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interfere with the effective provision of cognitive therapy. The structure, content, and process of cognitive therapy supervision are then presented and problems that may arise in the process of supervision are discussed.

OVERVIEW OF COGNITIVE THERAPY

The Evolution of Cognitive Therapy

Cognitive therapy was developed by Dr. Aaron T. Beck more than 30 years ago as a treatment for depression (Beck, 1964; Beck, Rush, Shaw, & Emery, 1979). Since that time, Beck and his colleagues have applied cognitive therapy to a wide variety of problems, and outcome studies have demonstrated its efficacy for panic disorder (Barlow, Craske, Maser, & Klosko, 1989; Beck, Rush, Shaw, & Emery, 1979; Clark, Salkovskis, Hackmann, & Gelder, 1992), generalized anxiety (Butler, Fennell, Robson, & Gelder, 1991), social phobia (Gelenberg et al., 1991; Heimberg et al., 1990), major depressive disorder (see Dobson, 1989, for meta-analysis), inpatient treatment of depression (Bowers, 1990; Miller, Norman, Keitner, Bishop, & Dow, 1989; Thase, Bowler, & Harden, 1991), substance abuse (Woody et al., 1983), eating disorders (Agras et al., 1992; Fairburn, Jones, Pesciter, Hope, & Doll, 1991; Garner et al., 1993) and couples problems (Baucom, Sayers, & Scher, 1990). Additional outcome studies are currently under way investigating the effectiveness of cognitive therapy for other disorders, including chronic pain, personality disorders, sexual dysfunction, and as adjunctive treatment for schizophrenia and bipolar illness.

Cognitive therapy places primary emphasis on cognitive processes, including the identification and modification of core beliefs, conditional assumptions, and automatic thoughts. A basic assumption is that the manner in which individuals process information influences their emotions, behavior, and physiology in reliable, predictable ways. The model in Figure 8.1 (Liese & Larson, 1995, p. 24) reflects the “basic” model of cognitive therapy, including the influence of life experiences. Cognitive formulations have been described for most major psychiatric disorders. These refinements to the basic cognitive model are outlined in the following sections for depression, anxiety, marital problems, personality disorders, and substance abuse.

Applications of Cognitive Therapy

Depression. Individuals who are depressed hold pervasive, negative, maladaptive beliefs about themselves, their personal world, other people, and the future (Beck et al., 1979). These beliefs mediate their interpretations of experiences and subsequent thoughts, emotions, and actions. For example, the core belief “I am unlovable” may lead an individual in certain situations to think “I'll always be abandoned,” which is likely to lead to feelings of sadness, despair, and (behaviorally) to interpersonal withdrawal.

Anxiety. Anxious individuals hold beliefs that involve vulnerability to harm and danger (Beck & Emery with Greenberg, 1985). Individuals with anxiety disorders make dire predictions about what will happen to them or others, including failure, humiliation, and physical harm. For example, a common cognition among patients with panic disorder is “My racing heart means I'm having (or am about to have) a heart attack.” Social phobics frequently believe, “If I take interpersonal risks I'm likely to be terribly embarrassed.” Gen-
The structure of corrective therapy supervision

The structure of corrective therapy supervision is designed to ensure that therapists are provided with the necessary feedback and support to improve their skills and outcomes in therapy. It typically involves a series of sessions, each lasting 2-3 hours, where therapists present cases for review and discussion. The process is iterative, with therapists receiving feedback on their presentation, case formulation, and therapeutic approach. The structure includes a variety of elements, such as case presentations, discussion of therapeutic goals and techniques, and feedback from peers.

1. Introduction to case presentation.
2. Case formulation: Therapeutic approach and rationale.
3. Discussion of therapeutic strategies and techniques.
4. Feedback from peers on case and approach.
5. Review of previous sessions and progress.
7. Plan for next session.

The structure aims to provide therapists with a supportive environment where they can explore their clinical practice and receive constructive feedback to enhance their skills and effectiveness in therapy.
STRUCTURE OF SUPRESSION

The suppression process involves the interaction of neural and hormonal mechanisms. Neural impulses from various brain regions modulate the activity of the hypothalamus, leading to the release of adrenocorticotropic hormone (ACTH) from the anterior pituitary gland. ACTH stimulates the adrenal cortex to produce corticosteroids, which are hormones that help regulate stress and inflammation.

The hypothalamus receives feedback from the pituitary gland regarding the amount of corticosteroids produced. This feedback is crucial in maintaining a balance between the levels of these hormones and the body's stress response. For example, when the body is under stress, the hypothalamus increases ACTH release, leading to an increased production of corticosteroids.

The corticosteroids then act on various tissues throughout the body. For instance, corticosteroids can reduce inflammation, decrease allergic responses, and help regulate blood pressure. However, prolonged cortisol exposure can have negative effects on the body, such as increased risk of diabetes and hypertension.

In summary, the structure of suppression involves a complex interaction between the hypothalamus, pituitary gland, and adrenal cortex, which work together to maintain homeostasis and respond to stress.

REFERENCES


The content of cognitive therapy suggests that reorganizing the thought processes can lead to improvement in various aspects of life. Cognitive therapy is aimed at changing the way individuals think, feel, and behave. It involves identifying and challenging negative thought patterns to improve mental health and well-being.

Principles and Application of Cognitive Therapy

Cognitive therapy is based on the idea that our thoughts, feelings, and behaviors are interconnected. By changing our thoughts, we can change our feelings and behaviors. Cognitive therapy techniques include:

1. Identifying and challenging negative thoughts
2. Developing more positive and realistic thinking patterns
3. Using relaxation techniques to reduce anxiety and stress
4. Practicing problem-solving skills to better cope with challenges
5. Learning and practicing coping strategies to manage symptoms
6. Developing a sense of control and mastery
7. Building self-confidence and self-esteem
8. Improving communication skills
9. Reducing stress and improving health
10. Enhancing overall well-being

Cognitive therapy can be used to treat a variety of mental health issues, including depression, anxiety, and stress. It can also improve relationships, increase job satisfaction, and enhance overall quality of life.
INTERPERSONAL PROCESS IN COGNITIVE THERAPY

The approach to therapy is based on the concept that emotional and psychological problems are the result of ineffective or distorted ways of perceiving and reacting to the environment. The therapist helps the client to identify and challenge these distortions, to develop more adaptive coping strategies, and to improve their overall functioning.

1. **Assessment and Problem Identification**
   - The therapist gathers information about the client's symptoms, past experiences, and current circumstances.
   - Identifies areas in need of improvement.

2. **Goal Setting**
   - Establishes specific, measurable, achievable, relevant, and time-bound (SMART) goals.
   - Focuses on both short-term and long-term objectives.

3. **Implementation**
   - Provides education and training on specific coping techniques.
   - Facilitates role-playing and practice sessions.

4. **Evaluation and Feedback**
   - Regularly reviews progress towards goals.
   - Adjusts interventions as needed.

5. **Relapse Prevention**
   - Prepares clients for potential setbacks.
   - Develops strategies to overcome barriers to change.

This process is iterative, with the therapist and client working collaboratively to address emotional and behavioral dysfunctions, leading to improved adaptive functioning and overall well-being.