

Cognitive Therapy Today®

Volume 13 Issue 1

Spring 2008

From the Director

Judith S. Beck, Ph.D.

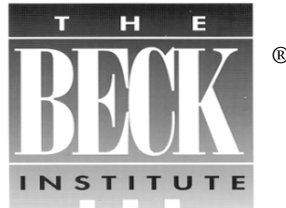
Mastering Pre-Dieting Skills

We have learned so much in the past year, since the publication of the book and workbook on a Cognitive Therapy approach to dieting. The Beck Institute Diet Program Coordinator and I have gleaned important principles from our counseling of dieters (individually and in groups), from supervision, and from the 1000+ emails we have received. We have especially been informed by online support communities (that have developed quite independently from us), whose members are using the book and posting about their experiences daily on various websites.

A central tenet of the book is that dieters must learn essential cognitive and behavioral skills *before* they change what they eat. For example, they have to learn in advance what to do to prevent or recover from a lapse, an inevitable part of dieting. But just learning these pre-dieting skills is insufficient. What we have more recently discovered is that dieters need to *master* these skills before focusing on following an eating plan.

Dieters invariably want to begin cutting calories immediately so they can start losing weight as soon as possible. But it is crucial that they first learn how to motivate themselves daily, use good eating habits (eating everything sitting down, slowly, and mindfully), arrange their home and work environments, diminish their fear of hunger, cope with craving, eliminate emotional eating, desensitize themselves to the number on the scale, get back on track immediately when they make a mistake,

(Continued on page 4)



For Cognitive Therapy
and Research

From the President

Aaron T. Beck, M.D.

Questions and Answers with Dr. Aaron T. Beck

Below are some highlights from a recent interview by a journalist with Dr. Aaron Beck.

Q: What are the origins of CT?

A: In the early 1960s, after numerous clinical observations regarding automatic thoughts and cognitive distortions, as well as research showing a negative bias in depressed individuals' perceptions of their experiences, I noted that depressed people had many negative beliefs about themselves and their futures. This led to the discovery that the negative beliefs shaped the way the individuals interpreted and distorted their experiences. It was these negative interpretations that led to sad feelings, social withdrawal, and, especially, suicidal ideas. Modifying beliefs in therapy reduced or eliminated these distorted interpretations, and symptoms of depression similarly reduced or disappeared. The theory was summarized in *Depression: Clinical, Experimental, and Theoretical Aspects* (1967).

Q: What motivates your research?

A: An insatiable curiosity about human nature and a commitment to doing what I can to help people.

Q: If you had not become a psychiatrist, what career would you have pursued?

(Continued on page 5)

Inside This Issue:

Mastering Pre-Dieting Skills.....	Page 1
Q & A with Dr. Aaron T. Beck.....	Page 1
Cognitive Therapy for Psychosis.....	Page 2
Speaking Engagements.....	Page 6

Have you visited our blog?

WWW.CTTODAY.ORG

We welcome your comments!

*Be sure to tell your
colleagues about our
Newsletter!*

To subscribe, visit our website

WWW.BECKINSTITUTE.ORG

and click on *Newsletters*



**The 6th International Congress of Cognitive Psychotherapy
June 19-22, 2008 ■ Rome, Italy**

For more information and to register visit: www.iccp2008.com

Does Cognitive Therapy Work for Psychosis? Some Results from a Meta-Analysis

Tania Marie Lincoln, Ph.D., Phillips-Universität Marburg, Germany,
Beck Institute Scholar 2007-2008

Introduction

Cognitive Therapy (CT) for delusions and dysfunctional cognitions is now frequently being used in the treatment of schizophrenia (Kuipers et al., 2006). There was some doubt when CT began being advanced by British researchers, with skeptics stating that a cognitive approach might intensify the delusional beliefs. However, there were also a number of good reasons to promote cognitive approaches. One of these reasons was the increasingly clearer limitation of pharmacological treatment. Although medication remains an important line of treatment, it is far from being wholly effective, in particular as it is not taken as prescribed by approximately 50% of the patients, but also because of treatment-resistant symptoms and adverse side effects (Conley & Buchanan, 1997; Gilmer et al., 2004). Another reason was a series of epidemiological findings demonstrating that positive symptoms such as delusions and hallucinations are not restricted to persons with schizophrenia but lie on a continuum with normality. For example, many people from the normal population report feeling observed by others and hallucinatory experiences such as hearing a voice when nobody is present (Johns & van Os, 2001; Lincoln, 2007). Therefore normal mechanisms of perception and reasoning could be involved in delusional interpretations and patients with psychosis might thus be susceptible to adaptations of the cognitive therapies.

The first description of a cognitive approach to delusions was provided by Beck (1952) in a case study. However, the main evidence for cognitive behavioral therapy (CBT) for psychosis comes from the United Kingdom, driven by various research groups (e.g., Chadwick, Birchwood & Trower, 1996; Fowler, Garety & Kuipers, 1995; Kingdon & Turkington, 1994; Morrison, 2004). Since then, the efficacy of CBT has been demonstrated in numerous intervention trials and an almost equal number of meta-analyses. In the first meta-analysis by Rector and Beck (2001), seven randomized controlled trials were

evaluated and effect sizes were calculated in comparing CBT to supportive therapy revealing a high effect size of $d=.91$ in favor of CBT. A further meta-analysis of seven trials revealed a mean effect of $d=.65$ for CBT and a slight increase in effectiveness by follow up (Gould, Mueser, Bolton, Mays & Goff, 2001). However, later meta-analyses, including larger numbers of studies *and using different methodology*, slightly dampened the first optimism by finding small to medium overall effect sizes (Jones, Cormac, Silveira da Mota Neto & Campbell, 2004; Pilling et al., 2002; Tarrier & Wykes, 2004; Zimmermann, Favrod, Trieu & Pomini, 2005). Apart from the varying estimations of the overall effect, one major problem with the interpretation of the meta-analyses is that they have integrated very heterogeneous interventions (apple and orange problem). Some of the included intervention studies did not investigate cognitive elements at all, but focused on coping strategies or problem solving (e.g., Tarrier et al., 1998), compliance with medication (Kemp, Hayward, Applewhaite, Everitt & David, 1996) or psychoeducation (Buchkremer, Klingberg, Holle, Schulze Mönking & Hornung, 1997). The concoction of different interventions makes it hard to draw conclusions with regard to the effectiveness of the cognitive approach to psychosis. Thus the question of whether CT can provide a helpful contribution to reducing symptoms of psychosis needs further investigation.

Method

We conducted an additional meta-analysis of cognitive interventions for schizophrenia and restricted our selection criteria to interventions that had included cognitive elements (Lincoln, Suttner & Nestoriuc, in press). In addition, we used a moderator analysis to investigate whether interventions with a larger proportion of cognitive elements were more effective than those with fewer CT elements. In order to this, we rated the number as well as the proportion of cognitive elements in each of the included studies. We defined the following elements as cognitive: (1) an individual's cognitive model; (2) cognitive restructuring of delusions; (3) cognitive

restructuring of dysfunctional self-concepts; and (4) cognitive symptom monitoring or restructuring of dysfunctional meta-cognition with regard to symptoms. Above this, we rated the proportion of cognitive elements in relation to the complete therapy time according to whether the interventions were exclusively cognitive (100%), mainly cognitive (75%), half cognitive (50%), or mainly not cognitive (25%). An intervention was labeled "cognitive" if it involved at least three of the four cognitive elements with a proportion of at least 75% of the total intervention time. The moderating effect of the intervention elements on the total symptom reduction was calculated in a multiple regression analysis controlling for the quality of the study (details on the methodology of the meta-analysis can be obtained from the author upon request).

Results

Eighteen studies including 1667 patients with schizophrenia spectrum disorders were analyzed. All studies were randomized controlled trials comparing CBT plus treatment as usual (TAU, including medical treatment) with either TAU alone or TAU in combination with an active control intervention. With regard to the overall pathology, the CBT interventions produced small but significant effects in comparison to TAU by the end of treatment ($n=908$; $k=9$; $d=0.25$; $CI=0.14-0.36$) and at follow-up assessment ($n=663$; $k=6$; $d=0.35$; $CI=0.21-0.48$). In comparison to the active control interventions, CBT did not produce significantly higher effects by the end of treatment ($n=559$; $k=10$; $d=0.07$; $CI=-0.22-0.36$). It was, however, superior to the control interventions at follow up ($n=416$; $k=6$; $d=0.24$; $CI=0.07-0.42$).

The mean weighted pre-post effect sizes for the overall symptomology were significantly correlated with a cognitive emphasis of the interventions ($r=.75$, $p \leq .001$, $k=18$) but not with the methodological quality of the studies as

Mastering Pre-Dieting Skills — continued from page 1

exercise daily, and build a sense of self-efficacy. It is not enough to learn about these skills, though; dieters need to learn how to make themselves practice these skills daily by effectively responding to interfering and potentially sabotaging automatic thoughts (“I don’t have to read the list of reasons to lose weight; I remember them.” “I don’t deserve credit for using good eating habits; I should have been doing these things all along.” “I can’t let myself get too hungry or I won’t be able to stand it.” “Dieting should be easy. I shouldn’t have to make changes that inconvenience me or others.” “It’s okay to deviate from my plan, it won’t really matter.” “Since I cheated, I may as well eat whatever I want and start again tomorrow.”)

Allison is a typical dieter. She had been trying to lose weight ever since she was a young teenager. She had tried many different diets, supplements, and weight loss programs. The most she had ever lost was 22 pounds. She sustained this weight loss for about six months, then gained 25 pounds back. When she first came to us, she weighed 202 pounds. She was physically and psychologically uncomfortable at that weight and her health was beginning to suffer. She saw dieting as a terrible and painful deprivation and for several reasons she wanted to lose weight very quickly. One, she wanted the deprivation to end as soon as possible (that is, she wanted to be able to stop dieting and return to her old way of eating). Two, she wanted to achieve the benefits of weight loss as soon as possible. Three, her niece was getting married in four months and she wanted to “look good” in the wedding photographs.

Allison was disappointed when we told her that we needed to help her master certain pre-dieting skills before we focused on changing her eating. We related that many dieters lose a little weight in this pre-

dieting phase, but they do not lose much. When she protested, saying that she just *had* to lose weight fast, we reviewed her history. Through Socratic questioning, she concluded that crash dieting had *never* led to lasting weight loss and she could find no evidence to support a conclusion that doing so *this* time would be any different.

We explained to Allison that it was too difficult to do everything at once. It is not enough to resolve to follow a specific eating plan. She needed to learn how to *stick* to the plan. She needed to know what to say to herself and what to do when she was hungry, craving, tired, stressed, busy, discouraged, disappointed, bored, or frustrated. She needed to know what to say to herself and what to do when she ate out, when people pushed food on her, and when she was traveling. She needed to learn how to motivate herself every day and how to build her confidence. She needed to learn how to get back on track immediately when she strayed from her plan and how to continue to make time and energy for diet and exercise, even when life circumstances made it difficult. Equally importantly, she needed to learn how to get herself to practice her skills daily, whether she “felt” like it or not. She needed to learn all of these things *before* she started focusing on changing what she ate and all *that* entails: finding the time and psychic energy to choose what she was going to eat, get to the store often enough (to ensure she always had the food she needed on hand), prepare her snacks and meals, eat every bite of food slowly and mindfully, while sitting down, and do problem-solving and respond to automatic thoughts that would hinder the continuous implementation of her eating plan.

From online correspondence and perusing the postings of community support groups, we have found a difference between those

dieters who are successfully following the program in the book and those who are less successful. Individuals in the less successful group try to learn these pre-dieting skills at the same time as they change what they eat—and do not master either one. They pick and choose which pre-dieting skills they want to learn, instead of learning them all. They employ skills when they feel like doing so and not when they don’t. They have not accepted that dieting requires a sustained effort to use essential cognitive and behavioral skills throughout the day, every day. The successful dieters, on the other hand, take the time to master all these skills first. When they actually start their diet, they are well-prepared, which not only makes them more successful at dieting, but also at getting back on track when they do make a mistake. Their initial preparation time also helps them look at their mistakes objectively, analyze what happened, and come up with a plan for the next time so they do not end up repeatedly making the same errors.

Our experience has shown us that rushing into a diet ultimately does not lead to long-term success. Only those dieters who are willing to spend time initially mastering the crucial pre-dieting skills are able to then successfully change their eating, and sustain those changes for the long term.

References

Beck, J.S. (2007). *The Beck Diet Solution*. Birmingham, AL: Oxmoor House Publications.

Beck, J.S. (2007). *Beck Diet Solution Weight Loss Workbook*. Birmingham, AL: Oxmoor House Publications.

**For information about Beck
Institute training opportunities,
please visit:**

WWW.BECKINSTITUTE.ORG

Question and Answers with Dr. Aaron T. Beck— continued from page 1

(Continued from page 1)

Why?

A: After graduating from medical school, I had intended to become a neurologist. I found it very interesting. But psychiatry seemed more exciting and more of a challenge.

Q: Why is CT applicable to such a wide range of disorders?

A: Because it is a basic structure for understanding human nature, and, specifically, emotional disorders. From this, therapies can be devised for specific problems. Depressed patients, for example, interpret experiences in terms of a sense of failure and helplessness. Anxiety disorder patients interpret their experience in terms of threats and dangers to their physical well-being or social acceptability. Using cognitive theory and principles, we formulate their core psychological problems and devise appropriate techniques for solving them.

Q: How do you determine a cognitive therapist's competence?

A: The competency scale (Young & Beck, 1980) we developed can actually measure the degree of skill. Scores on the competency scale have been found to correlate with the degree of improvement from cognitive therapy. It measures, among other critical components, the development of a solid therapeutic alliance, an accurate conceptualization of the patient's difficulties, and the application of cognitive techniques. The Academy of Cognitive Therapy (www.academyofct.org) uses this performance-based instrument to certify people as cognitive therapists.

Q: How can suicide be predicted? How does CT help?

A: The Beck Hopelessness Scale (Steer & Beck, 1988) assesses individuals' predictions and evaluations of their futures, and has been the most effective in predicting suicide. A thirty-year study found that administering the Hopelessness Scale at the time of hospital admission was successful in predicting suicide over

the next thirty years in a significant portion of cases.

We have just completed a 500-page volume on cognitive formulations of patients' problems and how they contribute to hopelessness and suicidality. Depression, substance abuse, impulsivity, poor problem-solving ability, and difficult environmental situations are among the relevant problems. CT can intervene with these problems and lead to the reduction or elimination of hopelessness and suicidal impulses.

Q: Does CT only treat the symptoms?

A: In numerous studies, CT has been shown to have a more enduring effect than pharmacotherapy, which indicates that it must be treating underlying "causes." It has also been shown that early CT intervention can prevent the occurrence of depression. Brain scans have shown that cognitive therapy of depression, phobias, and obsessive-compulsive disorder has an observable and significant impact on the dysregulation or overactivation of certain brain regions. All of this further indicates CT's causal effect on disorders.

Q: Do you feel any important psychological disorders have been overlooked or forgotten by the mental health community?

A: I have been extremely interested in the issue of hostility, not only between individuals but between ethnic and religious groups, nations, and the like. I wrote a book on this topic entitled *Prisoners of Hate* (1999). Dealing with national issues of hostility would not involve treatment in the usual sense, but it would require a profound understanding of the psychological issues that lead people to hurt one another, wage war, and commit genocide.

Q: What are you currently working on?

A: Co-authors and I have just completed volumes on CT of schizophrenia and CT of suicide. We are currently working on a volume on cognitive approaches to anxiety disorders, and we are producing new editions of my two books on depression.

Q: What is the future of CT?

A: CT is moving in many exciting directions. We are conducting a trial of CT for symptoms of schizophrenia. Considerable work using cognitive therapy in conjunction with pharmacotherapy for schizophrenia has already been done (and continues to be done) in the United Kingdom.

I expect a continuing—and increased—use of CT for medical problems such as hypertension, chronic fatigue, chronic back pain, and others. CT has also been found to be useful for Gulf War veterans suffering from post-concussion syndrome and post-traumatic stress disorder.

I expect that CT will continue to maintain a very strong empirical base. There is increasing emphasis on disseminating cognitive therapy into the community. We are currently involved in training therapists in community mental health centers and in the Veterans Administration.

Finally, CT continues to grow in importance and use in the U.S. and around the world. For example, CT instruction is mandated for all U.S. psychiatric residents. The German health system includes CT among its approved, empirically validated therapies, and Britain has recently allotted £309 million to training therapists in CT.

References

- Beck, A. T. (1967). *Depression: Clinical, experimental, and theoretical aspects*. New York: Harper and Row.
- Young, J. E., & Beck, A. T. (1980): *Cognitive therapy scale: Rating manual*. Bala Cynwyd, PA: Beck Institute for Cognitive Therapy.
- Beck, A. T., & Steer, R. A. (1989). *Manual for the Beck Hopelessness Scale*. San Antonio, TX: The Psychological Corporation. (www.beckscscales.com)
- Beck, A. T., (1999). *Prisoners of hate: The cognitive basis of anger, hostility and violence*. New York, NY: HarperCollins.

assessed by a validity rating ($r=-.20$, $p \leq 17$, $k=18$). A weighted regression analysis using both predictors (type of intervention and quality of intervention) produced a significant proportion of explained variance of the effect sizes ($p \leq .01$; $R^2_{\text{corr}}=.55$), with a significant regression weight for type of intervention ($B=.76$, $p \leq .01$), but not for quality of study ($B=-.09$, $p \leq .25$).

Discussion

Our analyses demonstrated a small but stable effect of cognitive behavioral interventions over and above medication. The moderator analysis revealed the number and amount of cognitive elements in the CBT interventions to be significantly and positively correlated with the pre-post effect sizes for overall pathology—even after controlling for the methodological quality of the studies. This indicates that a more extensive use of cognitive strategies might enhance the effectiveness of CBT for psychosis. Nevertheless, this conclusion must be drawn with some caution because our rating of studies as being cognitive relied strongly upon the description of the interventions in the original studies and these might sometimes differ from what was actually done in therapy.

Conclusions

CBT in combination with medical treatment produces more short- and long-term change in the overall pathology of schizophrenia than medical treatment alone. In comparison to alternative interventions, CBT is superior in the long run. Possibly, the effectiveness of CBT could be augmented by an increased use of cognitive elements.

References

Beck, A. T. (1952). Successful outpatient psychotherapy of a chronic schizophrenic with a delusion based on borrowed guilt. *Psychiatry*, *15*, 305-312.

Buchkremer, G., Klingberg, S., Holle, R., Schulze Mönking, H., & Hornung, W. P. (1997). Psychoeducational psychotherapy for schizophrenic

patients and their key relatives or care-givers: Results of a 2-year follow-up. *Acta Psychiatrica Scandinavica*, *96*, 483-491.

Chadwick, P., Birchwood, M., & Trower, P. (1996). *Cognitive Therapy for Delusions, Voices and Paranoia*. Chichester: Wiley.

Conley, R. R. & Buchanan, R. W. (1997). Evaluation of treatment resistant schizophrenia. *Schizophrenia Bulletin*, *23*, 663-674.

Fowler, D., Garety, P., & Kuipers, E. (1995). *Cognitive Behaviour Therapy for Psychosis. Theory and Practice*. Chichester: Wiley.

Gilmer, T. P., Dolder, C. R., Lacro, J. P., Folsom, D. P., Lindamer, L., Garcia, P., & Jeste, D. V. (2004). Adherence to treatment with antipsychotic medication and health care costs among medical beneficiaries with schizophrenia. *American Journal of Psychiatry*, *161*, 692-699.

Gould, R. A., Mueser, K. T., Bolton, E., Mays, V., & Goff, D. (2001). Cognitive therapy for psychosis in schizophrenia: An effect size analysis. *Schizophrenia Research*, *48*, 335-342.

Johns, L. C. & van Os, J. (2001). The continuity of psychotic experiences in the general population. *Clinical Psychology Review*, *21*, 1125-1141.

Jones, C., Cormac, I., Silveira da Mota Neto, J. I., & Campbell, C. (2004). Cognitive therapy for schizophrenia. *The Cochrane Database of Systematic Reviews*, *4*.

Kemp, R., Hayward, P., Applewhaite, G., Everitt, B., & David, A. (1996). Cognitive therapy in psychotic patients: Randomized controlled trial. *British Medical Journal* *312*, 345-349.

Kingdon, D. G. & Turkington, D. (1994). *Cognitive-Behavioural Therapy of Schizophrenia*. New-York: Guilford Press.

Kuipers, E., Garety, P., Fowler, D., Freeman, D., Dunn, G., & Bebbington, P. (2006). Cognitive, emotional, and social processes in

psychosis: Refining cognitive behavioral therapy for persistent positive symptoms. *Schizophrenia Bulletin Advanced Access*, *32*, 24-31.

Lincoln, T. M. (2007). Relevant dimensions of delusions. Continuing the continuum versus category debate *Schizophrenia Research*, *93*, 211-220.

Lincoln, T. M., Suttner, C., & Nestoriuc, Y. (in press). Wirksamkeit kognitiver Interventionen in der Reduktion schizophrener Symptomatik. Eine Meta-Analyse. *Psychologische Rundschau*.

Morrison, A. P., French, P., Walford, L., Lewis, S. W., Kilcommons, A., Green, J., Parker, S., & Bentall, R. P. (2004). Cognitive therapy for the prevention of psychosis in people at ultra-high risk. *British Journal of Psychiatry*, *185*, 291-297.

Pilling, S., Bebbington, P., Kuipers, E., Garety, P., Geddes, J., Orbach, G., & Morgan, C. (2002). Psychological treatments in schizophrenia: I. Meta-analysis of family interventions and cognitive behaviour therapy. *Psychological Medicine*, *31*, 763-782.

Rector, N. A. & Beck, A. T. (2001). Cognitive behavioural therapy for schizophrenia: an empirical review. *The Journal of Nervous and Mental Disease*, *189*, 278-287.

Tarrier, N. & Wykes, T. (2004). Is there evidence that cognitive behaviour therapy is an effective treatment for schizophrenia? A cautious or cautionary tale? *Behaviour Research and Therapy*, *42*, 1377-1401.

Tarrier, N., Yusopoff, L., Kinney, C., McCarthy, E., Gledhill, A., Haddock, G., & Morris, J. (1998). RCT of intensive CBT for patients with chronic schizophrenia. *British Medical Journal*, *317*, 303-307.

Zimmermann, G., Favrod, J., Trieu, V. H., & Pomini, V. (2005). The effect of cognitive behavioral treatment on the positive symptoms of schizophrenia spectrum disorders: A meta-analysis. *Schizophrenia Research*, *77*, 1-9.

SPEAKING ENGAGEMENTS— SEE WEBSITES FOR REGISTRATION INFORMATION

May 3-8, 2008. Washington, DC. American Psychiatric Association Annual Meeting. Workshop: *Cognitive Therapy for Personality Disorders*. Workshop: *Cognitive and Behavioral Techniques to Improve Brief Pharmacotherapy Sessions*. Speaker: Judith S. Beck, Ph.D. Website: www.psych.org

May 12, 2008. Providence, RI. 13th Annual Irving M. Rosen Memorial Program. Workshop: *New Directions in Cognitive Behavioral Therapy*. Speaker: Leslie Sokol, Ph.D. Website: www.butler.org

May 16, 2008. Portland, ME. Maine Medical Center. Workshop: *Cognitive Therapy for Personality Disorders*. Speaker: Leslie Sokol.

May 23-24, 2008. Dominican Republic. Centro de Capacitation de Psicologia. Workshop (2days): *Cognitive Therapy of Depression; Cognitive Therapy of Anxiety*. Speaker: Leslie Sokol, Ph.D. Website: www.worldwidetrainings.com

May 28, 2008. Istanbul, Turkey. Marmara Hotel, Taksim Square. Workshop: *The Case for Cognitive Therapy*. Speaker: Judith S. Beck, Ph.D. Contact: Emel Stroup, Ph.D. Tel. (US): 646-403-4871. Tel. (TR): 90-538-304-0415. Email: emel@kognitifterapi.com

June 6-7, 2008. Istanbul, Turkey. Boylam Psychiatric Institute. Workshop: *Cognitive Therapy Workshop*. Speaker: Leslie Sokol, Ph.D. Website: www.mested.com

June 16-20, 2008. Kalamazoo, MI. Focus Corporate Education and Training. Workshop: *Intensive Cognitive Therapy*. Speaker: Leslie Sokol, Ph.D. Website: www.focustraining.org

June 19-22, 2008. Rome, Italy. International Congress of Cognitive Psychotherapy (ICCP). Keynote: *Cognitive Therapy for Personality Disorders*. Speaker: Judith S. Beck, Ph.D. Workshop: *Cognitive Therapy for Weight Loss and Maintenance*. Speaker: Judith S. Beck, Ph.D.

June 23-24, 2008. Hattiesburg, MI. Pine Belt Mental Health. Workshop: *CBT with Dual Diagnosis*. Speaker: Leslie Sokol, Ph.D.

July 9, 2008. Baltimore, MD. Sheppard Pratt Health System. Workshop: *Cognitive Therapy Today*. Speaker: Leslie Sokol, Ph.D.

August 14-17, 2008. Boston, MA. American Psychological Association Annual Convention. Workshop: *Cognitive Therapy for Personality Disorders*. Symposium: “Eminent Psychotherapists Revealed— Microanalysis of Essential Components of Psychotherapy” as part of *Modifying Core Beliefs in Cognitive Therapy*. Symposium: “Metacognition in Supervision— Implicit and Explicit Structure in Clinical Supervision” as part of *Planning Cognitive Supervision before and within supervision sessions*. Speaker: Judith S. Beck, Ph.D. Website: www.apa.org

August 27-28, 2008. Dallas, TX. Department of State Health Services. Workshop: *An Introduction to Cognitive Therapy*. Speaker: Christine E. Reilly, Ph.D.

October 24-25, 2008. Dominican Republic. Centro de Capacitation de Psicologia. Workshop (2days): *Cognitive Therapy of Bipolar Disorder; Cognitive Therapy of Anger Disorder*. Speaker: Leslie Sokol, Ph.D. Website: www.worldwidetrainings.com

December 11-14, 2008. San Diego, CA. Seventh Brief Therapy Conference: Lasting Solutions. 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*. Speaker: Judith S. Beck, Ph.D. Website: www.brieftherapyconference.com

FOR TRAINING OPPORTUNITIES AT THE BECK INSTITUTE, VISIT www.beckinstitute.org

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.