helped him to modify his behavior. For her part, the wife came to see that her husband's communication was a reflection of his frustration, and not of how he felt about her. Helping her to see that he really did care about her made tolerating this hurtful communication a little easier; knowing he was working on curbing his aggressiveness also helped.

When both parties learned not to misinterpret one another's communications, they stopped living in fear of what the other might say or do. At the same time, they learned how to communicate more effectively, particularly by being more nicely assertive. The husband stopped waiting for his wife to read his mind and instead learned to explicitly tell her what he wanted. The wife stopped taking the way he communicated so personally and reminded herself it was simply his stress talking. She then assertively let him know what she wanted or what he did that was

*(Continued on page 5)*

## New Initiatives

*continued from page 1*

room, and the vets do not receive psychiatric care. Our project will be training medical specialists to uncover suicidality and do brief interventions.

Finally, our Schizophrenia project has been achieving good results in improving patients' negative symptoms: lack of motivation, inactivity, staying home, and social isolation. Our patients report that they would like to reach the same kinds of goals as most people without schizophrenia: They want to get jobs, receive more education, and have relationships. Treatment involves a modified recovery system, as opposed to a "cure." The therapist helps patients set short-term and long-term goals. Standard and advanced CT interventions are used to deal with obstacles, including delusions, lack of motivation, and low self-efficacy. Patients are treated for a year. (We found that six months is insufficient.) The results have been remarkable for some patients who have terminated after 12 months.

We've discovered some interesting features in these patients. At their initial examination, they are given the same neurocognitive tests that brain damaged patients with impairment of brain function are given. The tests are difficult, concrete tests of executive function, attention, and memory. Their cognitive flexibility, the ability to mentally shift gears and change from one line of thinking to another, is also tested. In all of the patients who have terminated treatment thus far, we have found an improvement in brain function. This is rather striking, given that these problems have been considered to be immutable. As a result of therapy, attention improves and, in some of the higher functioning patients, memory and executive function improve to a level approaching normal. As a result, patients are able to take steps that previously were not possible, for example, returning to college or work. If this trend continues, it will be a really exciting breakthrough.

## Dieting is about Food, Too

*continued from page 1*

- ◆ They fool themselves, vastly underestimating their caloric intake.
- ◆ They fill up on "free" foods to avoid ever feeling hungry.
- ◆ They try to outlaw certain foods forever (setting themselves up for a potential binge when they "cheat").
- ◆ They eat in a controlled way on weekdays but loosen up too much on weekends, holidays, and special occasions.

I based the structure of the eating plan in the new book on the ketogenic diet for epilepsy, which my son had followed for a number of years. For example, for lunch on my plan, dieters choose a protein from the protein list; a soup, salad or vegetable from the side dish list; a fruit and/or grain/starch from another list; a healthy fat from the Add-Ons list; a condiment; and another vegetable. Plus they get either 150 or 200 daily "Bonus Calories" which they can spend any way they want. They can have a candy bar or chips or alcohol every day, if they choose.

Dieters use a formula based on their basal metabolic rate to determine how many calories to start with and they stay at that level until they reach a plateau. Then they move down to the next lower level *if they judge that they can sustain this lower calorie count for life*. There's no magic to the diet. It's just a very healthy eating plan that incorporates dieters' favorite foods and is flexible enough for a lifetime.

An important feature of the program is that dieters don't change their eating until they have mastered preliminary skills, because it's too difficult to do both at once. For example, they have to learn to motivate themselves each day, tolerate hunger, cope with cravings and emotional eating, plan and monitor their food intake, and get back on track as soon as they stray—*before* they change what they eat.

After mastering these and other skills, they choose the slow track, changing only their breakfast; the medium track, changing all their meals; or the fast track, changing all their meals and snacks. At first they learn to follow their plan inflexibly; at a later stage of the program, they learn how to follow a basic plan flexibly. In order to individualize the plan so it suits them, I ask dieters to do some experiments, for example:

- ◆ They assess whether it's better for them to have snacks and smaller meals or fewer snacks and bigger meals.
- ◆ They evaluate their level of hunger and craving when they add back in some of their favorite foods (perhaps cereal instead of protein for breakfast).
- ◆ They see what happens when they make last minute substitutions at times, instead of following their plan.

These experiments guide their decisions about altering the eating plan so they can follow it for life.

A final stage teaches dieters how to keep going for the long haul, since their motivation tends to decrease when they no longer see the scale going down, when they don't have to keep buying smaller sizes of clothes, and when everyone is so accustomed to their new shape that they stop getting compliments. The book teaches them techniques to re-motivate themselves when dieting or maintaining becomes more difficult and to recover quickly from a relapse.

Almost anyone can lose at least some weight by following almost any diet and without learning any cognitive or behavioral skills. But to keep weight off permanently, they need a sustainable diet and the tools to discipline themselves to stick to it.

## Obsessive Compulsive Disorder

*continued from page 2*

to. Ridding himself of rituals meant he would

1. Have more time, concentration, and focus.
2. Have less stress.
3. Have less of a burden, get rid of the 100-pound backpack.
4. Be able to accomplish more.
5. Not worry about hiding things.
6. Have time to do more of the things I enjoy that are fun and healthy.
7. Have time to do more practical things.
8. Get things done better and faster.
9. Feel I'm on a level playing field with people.
10. Feel I can be open with people.

When John weighed the costs and benefits of the rituals, they seemed even: 50/50. But when he weighed the costs and benefits of response prevention, it was clear: 70/30 in favor of doing it. His homework: pick a compulsion, hold off on doing it for fifteen minutes, and engage in some pleasurable or productive activity. If he could not do this, his assignment was to record the thoughts and beliefs that stopped him. Regardless of whether he "believed" the thoughts or felt compelled to engage in the rituals, he was willing to take a chance to be free of them.

In the end, that is the price of overcoming an OCD: a willingness to temporarily feel considerable anxiety and other discomfort (perhaps feeling dirty, out of control, bad, or guilty) in the service of a higher and deeper goal: freedom.

### References

Rachman, S. & de Silva, P. (1978). Abnormal and normal obsessions. *Behaviour Research and Therapy*, 16, 233-248.

## Cognitive Therapy for Couples

*continued from page 2*

problematic for her, and what she would like instead. Often couples are asked to make wish-lists of what they want from each other. With this couple, both asked to have their needs met, a goal that they were ultimately able to accomplish.

~~~

When relationships start to dissolve, people become cognitively biased. Their attention gets drawn to their negative experiences, and so they discount, fail to recognize, or fail to pay much attention to positive experiences; they may also interpret neutral experiences in a negative way. To change this, the cognitive therapist guides couples to look at the larger picture. I ask my clients to think back through their time together, and talk about what they used to like about each other and whether those qualities still exist. They also learn to identify and focus on positive qualities to which they may have become blind. I tell my couples to be mindful of their positive experiences with each other and to make lists to capture that information, which will also prevent them from forgetting in the future. From this exercise, couples start to draw different conclusions about their relationship such as, "I really like this person. I don't want to lose this person. We have a lot going for us."

When relationships deteriorate, expressions of love, companionship, intimacy, and closeness often fall by the wayside. Another tool I use in therapy is the questionnaire "Expressions of Love" (Beck, 1988), which helps to raise a couple's awareness of what has diminished in their relationship and of how straight-forward it can be to bring it back. Even if the positives—doing exciting things with one's partner,

enjoying his or her company, using terms of endearment, or showing affection—were never there, couples can learn these skills. This particular couple realized that expressions of love, acceptance, sensitivity, and their feelings of being friends had never really

disappeared. This led the husband (who came in believing he should leave his wife) to recognize that many aspects of the relationship were good and that they shared much more than he had realized. He came to accept that his wife was not working against him, that she actually continually put his needs on the agenda, and that she respected him. The more the husband came to realize how many good qualities the relationship possessed, the more his inclination to leave diminished. The more he experienced and communicated a sense of connectedness with and commitment to his wife, the more she relaxed and stopped avoiding.

Finally, after goals for treatment are achieved and the couple is operating as a team, they have to learn how stay on track. Understanding what allows them to be successful as a couple enables them to guide their relationship in the future. They particularly need to continue to use good communication, try to perceive each another accurately, focus on the positive, put the negative in perspective, solve problems together, and ensure that they create common experiences in the leisure, routine, and social aspects of life. The result is a good relationship.

References

Beck, A. T. (1988). *Love is never enough*. New York: Harper & Row.

Have you visited our blog? ■ WWW.CTTODAY.ORG ■ We welcome your comments!

SPEAKING ENGAGEMENTS —CHECK WEBSITES FOR MORE INFORMATION

December 11-14, 2008 – San Diego, CA. Seventh Brief Therapy Conference: Lasting Solutions. Speaker: Judith S. Beck, Ph.D. **Workshop:** *Dieting and Maintenance: A Cognitive Behavioral Approach.* **Workshop:** *Successful Dieting and Maintenance: Dealing with Emotional Issues.* **Clinical Demonstration:** *Cognitive Behavioral Approach to Weight Loss.* **Website:** <http://www.brieftherapyconference.com/>

March 26-29, 2009 – Washington, DC. Annual Networker Symposium. Speaker: Judith S. Beck, Ph.D. **Workshop:** *A Cognitive Behavioral Approach to Permanent Weight Loss.* **Website:** <http://www.psychotherapynetworker.org/>

April 4-5, 2009 – Athens, Greece. Mediterranean College. Speaker: Leslie Sokol, Ph.D. **Workshop:** *Cognitive Therapy for Personality Disorders, Bipolar Disorder, and Anger Management.*

May 15-16, 2009 – Porto Alegre, Brazil. PROJECTO Centro Cultural e de Formacao. Speaker: Leslie Sokol, Ph.D. **Workshop:** *Cognitive Behavioral Therapy for Personality Disorders.* **Email:** circe@terra.com.br

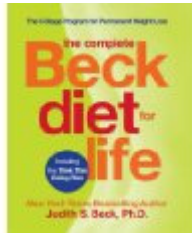
May 18-21, 2009 – San Francisco, CA. American Psychiatric Association Annual Meeting. Speaker: Judith S. Beck, Ph.D. **Workshop:** *Cognitive Therapy for Personality Disorders.* **Workshop:** *Cognitive and Behavioral Techniques to Improve Brief Pharmacotherapy Sessions.* **Course:** *Practical Cognitive Therapy*, presented with Robert Goisman, M.D., Donna Sudak, M.D., and Jesse Wright, M.D., Ph.D. **Website:** www.psych.org

August 6-9, 2009 – Toronto, ON. American Psychological Association Annual Convention. Speaker: Judith S. Beck, Ph.D. **Workshop:** *Cognitive Therapy for Personality Disorders.* **Symposium:** *Changing Core Beliefs in Cognitive Therapy* as part of *Eminent Psychotherapists Revealed.* **Website:** www.apa.org

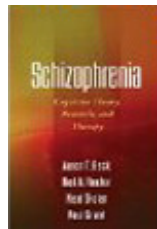
September 13, 2009. — Philadelphia, PA. Beck Institute for Cognitive Therapy & Research. Speaker: Judith S. Beck, Ph.D. **Workshop for professionals and the public:** *The Beck Diet Program.* Email: dietprogram@beckinstitute.org. Website: www.beckinstitute.org

November 5-7, 2009 – Philadelphia, PA. Annual National Nursing Centers Consortium (NNCC) Best Practices Conference. Speaker: Judith S. Beck, Ph.D. **Workshop:** *A Cognitive Behavioral Approach to Weight Loss and Maintenance* (tentative title) **Website:** <http://nncc.us/>

ANNOUNCEMENTS: NEW BOOK RELEASES BY DRs. JUDITH BECK, AARON BECK, AND COLLEAGUES



The Complete Beck Diet for Life: The Five-Stage Program for Permanent Weight Loss (2008), Beck, J.S.



Schizophrenia: Cognitive Theory, Research, and Therapy (2008), Beck, A.T., Rector, N.A., Stolar, N., Grant, P.



Cognitive Therapy for Suicidal Patients: Scientific and Clinical Applications (2008), Wenzel, A., Brown, G.K., Beck, A.T.

Cognitive Therapy Today®

Beck Institute for Cognitive Therapy and Research
One Belmont Avenue, Suite 700, Bala Cynwyd, PA 19004-1610
Telephone: 610.664.3020 Fax: 610.664.4437 Email: beckinst@gim.net
Website: www.beckinstitute.org

Editor-in-Chief: Judith S. Beck, Ph.D.