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Kristene A. Doyle, *Editors*

# Cognitive Behavioral Therapy in a Global Context

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# Preface

We are very excited to have had the opportunity to edit this book with chapters by recognized professionals from around the world who have contributed to the growth of cognitive behavior therapy (CBT) and many of its specific approaches, such as rational emotive behavior therapy, cognitive therapy, dialectical behavior therapy, and acceptance and commitment therapy. The goal of this book is to present the similarities and differences in CBT practice across a wide range of countries to further supplement an understanding of the unique aspects of the therapy. While many of the CBT tenets are consistent from country to country, adaptations for language and culture are important considerations. We believe the readers will gain a wealth of information that will inform their own practice, regardless of where they live and/or work. The chapters specifically discuss modifications to consider when using CBT with individuals from around the world.

Having travelled extensively around the world to train mental health professionals in the theory and practice of CBT in general and REBT specifically for over 20 years, it is worth noting that we have learned from our colleagues as they have from us the idiosyncrasies of applying CBT to various populations. Critical discussions regarding what will and will not work in different countries as well as what irrational beliefs/cognitive distortions tend to be more "cultural" and less "individualistic" has contributed to a better understanding of the need to modify one's CBT practice and research. The international CBT community continues to grow, and we thank the authors of this book for being an integral part of the expansion of knowledge for professionals working in the areas of practice, training, and research.

We prepared this book with the objective to have uniformity in chapter structure to assist trainers, researchers, practitioners, and other professionals in comparing, contrasting, and understanding similarities and differences of CBT globally. Efforts were made to gather chapters from over 50 countries, and while the countries presented in this edited volume are important, this list is not exhaustive. In reviewing the literature and soliciting authors, some challenges were noted in identifying professionals to be able to write about the status of CBT in a number of important areas and geographic regions. This does not mean that CBT is not practiced in these areas,

but further underscores the importance of the establishment of more of a global community where science, resources, and practices are shared.

Our aim is to have readers develop a more intricate level of understanding in how one might practice, train, teach, and research CBT taking into consideration factors such as culture, language, and history. Each chapter provides an overview of the country, a brief history of psychotherapy, regulations for psychotherapy practice, CBT organizations, training opportunities, how to use and adapt CBT for the particular country, populations most frequently treated with CBT, research on CBT for the specific country, and special populations treated with CBT. We hope by reading the various chapters you will see the various ways in which CBT is similar and dissimilar internationally.

Reviewing each chapter has left us with a sense of excitement and awe at how CBT has grown and continues to grow internationally. We hope the readers take away specific applications for their practice when working with individuals from varying cultures. We also hope that the reader views this book as not the end of knowledge of CBT internationally, but rather as a stepping stone into further growth and expansion.

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# Contents

# Contributors

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**Reham Aly** is a consultant psychiatrist at the Ministry of Health, Cairo, Egypt. She is the founder and president of the Egyptian Association of Cognitive Behavior Therapy (the EACBT). She is also the CEO & Chief Instructor of the CBT clinical diploma organized & presented by the EACBT conjointly with the Egyptian Medical Syndicate initiated in 2013 and the CEO of the Egyptian Center of CBT providing clinical & psychological services for adults, children, adolescents suffering from different psychological services since 2013.

**Lena S. Andersen** is a clinical psychologist and Assistant Professor in the Global Health Section in the Department of Public Health at the University of Copenhagen. She was a Senior Research Officer in the HIV Mental Health Research Unit in the Department of Psychiatry and Mental Health at the University of Cape Town (UCT). For 10 years, she was the convener of the cognitive-behavioral therapy course in the clinical psychology-training program at UCT.

**Simon Bennett** was born in Ōtautahi, Christchurch and raised in Te Tai Tokerau, Northland. He completed his undergraduate training in psychology and then postgraduate training in clinical psychology all at Massey University, New Zealand. Upon completing his professional training, Dr. Bennett worked for several years as a clinical psychologist at Te Whare Mārie – a kaupapa Māori mental health team that services the greater Wellington region. Following this, Dr. Bennett returned to academia and completed his Ph.D. under the auspices of a Health Research Council Clinical Research Fellowship. His doctoral research explored the adaptation of cognitive behavioral therapy for Māori and incorporated Māori concepts into a

traditionally Western model of treatment. Dr. Bennett is a Senior Lecturer in Clinical Psychology and Associate Head of School (Clinical) at Massey University, Wellington.

**Sara Bernardelli** is a psychologist and Cognitive-Behavior Psychotherapist. She is a Supervisor at Albert Ellis Institute, New York. She is in the Board of Journal of Rational-Emotive Cognitive-Behavior Therapy. She is trainer at SPC-Scuola di Psicoterapia Cognitiva and APC-Associazione di Psicologia Cognitiva, Verona, Italy. She is member of APA-American Psychological Association and SITCC-Società Italiana di Terapia Comportamentale e Cognitiva.

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**Tania Cargo** (Ngāti Maru, Ngāti Manu, Ngāpuhi) is a Māori clinical psychologist and senior lecturer in Psychological Medicine and Psychology at the University of Auckland. She has more than 25 years' experience as a clinician in Infant and Child Mental Health services in Auckland, in Māori NGOs, and in Care and Protection services. Her research interests are in: digital e-mental health tools for rangatahi; attachment relationships; suicide prevention; and parenting interventions for whanau Māori. She also works as a court report writer for family court and Oranga Tamariki. Her governance roles in the education, community and ministerial sectors demonstrates her strategic planning experience. As an academic, Dr. Cargo works to ensure that clinical psychologists training in Aotearoa demonstrate their responsibilities under Te Tiriti o Waitangi. She also supports the aspirations of He Paiaka Totara the Māori Psychologists group, which aims to increase the number of Māori psychologists with Māori knowledge across all sectors in New Zealand.

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**Keith S. Dobson** is Professor of Clinical Psychology at the University of Calgary, and a Consultant for the Mental Health Commission of Canada. His research focuses on models and treatments of depression, as well as stigma related to mental health problems. He is a Past- President of the Canadian Psychological Association and current President of the World Confederation of Cognitive and Behavioural Therapies.

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**Courtney Duhning** is a certified school psychologist and postdoctoral fellow in New York. She has experience working in a variety of mental health settings including schools, hospitals, and clinics. Courtney strives to stay up to date in conducting research to provide the most empirically sound interventions. She attends trainings and presents her research at conferences around the United States.

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**Wayne Froggatt** practiced as a social worker for over 30 years, and his professional activities involved psychotherapy, supervision, training, stress management, organizational consulting, and writing. In his clinical work, he used cognitive-behavioral methods comprising a blend of Beck's "Cognitive Therapy" and Ellis' "Rational Emotive Behaviour Therapy" (REBT), and he was the Executive Director of the New Zealand Centre for Rational Emotive Behaviour Therapy. He also served as the director of Rational Training Resources. Sadly, Wanye passed away shortly after completing this chapter.

**Adriana Gamboa Bou** is a clinical psychologist. She specializes in Rational Emotive Behavioral Therapy and Cognitive Therapy, and is an International Supervisor for The Albert Ellis Institute. She is one of the founders of CETREC, a center for therapy and training in REBT and CBT located in Costa Rica. Adriana is also one of the founders for The International Association for REBT (IAREBT). She has been providing trainings in Costa Rica and other countries for the last 15 years, as well as overseeing patients in her private practice.

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**G. Row Kavi** is a psychologist and founder of Self Align – Therapy for Mental Health. She is an Associate Fellow and Training Faculty Level 2, with the Albert Ellis Institute and a credentialed Professional Certified Coach (PCC)™ from the International Coach Federation (ICF)™, USA. Apart from her private practice, she teaches several cognitive behavioral and evidence-based therapies, for students and professionals alike. Gauri has taught at premier universities, and successfully facilitated world renowned leadership/management workshops for corporates, across industries, in India and abroad, for 20+ years.

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# Chapter 1
# Global Adaptation and Practice of Cognitive Behavioral Therapy: An Introduction

**Mark D. Terjesen, Kristene A. Doyle, and Rebecca L. Wade**

Cognitive behavioral therapy (CBT) built upon the field of behavior therapy (BT) in efforts to understand the influence of cognition on behavior (Iwamasa & Hays, 2019). CBT operates on the assumption that thoughts, feelings, and behaviors are interrelated (Dobson & Dozois, 2019) with cognitions mediating the relationship between the environment and emotional and behavioral reactions (Beck & Dozois, 2011; Iwamasa & Hayes, 2019; Wampold, 2012).

CBT is often discussed along a developmental paradigm consisting of different "waves" of progression (David & Hofmann, 2013). The first waves were the primarily behavioral approaches to therapy that were based on principles of learning theory (i.e., classical conditioning, operant conditioning). This was followed in the 1950s and 1960s by the "second wave" of CBT, which included rational emotive behavior therapy (REBT) and cognitive therapy (CT). These approaches centered clinically on cognitive restructuring of automatic thoughts or irrational beliefs that considered maladaptive and lead to unhealthy affective and behavioral responses. The third wave includes clinical approaches such as acceptance and commitment therapy (ACT) and dialectical behavior therapy (DBT) with less of a focus on the cognitive restructuring component (David & Hofmann, 2013).

CBT has become more of a broad umbrella term to describe a variety of clinical approaches that focus on maladaptive cognitions (Hofmann et al., 2012; Matweychuk et al., 2019) and emotions that have a negative impact on functioning. Dobson and Dozois (2019) highlight the behavioral component of CBT involves clinical efforts to changing behavior, as well as indirectly change thoughts by applying behavioral

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techniques. This may include assessing behavior, teaching skills, and assigning homework to promote generalization (Lochman et al., 2011).

The overall field of CBT includes clinical interventions such as ACT, CT, DBT, and REBT (Matweychuk et al., 2019). While the models may differ in terms of what degree they focus on cognitive restructuring (i.e., working to directly change faulty cognitions), all assign cognitions as a primary factor in contributing to duress. For a more thorough review that breaks down the historical and philosophical underpinnings of the varied CBT models, the reader is referred to Dobson and Dozois (2010) and Dozois (2019).

While CBT is considered to be the "gold standard" of psychological treatment (David et al., 2018), is applicable across a wide-range of populations (Hofmann et al., 2012), and is taught and practiced worldwide (Dobson & Dozois, 2019), the challenge persists in understanding to what degree CBT is adaptable to reflect cultural and linguistic factors. Iwamasa and Hays (2019) discuss how multicultural therapy (MCT) has expanded to involve more minority cultures, but that MCT fails to be integrated into the major theories of psychotherapy, including CBT. While there has been an increase in the number of studies that have culturally adapted CBT, to what degree do these studies actually change core CBT strategies is still debatable (Chu & Leino, 2017).

This edited volume aims to reflect how the application of CBT has been influenced by a number of factors including geography and history of the country, systemic societal influences on the practice of psychotherapy, and the role of culture and language (Hays, 2009). As psychotherapy practice is guided by science, it is important to consider how, where, and with whom the research is conducted.

## Psychotherapy, Culture, International Research, and Ethics

One of the biggest challenges that affects the bridging of the science-practice gap in psychotherapy is *where* the science is conducted. Over 90% of psychological research is conducted on groups which constitute approximately only 60–70% of the world (Keller, 2017; Kline et al., 2018). This leads to significant underrepresentation (less than 10%) of the psychological research for over 30–40% of the world (Wade, 2021). Wade describes that one of the bigger challenges in having a truly representative science to guide practice is the fact that the groups for whom the research has been conducted upon are relatively homogenous. The term Western, Educated, Industrialized, Rich, and Democratic (WEIRD) (Granqvist & Nkara, 2017; Hays, 2018; Kline et al., 2018) is used to describe the homogenous samples seen in psychology research and geographically is represented by the United States of America (USA), Canada, and Europe (Kline et al., 2018; Pantalone et al., 2010). Wade further points out that specific populations of diverse groups (i.e., Native Americans, Asian Americans, LGBTQ+) continue to be underrepresented in research studies (Pantalone et al., 2010). This leaves much of the world's population underrepresented in psychological literature. Pantalone and colleagues also propose

that populations may not utilize mental health resources as the WEIRD definitions and conceptualizations of mental health are not consistent with their views and may find WEIRD developed psychotherapy treatments invaliding and intrusive (Arora et al., 2016; Smith & Trimble, 2016). Given this, it is important to consider the application of CBT in non-WEIRD locations to help inform and possibly revise clinical methods (Miller, 2005).

An important factor to consider is the role of culture in the psychotherapy literature as one's culture may have a significant impact on their behaviors (Psaltis, 2012) and response to psychotherapy. While culture is often equated with a country (Keller, 2017), this may not be the best practice as countries may have many varied cultural constructs which serve to impact behavior. We have asked the authors in this edited volume to consider *broadly* culture and its role in mental health application.

Hofstede and colleagues identify a number of cultural dimension themes that we argue may be important for clinicians to consider in the application of CBT within the country and with diverse populations. These dimensions include individualism versus collectivism, indulgence versus restraint, long-term orientation versus short-term normative orientation, masculinity versus femininity, power versus distance, and uncertainty versus avoidance (Hofstede, 1983; Hofstede et al., 2010). In the research of individuals from 76 countries (Hofstede et al., 2010), there were a number of trends between and within countries as well as more large-scale trends (Moskowitz & Moskowitz, 2009). For example, it is common for Western cultures to hold certain beliefs such as individualism, while in non-Western counterparts, collectivism prevails (Wade, 2021). It may be important for clinicians to consider these dimensions in both their CBT practice and science.

## *Challenges in Conducting International Research*

Barriers exist that limit the development of science among culturally and ethnically diverse environments (Wade, 2021). Among these barriers is the geographic location of the researcher as most who engage in psychological research are from areas which are considered to be WEIRD (Hays, 2018). The geographical and relatedly the probable lack of cultural diversity amongst the researchers will create logistical barriers for clinical adaptations (Wade, 2021). Furthermore, when adaptations of psychotherapy are *culturally specific*, the clinical intervention is more effective (Huey et al., 2014). However, these kinds of adaptations are seen less often, and as a result, the research and conclusions conducted in WEIRD cultures by WEIRD researchers become the "norm" and are more likely to guide clinical practice (Wade, 2021). However, as technology has assisted in the ability to collaborate and share knowledge and resources, these barriers are not as insurmountable as previously considered (Jensen, 2012; Kline et al., 2018).

## *Culture and Mental Health: The Role of Ethics in Practice and Science*

It is a clinician's ethical duty to be aware of cultural differences and consider them within treatment (American Psychological Association, 2017; Pantalone et al., 2010; Smith & Trimble, 2016). Wampold (2012) argues that in the case of conceptualization, clinicians need to consider the cultural beliefs, goals, and values of clients as it relates to treatment planning. Further, mental health practitioners have an ethical duty to integrate evidence-based findings to guide clinical interventions (American Psychological Association, 2016; Smith & Trimble, 2016). As such, it is important for practitioners to be mindful of the evidence base in the clinical application in culturally diverse settings and with culturally diverse clients (Cabassa & Baumann, 2013; Wade, 2021).

Culturally adapted treatments are shown to be more effective than treatments that were not adapted (Hall et al., 2016; Huey et al., 2014). Further, the more that interventions are individualized to consider factors such as culture, language, and race, clients are more likely to remain, engage, and participate in treatment (Soto et al., 2018). However, adaptations may be influenced by the cultural beliefs and values of the clinician (Eklund et al., 2014) and as such there may be variability as a function of clinician within a specific culture. Awareness of clinician's potential biases is linked to stronger therapeutic alliance and better client outcomes (Eklund et al., 2014; Pantalone et al., 2010).

A number of general guidelines for adapting psychotherapies to be culturally sensitive are developed with related but distinct foci. Pantalone and colleagues suggest that in adapting psychotherapy for culturally diverse groups it is important that clinicians consider thematic differences – that is, communication styles, family structure, health beliefs, the concepts of individualism and collectivism, self-identification, and therapy goals (Pantalone et al., 2010). Similarly, Smith and Trimble (2016) recommend an ecological validity model that addresses concepts, content, context, goals, language, metaphors, methods, and persons. More specific to CBT, Hays (2018) suggests consideration of age/generation, developmental disabilities, disabilities acquired later in life, ethnic and racial identity, gender, indigenous heritage, national origin, religious and spiritual orientation, sexual orientation, and socioeconomic status.

While adapting psychotherapy, and more specifically CBT interventions for culture, is logically a principle that most would support (Smith & Trimble, 2016; Soto et al., 2018), the *how* to do this is still not clear. Arguing that the basic interventions and strategies of CBT will be effective for diverse clients without scientific evidence is problematic (Pantalone et al., 2010). In their meta-analytic review, Smith and Trimble (2016) point out that 42% of cultural adaptations to therapy were guided by research or theory, or in other words, over half of the published work regarding cultural adaptations of therapy are *not* from an evidence-based perspective (Wade, 2021). Further, Wade points out that when studies do not describe *how* treatments were adapted (Soto et al., 2018) or fail to compare an adapted treatment to a

non-adapted treatment (Hall et al., 2016), we may not be learning much in terms of how to adapt for clinical care.

Recently, David and colleagues (David et al., 2019) proposed that we re-consider the model of CBT from an individual level to one seen more within a cross-cultural context, that is, examining countries and cultures as a unit of analysis rather than the individual. From a scientific and applied perspective, this may be an important model to guide the field. The CBT model has been disseminated globally and has had a significant impact on the practice of psychotherapy. By best understanding the intersection of culture, language, and clinical interventions, the field of psychotherapy may be best able to ascertain *what* clinical applications work for *which* clients under *what* conditions. Working with in-country practitioners, we may be at a better place to develop scientific models and applications of CBT within country, and as such be more confident in avoiding post-hoc explanations for change (or lack thereof). Understanding what mediating factors that reflect culture and language impact on the effectiveness of specific CBT interventions will lead to better serving our clients and advancing the science and practice of CBT.

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# Chapter 2
# Cognitive Behavioral Therapy in Aotearoa/ New Zealand


**Fiona Mathieson, Simon Bennett, Tania Cargo, and Wayne Froggatt**

## Overview of New Zealand

Aotearoa ('land of the long white cloud') is a collection of islands in the South Pacific occupied by a nation of independent-minded, laid-back do-it-yourselfers whose response to most problems is 'she'll be right, mate' (a stereotype, certainly – but not without foundation). Most live on the two largest islands, the (rather unimaginatively named) North and South Island.

Geographically, New Zealand is a paradox: a land mass larger than that of the United Kingdom is occupied by less than five million people. Of these, three quarters identify themselves as European; 15% as Māori, Asian and Pacific peoples 12% and 7%, respectively. The median age for Europeans (41 years) is nearly double that of the other ethnic groups (Statistics New Zealand, 2018).

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## *Some Historical Background*

Māori are the indigenous people of New Zealand. The foundational event in the birth of New Zealand as a nation was the signing of the *Treaty of Waitangi* in 1840. The Treaty made a range of promises, which included giving Māori the right to be citizens of the British Empire while maintaining full and undisturbed possession of their lands. In signing, Māori ceded to the British Crown the rights of kawanatanga (governorship) and an exclusive right for the Crown to purchase their land (Orange, 2004).

Subsequently, New Zealand was systematically colonised by the British Empire through the late nineteenth and early twentieth centuries. This period of time was marked by substantial loss of Māori land, rapid deterioration in Māori health and a consequential population decline (Belich, 2013). A full discussion of New Zealand's colonial history is beyond the scope of this chapter; however, suffice it to say that the link between history and Māori mental health problems has been well documented (Durie, 2001; Lawson-Te Aho & Liu, 2010). Furthermore, these trends are in line with what has been observed of indigenous populations throughout the world who have experienced the impact of European colonisation.

Despite its early mistakes at nation building and small population, New Zealand has often led the world with key social changes. It was the first country to give women the right to vote, first to introduce the 8-hour working day and one of the first to develop a welfare state with universal provisions. This history might provide some confidence that the country has the ability to see through what may be its most significant social challenge yet: attempting to redress the losses its indigenous people have suffered through colonisation.

The 1975 Treaty of Waitangi Act established the *Waitangi Tribunal*, through which Māori could seek reparation for breaches of the Treaty. For the last 40 years, claims and settlements dealt with by the Tribunal have been a feature of cultural and political life in New Zealand. This 'Māori Renaissance' has had a significant impact on the helping professions in New Zealand. It is now a standard expectation that key requirements of the Treaty – *partnership* based on cooperation, tolerance and respect; *participation* that is active and equitable; and *protection* by government of cultural practices and language – will be embedded in the code of ethics and operating principles of the professions. Later we will provide some examples of how this is being put into practice.

## *A Welfare State*

The New Zealand government is charged with providing 'cradle to grave' care for its citizens, beginning with child protection and support for mothers and babies, through to universal superannuation and subsidised rest home care for the elderly. The health system is mainly public and most health services are free. Central

government provides funding to District Health Boards (referred to as 'DHBs') which are responsible for the provision of health services in their defined geographical area, either directly or through sub-contracting with a variety of non-governmental organisations (NGO's).

There is an expanding private health system with increasing numbers of people purchasing medical insurance in order to avoid long waiting lists for treatment. This development is not without controversy – the fees are beyond the means of many people, and it is argued that private medical insurance is drawing resources away from the public health system.

The public–private dichotomy is also reflected in the provision of psychotherapy services. Forty years ago, the idea of counsellors/therapists working in private practice would have been almost unthinkable. Now, that sector has expanded significantly, though acceptance is still sometimes grudging and tempered by fears that it is contributing to a situation where access to mental health services is based on a person's ability to pay. Such a situation had already been identified over a decade ago by Dowell et al. (2009) who reported a gap in services for those with mild–moderate need who lacked the ability to pay for therapy.

In 2019, the New Zealand government announced its 'Wellbeing Budget' (The Treasury, 2019), with increased funding for mental health services and training due to a high degree of public concern about mental health and suicide in the community. This development has potential for increased access to cognitive behavior therapy (CBT) therapy and increased training of CBT therapists.

## Psychotherapy in New Zealand

### *Regulations Regarding Psychotherapy Provision*

The label 'psychotherapist' has recently become a protected term in New Zealand. According to the Psychotherapists Board of Aotearoa New Zealand (https://www.pbanz.org.nz), to legally practise in New Zealand, a psychotherapist must be registered and hold a current Annual Practising Certificate.

There are two pathways to registration: either a qualification accepted by the Board or membership of a recognised professional association. The options available would apply to practitioners of Jungian analysis, transactional analysis, psychoanalysis, psychosynthesis, gestalt, psychodrama and bioenergetics. No form of cognitive behavior therapy appears in the Board's list. There is one option – the NZ Association of Psychotherapists (NZAP) – where no particular therapy type is mentioned. A request was sent to the NZAP asking whether CBT therapists would qualify for membership, but at the time of writing, no reply has been received.

It might appear that practitioners of CBT are at a disadvantage by not being able to achieve registration and refer to themselves as psychotherapists. There are, however, some reasons why this may in fact be of little consequence:

1. There is a subtlety in the legislation: only the word ‘psychotherapist’ (which refers to the *person*) is protected – the term ‘psychotherapy’ (which refers to what the person *does*) is not. So an individual could say something such as ‘I practise psychotherapy’ or adopt a title such as ‘Practitioner of Psychotherapy’.
2. Another option is to use the catch-all label of ‘counsellor’, which is not protected. (Interestingly, some registered psychotherapists prefer to describe themselves as counsellors, possibly because ‘psychotherapy’ may be viewed as intrusive or only for people who have serious mental disorders).
3. Finally, most practitioners of CBT in New Zealand already belong to one or other of the occupational groups that are recognised as part of the helping environment (their ‘core profession’) and identify themselves accordingly as psychologists, nurses, social workers and so on. To them, the label of ‘psychotherapist’ is a non-issue.

## *Professional Organisations*

The various professional groupings all have professional bodies that provide services to members along with professional codes of ethics and sanctions for those who breach the code. The following list is a sample of organisations likely to contain CBT practitioners as members. It is (roughly) ordered from those more likely to cater to the needs of CBT practitioners to those less likely to meet their needs.

- New Zealand College of Clinical Psychologists.
- New Zealand Psychological Society.
- New Zealand College of Mental Health Nurses.
- Occupational Therapy New Zealand.
- New Zealand Association of Counsellors.
- Aotearoa New Zealand Association of Social Workers.
- New Zealand Nurses Organisation.
- New Zealand Medical Association.

In addition to holding membership in one of the professional associations, practitioners can join the *Aotearoa New Zealand Association for Cognitive Behavioral Therapies* (AnzaCBT; http://www.cbt.org.nz) an organisation that exists solely to promote and support the use of CBT in this country. At present, AnzaCBT has no licensing function, but it is currently working with a range of stakeholders to develop a certification process similar to that used in the United Kingdom by the British Association of Behavioral and Cognitive Psychotherapies.

## CBT Training in New Zealand

Training in CBT has been provided in New Zealand since the 1980s. Most universities have clinical psychology training programmes which have evolved from behavioral approaches, in line with evidence-based developments in the field. As evidence for the effectiveness of cognitive methods began to accumulate, increasing numbers of behaviorists came to regard them as worthy of incorporation into a science-based methodology.

Albert Ellis's *Rational Emotive Behavior Therapy* (Ellis, 1958; Ellis & Dryden, 2007) was initially the most commonly taught cognitive methodology; but during the 1980s, the emphasis shifted to Aaron Beck's *Cognitive Therapy* (Beck, 1963; Beck & Weishaar, 1989), due to the latter's more extensive research base. Currently, CBT remains the predominant psychotherapeutic modality taught to clinical psychology students. There is some coverage of other forms of therapy, including (in the past 10 years) so-called 'third wave' cognitive therapies such as *acceptance and commitment therapy* and *mindfulness* (J. McDowell, personal communication, September 17, 2018).

### *New Zealand College of Clinical Psychologists*

The NZCCP was founded in 1989 because the existing psychology organisation, the New Zealand Psychological Society, perceived as not adequately meeting the professional concerns and learning needs of clinical psychologists. Since then the NZCCP's annual conferences have usually included workshop presenters and keynote speakers from a CBT orientation (including prominent practitioners such as Drs. Christine Padesky, Kathleen Mooney, Judith Beck and Paul Salkovskis), with a growing emphasis on third wave cognitive therapies over recent years (New Zealand College of Clinical Psychologists, 2010).

### *University of Otago*

At its Wellington campus, the University of Otago has offered intensive CBT training to mental health professionals since 1999, initially training between 8 and 23 students per year. Initially this comprised a postgraduate certificate course covering basic CBT skills and their application to anxiety, depression, substance abuse and psychosis. A postgraduate diploma-level course began in 2011 adding cognitive-behavioral group work and treatment for PTSD, obsessive-compulsive disorder, bipolar disorder, personality disorders and co-existing substance use.

The focus on co-existing disorders was in line with service changes in New Zealand, where there was a growing expectation that mental health staff treat

substance use problems when they coexisted with mental disorders, rather than referring such clients to specialist alcohol and drug services.

Course content is shaped by an advisory group of stakeholders from a range of mental health services. The programme emphasises the importance of working in a culturally appropriate way with diverse groups, particularly Māori, in line with Treaty of Waitangi commitments. A recent addition to the training has been the inclusion of structured self-reflection practice, including self-application of CBT skills by students, based on a workbook by Bennett-Levy et al. (2015).

This course is based on best practice CBT teaching and learning (Padesky, 1996; Sudak et al., 2016) and modelled on the cognitive therapy training courses at Oxford (https://www.octc.co.uk/training) and Newcastle (https://www.ncl.ac.uk/postgraduate/courses/degrees/cognitive-behavioral-therapy-pgdip/#profile). It is practical and applied, in line with the considerable evidence suggesting that acquisition of clinical skills requires active and practical training in those skills rather than lecture-style teaching (Tarrier et al., 1999). The trainers are clinical psychologists who have attended intensive training by Drs. Christine Padesky and Kathleen Mooney of the Centre for Cognitive Therapy in Southern California.

The Otago course is half time, taught over a full academic year, using three block taught weeks, audio conferences and on-site workplace supervision by clinical psychologists experienced in CBT. Block courses are taught in a workshop format with a combination of lectures, demonstrations, discussion, role plays and case studies.

Students come from all parts of New Zealand and include nurses, social workers, occupational therapists, clinical psychologists, psychiatry registrars and alcohol and drug workers based in secondary and tertiary mental health services, primary care settings and mental health-related non-governmental organisations.

The course is assessed using multiple measures, based on the case histories, conceptualisations and treatment plans of clients with whom the students are using CBT. Research has indicated that the course leads to increased competence in CBT for students (Barnfield et al., 2007). Feedback on recorded treatment sessions is provided using the Cognitive Therapy Scale-Revised (Blackburn et al., 2001).

Funding for the course is provided by the New Zealand Ministry of Health via Te Pou o te Whakaaro Nui (https://www.tepou.co.nz). A challenge faced by the course is that funding is never confirmed for more than 1 year in advance (although thus far it has been consistently approved each year). Since the increase in funding for mental health as part of the government's 2019 wellbeing budget, course numbers have tripled to 63 students per year, taught across three streams.

In line with the Australian experience (reported by Hafner et al., 1996), while there were some initial reservations from clinical psychologists about sharing their professional 'turf', these quickly subsided and clinical psychologists were happy to supervise students.

### *Massey University*

The Massey University Post Graduate Diploma in CBT ran at the School of Psychology at its Albany campus in Auckland from 1999 to 2018, training on average 11 students per year. Like the Otago programme, the postgraduate diploma was modelled on the well-established Oxford and Newcastle CBT training programmes. The staff members all received specialist training in CBT either at Newcastle University CBT centre or from Drs. Christine Padesky and Kathleen Mooney.

Students came from the same professions as the Otago course, but also included the full range of psychologists (clinical, health and general) and students from a broader range of settings, including general hospital settings, the military, police, child protection services, Māori and Pacific mental health services and private practice. Unlike the Otago programme that has a primarily adult focus, the Massey programme covered the full developmental spectrum: children, adolescents, adults and the elderly. It approached CBT from a primarily Beckian-Padesky perspective (Padesky, 1996).

Part-time over 2 years, the programme was divided into theoretical and clinical practicum components. In the first year, four theoretical papers were completed: (1) theory and practice of CBT, (2) CBT for depression, (3) CBT for the anxiety disorders and (4) CBT for chronic and complex problems. Students had a number of assessment items to carry out:

1. The clinical practicum required trainees to complete CBT protocols with two clients suffering from depression or one of the anxiety disorders.
2. Thirty supervision sessions were required and provided by academic staff.
3. The trainees submitted seven recorded CBT sessions that are scored using the Cognitive Therapy Scale-Revised.
4. On completion of each case, trainees were required to complete a clinical presentation to staff and their peers and to write up a case study.
5. Finally, an oral exam based on an unseen clinical vignette was conducted.
6. As with the Otago course, an additional requirement of the clinical practicum was completion of a self-practice/self-reflection workbook (Bennett-Levy et al., 2015). Self-reflections were shared on an online stream site in order that trainees receive maximum benefit from the experiential exposure.

In 2017, despite glowing reviews of the programme, the Head of the School of Psychology decided to close the programme, which meant the final cohort of graduates finished in 2018. It is unclear why the University made this decision, but it may have been related to the specialist nature of the programme and a reluctance to appoint new staff in the face of one senior member retiring and another resigning (B. Haarhoff, personal communication, September 17, 2018).

## *Eastern Institute of Technology*

In 1998, the Eastern Institute of Technology (EIT), a polytechnic based in Hawke's Bay on the east coast of New Zealand, began offering a certificated postgraduate course in CBT. As students came from all parts of the country, the course used a combination of distance learning and attendance at three 5-day blocks throughout the academic year.

Prerequisites for entry were a relevant professional qualification and prior experience of working with clients. For the duration of the course, all students were required to have clinical supervision with an experienced CBT practitioner. The course assessments consisted of:

- Recordings of therapy interviews; some assessed individually, others in small groups.
- An in-depth analysis of a therapy session, to test familiarity with the main helping model taught.
- A detailed case conceptualisation based on the Jacqueline Persons model (Persons & Tompkins, 1997).
- Preparation of an 'instruction manual' (3000–6000 words) which described a problem area of interest to the student and how it could be treated using CBT. Each student presented a summary of their manual to the whole class at the third block course.

The teaching faculty included psychologists, social workers and nurses. The course coordinator had received advanced training at the Albert Ellis Institute in New York and was an Associate Fellow of the Institute.

A unique feature of the EIT programme was the use of an integrated CBT model that combined the work of the two major CBT theorists, Albert Ellis and Aaron Beck. A manual which describes that model and an article illustrating one application are available for download (see Froggatt, 2012, 2015). The course ran for 14 years and trained 200 practitioners. Figure 2.1 shows their professions.

## *New Zealand Centres for REBT and CBT*

In 1992 a small group of helping professionals formed a committee with the aim of organising CBT training available to all relevant helping professions in New Zealand. The first series was presented in Wellington in 1992, using trainers from the Australian Institute for Rational Emotive Behavior Therapy.

The original committee soon evolved into the 'New Zealand Centre for Rational Emotive Behavior Therapy'. In 2005 the directors decided that as the term 'cognitive behavior therapy' was becoming better known, they would create the 'New Zealand Centre for Cognitive Behavior Therapy' which would operate in tandem with the REBT Centre.

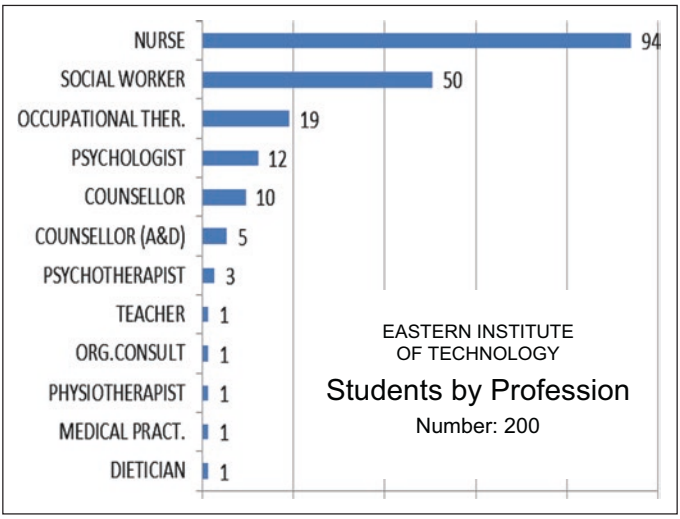


**Fig. 2.1** Eastern Institute of Technology. Students by Profession Number: 200

The centres arranged regular visits by Professor Stephen Palmer from the UK Centre for Rational Emotive Behavior Therapy. These trainings proved popular and his involvement made advanced certificate training possible. He is a consultant director of the New Zealand Centre.

The centres received no external funding, relying entirely on fees received from the training programmes presented. To minimise costs for participants or their employers (many facing cutbacks in government funding), it was decided to take the courses to them. A series of training events, usually consisting of a certificated programme plus a few short workshops, would be presented at two or three locations each year (in the smaller provincial cities as well as the main centres). Over its 19 years, the two centres presented a range of training programmes:

- *Certificated courses* in REBT, general CBT, stress management, cognitive-behavioral coaching and therapy with children and adolescents.
- *Short workshops* on specific aspects and applications of CBT including trauma, self-image, resistant clients, primary health practice, weight management, pastoral counselling, schema therapy, suicidality and chronic anger.
- *Special programmes on request*. A number of District Health Boards and other organisations contracted for certificated courses or specialised workshops for their staff. Short workshops were presented to professional groups including dietitians, psychologists, counsellors, dental nurses, social workers, occupational therapists and teachers. A number of government departments contracted stress management workshops for their staff. The largest ‘special’ programme carried out by the Centre was the presentation of 49 2-day workshops during 2008–2009 to mental health staff of all the District Health Boards in the South Island. The aim was to provide an introduction to CBT that would enable participants to

more effectively liaise with and assist CBT therapists to implement individual client treatment plans or to operate CBT programmes in inpatient units or other group settings. Six of the workshops were follow-up sessions for selected staff. Overall, 601 staff members were involved.

The *Primary Certificate in Rational Emotive Behavior Therapy* (the beginning qualification in REBT) was the keystone training event for the centres. Several innovations unique to NZ were introduced to increase the level of training:

- The *Multimedia Learning Programme*. This tool contains a range of creative exercises, short illustrative video clips and one video of a complete therapy session. Designed to speed up the learning of theory, it succeeded: after the tool was introduced, trainees arrived at their practicum noticeably better prepared than previously.
- The *Rational Analysis Training Simulator* is a pioneering piece of computer software that enables a trainee to practice using the ABC model without a client. Their computer provides guidance and points out when they got something wrong or could do it in a better way.

Between 1992 and 2011, the two centres provided 54 certificated courses (involving 700 participants) and 178 short workshops (over 1600 participants). In total, over 2300 practitioners were introduced to or increased their skills in CBT.

## *The Werry Centre*

The Werry Workforce Whāraurau (http://www.werryworkforce.org), a national workforce development centre for infant, child and youth mental health based at the University of Auckland has, since 2003, offered training to mental health professionals in the use of CBT with children and adolescents. One well-subscribed course is the one-day *Skate into Skills* training, based on the approach of Beck and Padesky, modified for the New Zealand context by Tania Cargo and Nikki Coleman (K. Isherwood, personal communication September 10, 2018).

## *Brief Undergraduate Training in Various Disciplines*

Brief introductory modules on CBT are often included across undergraduate mental health-related disciplines in New Zealand (counselling, social work, occupational therapy, nursing and psychiatry). These tend to be an overview and brief introduction to CBT concepts, sometimes with some brief role play practice or case studies, but without any practical application with clients.

In nursing, there are 18 degree programmes leading to registration, and there is no regulation of specific mental health content (A. Obrien, personal

communication, September 14, 2018). As part of deinstitutionalisation in New Zealand since the 1980s, there are a growing number of mental health nurses in community mental health teams. Nurses are in a good position to provide CBT because of their continual, direct client contact and (often) ongoing relationships with client (Nichols, 2006). The College of Mental Health Nurses has never provided continuing education courses in CBT (A. Obrien, personal communication, September 14, 2018). The University of Auckland offers a postgraduate course in 'Psychological Interventions', which covers a range of psychotherapies including dialectical behavior therapy, acceptance and commitment therapy and motivational interviewing. The course has been taught for about 5 years. A previous, briefer course on CBT (Nursing 760) was also offered for about 5 years. Both courses are taught to mental health and generalist nurses (A. Obrien, personal communication, September 14, 2018).

Occupational therapy training has included introductory modules on CBT for the past 20 years, with the amount and depth of teaching altering over time. The Otago Polytechnic course currently has a 3-week block of teaching in the second year which covers both the behavioral model and CBT. A large proportion of the block is spent on CBT. The total hours of in-class time over those 3 weeks is approximately 12–15 hours/week. They cover the theories of Ellis, Beck and Bandura, along with CBT assessment, goal setting and interventions in relation to the occupational therapy process, and students work through a case study (K. Govaertz, personal communication, September 13, 2018).

## *Other CBT Training*

There are several organisations offering professional training in *acceptance and commitment therapy* (ACT), one of the 'third wave' approaches to CBT mentioned earlier:

- *The Wellington ACT Centre* (http://actwellington.co.nz/) presents several ACT training courses each year.
- *New Zealand Acceptance & Commitment Therapy Training Ltd* (https://www.nz-act-training.com/) offers several 2-day beginner- and intermediate-level lists on their website a number of 2-day workshops in the upper North Island. Also on the site are some free resources including an e-book *ACT Quick Reference Guide* (Maher, 2014).
- *Mindfulness-based cognitive therapy* (MBCT) is another third wave approach which appears in a small number of NZ websites, but the training offered is aimed at consumers – not professionals. One organisation, *Mindfulness New Zealand* (https://mindfulnessinnewzealand.co.nz/), offers mindfulness training for helping professionals; however, no reference to MBCT could be found on their website, which raises the issue of compatibility with CBT (see David, 2014 for a discussion as to why this may be important).

## Using CBT in New Zealand

### *Applications with Specific Clinical Populations*

Mental health is the area where CBT is most commonly applied. According to Oakley et al. (2006), 39.5% of New Zealanders aged 16 and over will meet criteria for a DSM-IV disorder at some time in their lives: 24.9% with anxiety disorders, 20.2% with mood disorders, substance use disorders 12.3% and eating disorders 1.7%. Most people first experience their disorder early in their lives. Females are more likely to have anxiety, mood and eating disorders, whereas males have higher rates of substance use disorders. Māori have higher lifetime risk for all disorders. CBT is recommended for treating a range of mental disorders including depression, eating disorders and psychosis (Royal Australian and New Zealand College of Psychiatrists (2005, 2014, 2015). CBT is commonly used in the treatment of alcohol and drug abuse and other addictive behaviors such as gambling (Raki, 2014).

There is a growing awareness that CBT can help with physical health problems. This is illustrated by the increasing numbers of health practitioners such as occupational therapists, dieticians, physiotherapists and practice nurses who are enrolling for CBT training (see Figs. 2.1 and 2.2). Current points of focus include adjustment to disability, management of chronic medical conditions, pain management and facilitating dietary and other lifestyle changes.

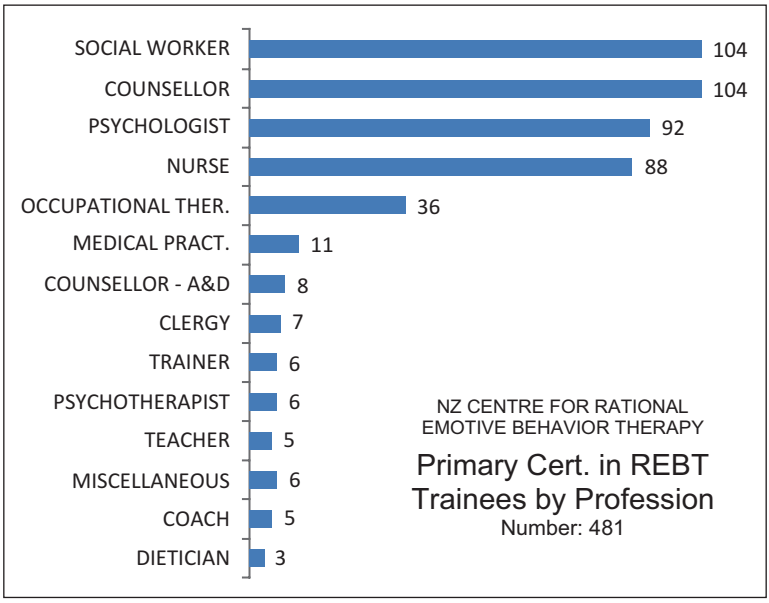


**Fig. 2.2** NZ Centre for Rational Emotive behavior Therapy. Primary Cert. in REBT Trainees by Profession Number: 481

CBT is used with a range of behavioral problems. Concerns about domestic violence and abuse of children have led to the development of anger management programmes, which are predominantly CBT-based. CBT is extensively used within the Corrections Department. For example, cognitive behavior/social learning theory forms the basis for the Te Piriti Special Treatment Unit for offenders imprisoned for sexual offences against children (Nathan et al., 2003). The Department states that 'Cognitive-behavioral therapy (CBT), involving techniques such as cognitive restructuring and social skills training, remains a "treatment of choice" in the correctional setting' (Department of Corrections, 2018).

## *Modalities*

Individual therapy is the most common modality used for delivering CBT. Group therapy is also used, particularly in prison settings.

## *Providers*

The helping professionals who carry out the actual delivery of CBT work in a variety of settings:

- District Health Boards are one of the larger employers, especially of psychiatrists, nurses, occupational therapists, psychologists and social workers. They usually work as part of a specialist team such as child and family mental health, adult mental health, alcohol and drug treatment and psychogeriatric services, in either inpatient or community settings.
- The Department of Corrections is a major employer of clinical psychologists and other professionals who may practice CBT. Some probation officers (traditionally viewed as a branch of social work, though opinions differ on this) may include CBT in their work. *Programme facilitators* run CBT programmes, delivered mainly in small groups, but sometimes with individual offenders. All of these roles are described in more detail at http://frontlinejobs.corrections.govt.nz/.
- Non-governmental organisations (known as 'NGOs') receive funding from the Ministry of Health and District Health Boards to provide a range of services to consumers in areas such as primary care, mental health, personal health, disability support and specialised services such as those for Māori and Pacific clients.

  *The Salvation Army* employs counsellors, psychologists, nurses and social workers in their alcohol and drug treatment programmes.
  *Plunket* is a nationwide organisation that offers parenting information, support and developmental assessments of babies. It also provides help with postnatal adjustment, including CBT groups.

*The Anglican Care Network* is a nationwide NGO that offers counselling, social work and youth development.
*The Raukawa Charitable Trust* is an Iwi (Tribal) organisation that provides a range of health, mental health, addiction, counselling and social development services to Iwi members and the wider community in the South Waikato area. It is one example of a number of similar Iwi-based organisations throughout the country providing services adapted to Māori cultural values and practices.

## Adapting CBT to New Zealand

Cognitive behavior therapy continues to evolve. As a scientific method, it is constantly open to new ways of improving its effectiveness. This section describes some ways that CBT has been modified to increase its effectiveness in the New Zealand setting. While there have not been randomised controlled trials of the efficacy of CBT in general New Zealand population samples, there has been some research into the acceptability and efficacy with specific groups, and these findings, where they exist, are included in the sections below.

## Special Populations

### *Working with Children and Young People*

Concern for the wellbeing of children has long been a focus of New Zealand's welfare system, with records as far back as the 1860s showing that resources were made available to families under stress due to the gold rushes of that period. More recently, there has been considerable activity developing wellbeing interventions for children and young people.

*Skate into Skills* is a CBT-based child and youth workshop developed by Tania Cargo and Nikki Coleman (Cargo, 2008) (see Figs. 2.3 and 2.4). It is supported by the Werry Centre (mentioned earlier) and presented nationally. The workshops are designed to upskill child and youth mental health workforce (social workers, occupational therapists, nurses, youth workers, counsellors and psychologists).

Cargo and Coleman took the skateboard – an object familiar to any New Zealand adolescent – and developed it into a metaphor to conceptualise and utilise CBT strategies with young people.

The deck of the skateboard represents situations to which the young person reacts. Connected to the deck are the four wheels, each of which represents a component of that reaction: the young person's thoughts, emotions, physical sensations and behaviors. The skate park represents the environment in which all of these things occur. Using this model, the therapist helps the young person to:

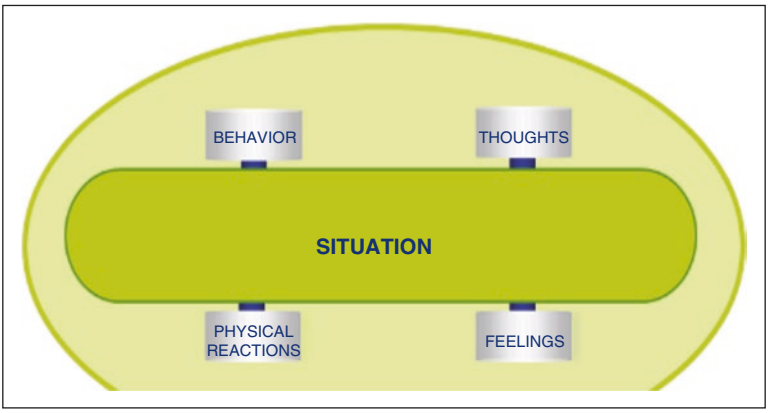


**Fig. 2.3** Cargo & Coleman's Skateboard Model

**Fig. 2.4** Graphics are used to explain the Skateboard model to young clients

1. Select one challenging situation, which they write on the deck of the skateboard.
2. Identify its four interconnecting parts, thoughts, feelings, physical reactions and behaviors, and write them on the four wheels.
3. Look for outside 'systemic factors' which may need to be addressed.
4. Develop targeted CBT strategies for each of the areas they feel ready to change:
   - Physical, behavioral, thoughts or feelings.
   - Systemic factors.
5. Create a new skateboard and add these new tools.
6. Finally, predict the type of ride they can expect.

The young person then tests the ride in the real world and reports back on how it went.

This procedure enables client and therapist to externalise, contain and understand the full experience. The skateboard metaphor helps support a collaborative relationship.

*Trauma-focused cognitive behavior therapy* was the subject of a manualised programme for maltreated children developed by Associate Professor Jacqueline Feather. This New Zealand developed programme was shown to be effective in both a pilot and small clinical trial (Feather & Ronan, 2009). This piece of work was important as it was the first time a New Zealand CBT programme had been implemented within this population. Feather later published the manual *Cognitive Behavioral Therapy for Child Trauma and Abuse: A Step-by-Step Approach* (Feather & Ronan, 2010), which demonstrated the four-phase programme in depth, so that other New Zealand practitioners could utilise this evidence-based model.

The ***SPARX*** programme developed by Professor Sally Merry and her team at the University of Auckland showed that a digital CBT programme could be an effective intervention for the treatment of youth depression in a variety of settings including schools, alternative education centres, youth health hubs, etc. and with Māori (Merry et al., 2012). SPARX won an array of awards and graced the cover of the BMJ (see Fig. 2.5). The programme is now available free online to all New Zealand residents (https://www.sparx.org.nz).

***Behavior intervention technologies*** (BITs) are an ongoing focus of development by the University of Auckland's Department of Psychological Medicine. Designed to target youth who spend from 4 to 8 hours a day on digital devices, they are predominantly based on CBT principles. There are increasing challenges associated with the digital space in terms of the consent process and safety, especially when the focus is on prevention which targets mental wellness during the years 12 to 25. The university is currently developing ecosystems of digital interventions which will sit on a digital platform likened to a New Zealand 'Trade Me' (eBay equivalent) for youth mental health. Currently being tested are a range of CBT apps which target youth emotional wellness, suicide prevention, parenting, safety, cultural practices


**Fig. 2.5** BMJ cover for SPARX edition

and alcohol and drug interventions. Chatbot technologies are in the final stages of design and will be tested early in 2019. Indigenous digital interventions (IDIs) are being developed within Māori communities which will target local those with unique challenges (i.e. very rural, multi-challenge families, high unemployment rates and low incomes).

## *Adapting CBT for Māori*

***Māori Mental Health*** New Zealand's first epidemiological study, *Te Rau Hinengaro: The New Zealand Mental Health Survey* (Oakley Browne et al., 2006), reported that across all disorder categories investigated, Māori experienced higher rates of depressive disorders, anxiety disorders, substance-related disorders and eating disorders as compared to the rest of the population. Māori rates of inpatient psychiatric admission continue to exceed those of non-Māori, and in 2010 the Māori suicide rate was 1.6 times higher than the non-Māori suicide rate (Baxter et al., 2006).

'How can we make CBT more relevant to Maori clients?' is a question that has been asked by New Zealand CBT therapists for a long time. Steps have been taken towards finding answers; though tentative and based largely on guesswork, they have at least been a start. The last decade, however, has seen us reach a turning point. Now we have real data and step-by-step guidance (Bennett et al., 2014, 2016).

***Theoretical Challenges*** The theoretical underpinnings of CBT challenge values inherent in the Māori culture. For example, the emphasis placed on scientific and intellectual reasoning in pursuit of evidence for and against one's negative cognitions may be at odds with a Māori perspective which could tend towards a spiritual or metaphorical interpretation of a given situation.

The sharp distinction made between cognition and emotion and the priority given to the thought – both fundamental assumptions essential to the effective delivery of CBT – represents another challenge to the cross-cultural generalisability of the approach. Specifically Māori models of health tend towards a more inclusive and integrated view of the human experience (Durie, 1985) which does not align easily with the notion that thoughts, emotions, behavior and physical reactions can be construed as clear and distinct units of reaction to a given situation.

Despite these theoretical challenges, there has been high-level recognition that the adaptation of widely used approaches such as CBT is an important and pragmatic (if not ideal) response to negative mental health statistics and low rates of treatment participation outlined above (Durie, 2012).

***Adapting to Core Values of Māori*** A number of authors have written about their approaches to adapting CBT for Māori. The first empirically evaluated example of such an adaptation was undertaken by Herbert (2001) who developed two modified versions of a standard CBT intervention for developing parenting skills.

The adapted parent training programmes were entitled the *Whanau Whakapakari Mātuatanga Relationships Model (MRM)* and the *Whanau Whakapakari Mātuatanga Values Model (MVM)*. MRM maintained the same structure as the standard programme with a particular emphasis on familial relationships between parents, children and the wider family support network (i.e. grandparents, aunts, uncles). Training sessions recognised the importance of whanau interactions in child management, whereby whanau can play an influential role in family decision-making.

MVM was also structured similarly to the standard treatment; however it was designed to emphasise a core set of values that were identified through a series of focus group interviews with key informants. These values included whakapapa, whanaungatanga and awhinatanga.

The two adapted parenting programmes (MRM and MVM) as well as the standard programme were administered to a cohort of Māori parents. Pre- and post-outcome evaluation was taken for support networks, parent expectations of children, parental self-efficacy, parental self-rating, critical-incident scenarios and programme evaluation. Results showed improved outcomes in these domains across all three programmes, and although there were no statistically significant differences between the programmes (perhaps due to the relatively small sample size), qualitative analysis demonstrated that the participants who received the adapted programmes reported greater enjoyment and higher levels of acceptance and valued the programme more highly.

***Adapted Brief Interventions*** Identifying the glaring absence of brief psychological mental health interventions designed specifically for Māori in primary care settings, Mathieson et al. (2012) adapted a self-guided and empirically supported CBT intervention for near-threshold mental health syndromes for Māori clients. The standard treatment, known as ultra-brief intervention (UBI), consists of three brief sessions of guided CBT-based self-management with a primary focus on problem solving and behavior change. The adapted version of UBI included inviting participants to commence sessions with culturally relevant prayer (karakia) or proverbs (whakatauki), clinician self-disclosure in pursuit of establishing a relationship (whanaungatanga) and utilising Māori visual imagery in the self-help material provided to participants. Although there was improvement in patients' global psychological distress following intervention, this was not statistically significant. Similar to Herbert's study however, qualitative analysis indicated that both clinicians and clients rated the intervention positively and provided favourable feedback.

***Adapting the Skateboard Model*** The skateboard metaphor was the basis for the postgraduate CBT child and youth mental health papers offered by the Department of Psychological Medicine at the University of Auckland. It was seen as important that in order to meet the needs of the indigenous Māori community, all interventions needed to be culturally responsive. Kaupapa Māori (Māori-originated) resources and bi-cultural CBT resources are both required. Cargo, a Māori clinical psychologist, developed the 'Waka Ama' model for use with Māori tamariki (chil-

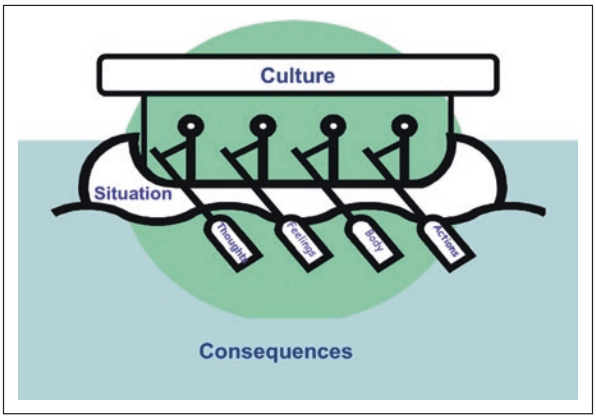


**Fig. 2.6** Waka Ama Model (Cargo, 2008)

dren) and their whānau (family). While the basic CBT components are the same as those in the standard skateboard model, there are three significant differences:

1. First is the use of a *waka ama* (outrigger canoe: see Fig. 2.6) as the metaphor. For Māori, each Iwi (tribe) has spiritual connections to waka (canoe) often seen as ancestors; thus the use of a waka image ensures that Māori cultural norms are reinforced in the work.
2. Second, the word 'culture' remains at the forefront for both therapist and tamariki in their work together.
3. Third, the fact that there are other kaihoe (paddlers) symbolises the importance of whānau (family) and sets the expectation that the child will never be alone, that connectedness to whānau, friends and communities is essential work.

These adaptations illustrate how CBT can be culturally responsive and inclusive in practical ways.

## Applying Research to Practice

Using a quantitative approach, Bennett et al. (2014) evaluated the effectiveness of an adapted approach to psychotherapy with Māori with the goal of providing empirically grounded guidance for psychologists aspiring to provide evidence informed treatment to their Māori clients. Sixteen Māori clients with a primary diagnosis of depression received an adapted treatment which incorporated Māori processes for therapeutic and interpersonal engagement, spirituality, family involvement and culturally relevant metaphor. Despite being small in scale, the results provided strong support for the adapted intervention with significant reductions in depressive symptomatology and negative cognition.

In a follow-up paper, Bennett et al. (2016) described the adaptations in greater detail. The adaptations were organised into four domains: connectedness, spirituality, extended family and metaphor. These domains had strong parallels with the highly influential work of Durie (1985, 2007).

1. *The domain of connectedness* was based on an assumption that forming a meaningful personal connection with the client was crucial to achieving positive clinical outcomes with Māori. In this regard, therapist self-disclosure was used to facilitate a more personal therapeutic relationship with the study participants. This approach is not entirely out of step with international trends, whereby several authors have found that a judicious degree of therapist self-disclosure can have a positive impact on the therapeutic alliance and thus treatment outcome (e.g. Barrett & Berman, 2001).
2. *Te taha wairua,* or *the spiritual domain,* is one of the four cornerstones of Māori health (Durie, 1985). The researchers used Māori proverbs (whakatauki) and Māori prayer (karakia) to commence and conclude sessions with their participants. Rather than this being a ritualistic procedure, emphasis was placed on selecting proverbs or prayer that had meaning to both the participant and the phase of treatment. Furthermore, participants were given the opportunity to take an active role in this process by identifying proverbs and prayer that have special meaning to their families.
3. *The domain of family* involved actively engaging the participants broader support network in their treatment including extending an invitation to participants to bring family support to sessions and involving close family as active participants in treatment objectives (e.g. participating in behavioral experiments).
4. *The domain of metaphor* involved the utilisation of culturally relevant metaphor throughout treatment. This included the identification of appropriate proverbs, using culturally resonant examples and where possible using Māori models of wellbeing.

## Summing-Up

CBT is alive and well in Aotearoa/New Zealand. Our geographic isolation and strong indigenous culture are both catalysts for exciting work in the intervention sphere. Most helping professionals in New Zealand are introduced to CBT in undergraduate programmes, and more in-depth training is available through specialist providers. CBT is delivered by a range of disciplines and to a diverse group of clients. A genuine attempt to find culturally appropriate ways of working with Māori using CBT is working. The future holds promise, particularly with the increased government funding for mental health.

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# Chapter 3
# Cognitive Behavioral Therapy in Argentina


**Guido Pablo Korman, Mercedes Sarudiansky, Cristian Javier Garay, and Mary Christine O'Brien**

## Country Overview

Argentina is the second-largest country in South America and the eighth-largest country in the world, with a population of more than 40 million (INDEC, 2010). Buenos Aires, the capital, is one of the largest cities in the world with a population of nearly three million. Most Argentinians speak Spanish, the national language, but many other languages are spoken, including indigenous and other European and Asian languages (Lewis et al., 2016).

Due to the Spanish colonization of Argentina in the sixteenth century, many Argentinians are descendants of Europeans, mainly from Spain, Italy, Germany, Ireland, France, and other Europeans countries (Lizcano Fernández, 2005). Nevertheless, approximately 2.5% of the population identify as Native-Americans, which includes several ethnic groups, such as Pilagás, Mbyas, Guaraníes, Mapuches, Whichis, among many others (INDEC, 2010).

The history of Argentina as an independent republic is relatively recent. Argentina was part of the Spanish colonial administration in South America beginning in the sixteenth century. First, its territories were included in the Perú Viceroyalty, with the capital in Lima. In 1776 the Rio de la Plata Viceroyalty was created, with the capital in Buenos Aires, which included the actual territories of Bolivia, Paraguay, Uruguay, Argentina, and part of Brazil. Argentina's independence from the Spanish

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administration, and King Fernando VII, started in 1810, with the creation of the first local government, *Primera Junta*. After several years of war, independence was declared July 9, 1816. However, despite Argentina's independence from Spain, internal conflicts between centralists and federalists caused a civil war in Argentina which lasted for decades (Rock, 1989).

At the beginning of the twentieth century, Argentina was considered one of the wealthiest countries in the world (Rock, 1989). This was accompanied by a great immigration wave, especially from Europe. Nevertheless, due to political and economic crisis, Argentina's promising progress began to decline. From 1930 to 1983, *coups d'état* and military dictatorships were systematic in Argentina's governments, creating political instability. This volatility culminated during the 1970s, when the last military government took power, leading to a crisis in political and civil rights. Thousands of people were killed and disappeared during this dictatorship (Rock, 1989).

In 1982, Argentina was involved in an armed conflict with the United Kingdom over the sovereignty of the Islas Malvinas, also known as the Falkland Islands. Although the armed conflict ended with the surrender of the Argentine army, the claim of sovereignty through diplomatic means continues to this day. The war of Malvinas highlighted the weaknesses of Argentina's military government, which led to a call for democratic elections. Since then, democratic governments have prevailed in Argentina. However, the social and economic consequences of decades of dictatorships and political instability continue to this day (Romero, 2013).

In terms of economy, Argentina's performance has been erratic, with alternating periods of economic growth and recession, with a significantly uneven distribution of wealth. The latest economic crisis in 2001 had consequences in local politics, generating several changes in the government. That year the country declared itself in default, which led to the implementation of economic measures that impacted inflation and the currency exchange rate. In addition, the social consequences are evident: the poverty rate during the last several decades has ranged from 20% to 30% of the population (INDEC, 2010).

Political unrest and economic downturns have impacted public health and educational standards (Organización Panamericana de la Salud & Organización Mundial de la Salud, 2011). Compulsory education begins at 4 years old, and access to free state schools are available from 45 days of age. The national literacy rate exceeds 95% and national public universities, many of which have been recognized for their high quality, are free to all citizens (Kraus, 2004).

Health services include public hospitals, as well as plans subsidized by the unions and private medicine (Acuña & Chudnovsky, 2002). All Argentinians receive free health services, including access mental health services. However, due to economic difficulties, there are problems with the health system, including a lack of technical and human resources and quality of care. The national mortality rate is similar to that of other developed nations (Acuña & Chudnovsky, 2002).

## History of Psychotherapy in Argentina

The history of cognitive behavioral therapy (CBT) in Argentina is intimately related to the development of psychoanalysis, and the professionalization of psychology during the twentieth century (Korman et al., 2015). Psychologists, rather than psychiatrists, primarily utilize CBT in Argentina.

Psychological language, particularly that of psychoanalysis, permeates the public sphere, the media, and everyday life in Argentina (Plotkin, 2003; Visakosky, 2001). Terms like *trauma* and *Freudian slip* are very popular in everyday conversational language (Korman, 2016).

Argentina has one of the highest rates of psychologists per capita in the world (Dagfal, 2009; Klappenbach, 2006; Rossi, 1997; Vezzetti, 1988, 1996). With a population of 40 million and almost 94,000 psychologists in Argentina, there is one psychologist for every 491 residents. Further, about 75,000 students are studying psychology (Alonso et al., 2014); and the University of Buenos Aires, the largest university in the country, has 13,000 psychology students (Alonso et al., 2014). A bachelor's degree in psychology is offered by 10 national universities and 31 private universities in Argentina (Alonso et al., 2014).

Psychology in Argentina is more than a scientific or clinical practice; it has become a cultural institution (Korman et al., 2015). Psychology in Argentina usually focuses on a clinical approach, and often the role of the psychologist is confused with that of a psychoanalyst (Dagfal, 2009). Many public figures in politics, sports, and entertainment have acknowledged that they are in therapy. For example, following his election win, President Mauricio Macri was asked what he would do on his first day of work to which he answered, he would go to the psychologist he has been in treatment with for twenty-five years (Gonzalez, 2016). This phenomenon could be related to the social value of psychotherapy in Argentina, which does not necessarily coincide with those of other contexts (Korman, 2016). In this regard, one study explored the differences between psychotherapy in Argentina and the United States (Jock et al., 2013); while most patients in the United States attend psychotherapy based upon referral from a doctor, most patients in Argentina go following a recommendation of a family member or friend. This is probably due to the fact that in Argentina, receiving psychotherapy is a valued and socially shared behavior and experience, and it is far from being stigmatized (Korman, 2016).

Psychoanalysis emerged in Argentina in the 1940s (Marín, 1995). The formal beginning can be found in 1942 when the Argentine Psychoanalytic Association was created. The Argentine psychoanalysis was Freudian in its beginnings with the only clinicians practicing as psychoanalysts being physicians. In the 1950s, debates about technical issues begin and it was around this time the importance of Melanie Klein as a reference was increased, whose most important moment was in the 1960s (Marín, 1995).

In the 1970s, Lacanian psychoanalysis began to replace Kleinian psychoanalysis (Marín, 1995). The incorporation of this thought outlined a distinction between psychology and psychoanalysis; the psychologists continued to dedicate themselves to

the clinical setting, and they stopped considering psychoanalysis a part of psychology (Dagfal, 2009). In fact, both psychologists and psychiatrists are often defined as psychoanalysts as a professional reference instead of distinctive professions (Dagfal, 2009).

The development of psychology in Argentina's universities has a long history, starting with the first chair of psychology, at the Faculty of Law and Social Sciences in 1900 (Klappenbach, 2003; Vezzetti, 1988, 1996). Teaching psychology in Argentina dates back to the late nineteenth century. At the beginning of the twentieth century, there were psychology courses for the training of teachers at the National University of La Plata and the University of Buenos Aires, the training of doctors at the National University of Cordoba, and the training of lawyers at the University of Santa Fe and in Buenos Aires (Klappenbach, 2006).

The first graduates in professional psychology finished training in the 1960s, and subsequently, psychoanalysis was no longer exclusive to the upper class in Buenos Aires. Instead, psychoanalysis became more widely available, as psychologists gained employment in public hospitals and clinics (Visacovsky, 2001).

Another interesting factor in the development of psychology in Argentina is that state universities, the largest universities in Argentina, have been governed by a board since the University Reform of 1918 (Caldelari & Funes, 1997), and are made up of teachers, graduates, and students. This restructuring meant that national universities would become highly politicized and influenced by local politics. In the late 1970s, when the experimental analysis of behavior began to reach Latin America, it was associated with capitalism and, therefore, strongly criticized. Up until this point, prevailing academic ideologies were linked to socialism (Korman, 2016; Mustaca, 2006). These political ideologies also impacted when CBT was to emerge in Argentina. Cognitive behavioral therapy was often criticized, not based on the efficacy of the interventions, but rather on the basis of political ideologies, as CBT was often associated with capitalist therapies because they responded to market demand rather than patient needs (E. Keegan, personal communication, July 4, 2017).

Professional psychology programs, and subsequently, professional psychology careers, emerged in the 1950s, and the first psychology graduates completed their training in the early1960s (Klappenbach, 2006). Since the development of academic curricula in psychology, psychoanalytic training has dominated almost all psychology studies (Mustaca, 2006). In discussions regarding the training of psychologists, developed mainly in the 1960s, many psychoanalysts argued that psychoanalysis should be considered a theory, a therapy, and a research method, so its inclusion within the undergraduate programs would subsume different areas of the academic curriculum (Klappenbach, 2006). Significantly, the hegemony of Lacanian psychoanalytic thinking can be seen in the national universities of Buenos Aires, Córdoba, Rosario, and Tucuman, and most private universities (Vázquez-Ferrero & Colombo, 2008).

During the 1970s, Argentina endured one of the cruelest dictatorships in Latin American history. The "Dirty War," which lasted from 1976 to 1983, was a period of censorship and state violence. During this period political dissidents were

arrested, abducted, tortured, and executed, and everyday life was strictly controlled by the government (Korman et al., 2015).

The return of democracy in 1983 ushered in a period of political and cultural openness characterized by the reconstruction of democratic institutions and increased freedom to associate in civil society, even among intellectual networks. As one analyst said, the 1980s were characterized by "cultural modernization, full participation, and above all pluralism and the rejection of all dogmatism" (Romero, 2013, p. 257). This coincided with society's desire for the exercise of free speech, which had been long repressed. It was in this context that alternative perspectives emerged in psychology and psychiatry, although the hegemonic dominance of psychoanalysis was still strong (Korman et al., 2015). Although the curricula at Argentina's schools of psychology tend to focus mostly on psychoanalysis, there are increasingly more opportunities for training in CBT (Korman, 2016).

## History of CBT in Argentina

In Argentina, CBT models were first discussed in informal settings (Korman et al., 2015). During the 1970s, most of the therapists interested in cognitive models were professionals with a thorough background in psychoanalysis, looking for alternative psychological treatments for their patients. During this time in Argentina, because of the dictatorship, communication among intellectuals was limited and knowledge circulated slowly through informal networks (Sábato, 1996).

Psychologists Héctor Fernández Álvarez and Sara Baringoltz played an essential role in the development of this model (Korman, 2011). Both came from a psychoanalytical background and taught in the School of Psychology at the University of Buenos Aires. Like many professors, they left teaching in public universities during the military dictatorship in Argentina. They both stressed the importance of private group study during that time.

Hans Eysenck's visit to Buenos Aires was a turning point in the field of psychology (Korman, 2011). In 1981, Hans Eysenck, the world-renowned director of the Department of Psychology at the University of London's Institute of Psychiatry at the time, gave a lecture at the first Argentine Psychotherapy Conference, for an audience of mostly psychoanalysts. In his lecture, Eysenck stressed the importance of psychotherapy and its connection with empirical clinical research, which created a controversy with the heavily psychoanalytic audience (Korman et al., 2015).

The Aiglé Foundation, founded in 1977, was the first Argentine institution studying cognitive therapy in the broader context of integration and eclecticism. In 1987, the Center for Cognitive Therapy (CCT) was founded by a group of psychologists and psychiatrists, specifically to focus on CBT. During the 1980s many mental health professionals began to travel abroad, mainly to the United States, to learn current trends in psychotherapy. At the same time, the first CBT institutions started organizing lectures and workshops, inviting personalities such as Michael Mahoney, Vittorio Guidano, Leslie Greenberg, Jeremy Safran, and Jeffrey Young to educate

their audiences about CBT. This was a stepping-stone to building international networks in CBT (Korman, 2011).

During the 1990s many CBT professionals started to organize postgraduate programs in National Universities. For example, Aiglé Foundation organized postgraduate courses at the National University of Mar del Plata (Korman, 2016). The National University of San Luis developed a master's degree in clinical psychology with a concentration in cognitive psychotherapy, which was the first master's program to gain recognition from the Ministry of Education (Korman et al., 2015). This master's program was directed by Claribel Morales Barbenza, Ph.D., who had a master's degree from an English university and was one of the first individuals to obtain a doctoral degree in psychology in Argentina.

In 1995, psychologist Eduardo Keegan created a postgraduate course in cognitive therapy at the School of Psychology at the University of Buenos Aires. In 2000, this university introduced a course in clinical psychology and psychotherapies, the first mandatory course that included CBT. The University of Buenos Aires now plays an important role in the institutionalization of CBT, due to its large number of students (Korman, 2016).

## Current Psychotherapy Provision Regulations

Most laws that regulate professional psychology were developed after the Falklands War and the end of the military dictatorship, in the early 1980s. (Ferrero & De Andrea, 2011). Regulations were implemented by higher education institutions, in different parts of the country (Klappenbach, 2000).

The practice of psychology is regulated by the law of professional practice of psychology 23277 (Law No. 23277, 1985). Before this law, psychologists could not practice psychotherapy (Klappenbach, 2000).

In Argentina, a psychology degree allows graduates to practice as psychologists and is comparable to a master's degree in the United States (Klappenbach, 2004; Korman, 2016). This role encompasses several fields including clinical psychology, forensic psychology, and educational psychology.

The healthcare system in Argentina includes private and public practice with the provision by private health organizations and union organizations. The government regulates the practice of psychotherapy through private health and union organizations. The Mandatory Medical Plan (Plan Médico Obligatorio), which is available to all Argentinians at no cost, includes a minimum of 30 psychotherapy sessions per year. Depending on an individual's diagnosis, additional sessions are also covered by the plan. Services include individual, group, couple and family therapy, psychiatry, psychopedagogy and psycho-diagnostic interviews.

There are several ethical codes developed by different professional associations or schools of psychologists. There is a Federation of Psychologists of the Argentine Republic that has a code of ethics that has a declaration among which is included:

Respect for civil rights, professional competence (updating of knowledge), scientific and professional commitment, integrity, and social responsibility.

## Professional Cognitive Behavioral Therapy Organizations

The 1990s were a period of expansion of CBT in Argentina, with a "cognitive revolution" in academic settings, as well as in the public and private health system (Korman et al., 2015). In 1992, the Argentine Cognitive Therapy Association (AATC) was created, 2 years after the International Association for Cognitive Psychotherapy was founded. This association was implemented by Aiglé and the Center for Cognitive Therapy. The first president was Fernando García from Aiglé (Korman, 2016). When seeking institutional affiliation, the ACTA chose to be aligned with the Internacional Association for Cognitive Psychotherapy in the international context, escaping the controversy that had been going on since the early 1980s in the Association for the Development of Behavioral Therapies. That is, when searching for a theoretical identity and institutional positioning, the ACTA chose the model developed by Beck and his institution, avoiding the controversy that had been brewing within the behavioral tradition regarding the validity of including cognition in behavioral treatments (Antony, 2003). As most of the early cognitive therapists in Argentina had training in psychoanalysis, the motives that led Beck to develop CBT resulted similar to their own experience. Also, Beck had an integrative position regarding other psychotherapeutic models from his early writings (Korman, 2013), which allowed local therapists to integrate their experience as psychoanalysts with CBT.

Another institution involved in the development of CBT was the Argentine Association of Behavioral Sciences (1987). Claribel Barbenza was the first president and was also the first director of the master's degree in clinical psychology with a concentration in cognitive psychotherapy developed in The National University of San Luis. This was primarily a scientific and academic association that had a minor impact on clinical training.

## Professional Training Opportunities in CBT

This section will describe training institutions that have formal programs endorsed by a local university or with connections to international CBT institutions. Further, all institutions included here are at least 10 years old, in order to check for continuity and permanence in the field. The authors decided that in order to meet inclusion criteria to be described below, each institution must have trained no less than one hundred professionals and have programs that involve more than one hundred hours of training in CBT. Most of the institutions are located in Buenos Aires. The names

of all institutions were translated to English, but acronyms were kept in the original language.

As previously noted, The Aiglé Foundation (1977) was the first Argentine institution to study cognitive therapy in a broader context of integration and eclecticism. It is an institution that focuses mainly on training, supervising, and supporting professional clinicians and researchers. More than 2000 professionals were trained in the Specialization in Cognitive Psychotherapy, which includes 440 hours of training (D. Kirzman, personal communication, May, 23, 2018).

The program also has a professional care network with about 100 professionals providing mental healthcare within the community. The program has three specialization courses in agreement with two universities (Maimonides University and University of Mar del Plata). It also provides two master's degrees: one in partnership with the University of Valencia and another with the University of Palo Alto (Aigle, 2018).

The Center for Cognitive Therapy (CTC) was founded in 1987 by a group of psychologists and psychiatrists interested in cognitive therapy. The CTC is primarily a CBT training organization and does not provide mental health services within the institution. In partnership with the University of Morón, CTC offers postgraduate training in cognitive therapy, with a total of 400 hours, of which there are already approximately 850 graduates. Between 2000 and 2018, CTC has offered various workshops for more than 14,000 participants (R. Wilner, personal communication, May, 30, 2018).

The Institute of Integrative Cognitive Therapies (CETEM) was founded in the late 1980s, by psychiatrist Herbert Chappa in the city of La Plata. Chappa was an early pioneer in bringing CBT training to Argentina. CETEM offers postgraduate training in CBT and is credited by the National University of La Plata. The two-year course includes 172 h of training. To date, more than 700 psychologists and psychiatrists have participated (H. Chappa, personal communication, June, 26, 2018).

Since 2010, the University of Buenos Aires (UBA) has offered a postgraduate program in clinical psychology and cognitive behavioral therapy, which provides credits for specialization in CBT. Run by psychologist Eduardo Keegan, the program includes 420 hours of theoretical and practical training. Approximately 80 students register for this program every year. Since 1999, this university has offered an updated program in CBT, which included 128 h, and about 60 students have participated each year. To date, approximately 1300 students have completed both training programs (M. Sicilia, personal communication, June, 1, 2018). Additionally, the university is currently offering a CBT-oriented training program specifically geared to the treatment of eating disorders.

The Argentine Association of Anxiety Disorders (AATA), created in 1996, aims to study anxiety and anxiety disorders in order to improve the quality of and prevent relapse. The AATA has an annual training program which includes 100 hours of training. Since its creation, approximately 1200 students have been trained (D. Bogiaizian, personal communication, June, 1, 2018).

Altué Cognitive Therapy was developed in the city of Rosario, Santa Fe, in 1999. Associated with the Aiglé Foundation, Altué Cognitive Therapy delivers training in cognitive psychotherapy and provides mental health assistance through community access to more than 30 professionals. More than 400 graduates have completed the program (N. Turkenkopf, personal communication, June, 1, 2018).

The Cognitive and Behavioral Therapy Association of the Littoral was created in 2004 in the city of Paraná. The training program includes 600 training hours and is organized in four levels. To date, nearly 100 graduates have completed the program (A. Facio, personal communication, June, 14, 2018).

Founded in 2008, the Foro Foundation is an institution dedicated to training, assistance, prevention, and research in mental health. It has several training programs certified by the University of Luján. The program delivers 380 hours of training in contemporary cognitive psychotherapy. To date, approximately 400 graduates have completed the program, including a network of 80 professionals that provide mental health assistance (J.P. Boggiano, personal communication, June 1, 2018).

The Institute of Cognitive Neurology (INECO) is associated with the Favaloro University. Since 2007, the institution has offered training in psychopathology and cognitive psychotherapy, which includes 128 hours of training.

The Northwestern Association of Cognitive Therapists has provided CBT training since 2007 in Tucumán and Santiago del Estero. Several training programs are offered, some of which are in partnership with the Aiglé Foundation. To date, this institution has trained more than 600 mental health professionals (D. Tolosa, personal communication, May, 15, 2018).

The Child and Adolescent Cognitive Therapy Team (ETCI) was founded in 2008 and provides training in cognitive therapy for professionals and mental health care providers working with children and adolescents. In 2018, about 16 professionals provided mental health assistance. ETCI delivers an annual 276-h training program, which includes clinical supervision and theoretical coursework. To date 276 has about 300 graduates (J. Mandil, personal communication, June, 12, 2018).

Since 2008, the University of Córdoba has offered a postgraduate training program in cognitive behavioral psychotherapy. The program includes 192 hours of theoretical and practical coursework. Currently, 600 professionals have graduated from this program (D. Mias, personal communication, June, 17, 2018).

Also in Córdoba, the Comprehensive Center for Contextual Psychotherapies (CIPCO) was created in 2009. CIPCO provides psychotherapeutic services and professional training. The 250-h training program has trained 800 students thus far (F. Olaz, personal communication, June, 28, 2018).

As previously noted, this is only an overview of some of the institutions offering CBT training in Argentina. Because CBT is in a stage of full expansion, it is likely that the number of institutions providing training in CBT will multiply over the next several years.

## CBT With Specific Clinical Populations

There is little evidence to suggest the availability of evidence-based CBT treatments for clinical populations served by the public health system in Argentina (Korman, 2016). To our knowledge, the only CBT interventions implemented with specific clinical populations are in private practice.

The Argentinean CBT research highlights a number of clinical areas often examined through the application of CBT in private institutions.

**Anxiety and Depressive Disorders** Herbert Chappa at the CETEM has worked and conducted research with individuals with anxiety disorders (Chappa, 2007a). As a psychiatrist, he made contributions in the psychopharmacological treatment of depressive and anxiety disorders with CBT and pharmacological interventions (Chappa et al., 1976). In the last decades he made contributions to the literature on the treatment of panic disorder (Chappa, 2006, 2007b), the premature interruption of treatment (Chappa, & Dowd, 2008), and eating disorders and obsessive disorders in adolescents (Chappa, 2012).

Daniel Bogiaizian, from the Argentine Association of Anxiety Disorders (AATA) and Ayuda Foundation, is currently providing treatment and researching smoking cessation for individuals with anxiety disorders (Bogiaizian et al., 2017). He also works in collaboration with Michael J. Zvolensky, from the United States, on the study of the relationship between anxiety sensitivity and rumination from a transdiagnostic perspective and the perceived racial discrimination in Latinos (Bakhshaie et al., 2016, 2017; Bernstein et al., 2008). More recently, he has focused his work in overwork and its correlations in mental disorders and quality of life (Bogiaizian et al., 2016).

**Obsessive-Compulsive Disorder** Tania Borda and colleagues from the Bio-Behavioral Institute have made contributions to the study and clinical practice of OCD spectrum. This Institute has a center in New York and in Buenos Aires, and these researchers work together in collaboration with Fugen Neziroglu. They provide treatment and develop studies with children with OCD (Borda et al., 2013), the status of body dysmorphic disorder in Argentina (Borda et al., 2011), the relationship of overvalued ideas of patients with OCD, and specific cognitions (Borda et al., 2017).

**Borderline Personality Disorders** Inspired by Marsha Linehan's work, the Forum Foundation conducted research and clinical practice with patients with borderline personality disorder (BPD). Pablo Gagliesi and his team have made important contributions in the dissemination of dialectical behavioral therapy (DBT) in Argentina. They organized the first workshop of Marsha Linehan in Buenos Aires in 2018, which had an important impact on the field. Their studies have focused on the comorbidity between bipolar disorder and cluster B personality disorders in Argentina (Apfelbaum et al., 2013) and other relevant aspects of BPD (Boggiano & Gagliesi, 2018; Puddington et al., 2017; Regalado & Gagliesi, 2012).

**Child and Adolescent** The Child and Adolescent Cognitive Therapy Team (ETCI) has conducted research with child and adolescent populations at a clinic attention focused on CBT (Bunge, 2008; Mandil et al., 2009). In 2017, this group published an English version of a CBT manual, focused specifically on Hispanic children and adolescents (Bunge et al., 2017; Consoli et al., 2018).

## Adaptation of CBT in Argentina

In recent decades, an important bias has been detected in psychotherapy research. Most of the participants in the empirical studies are white and middle class, and live in the United States or the United Kingdom (La Roche, 2005; La Roche y Christopher, 2008). This has led CBT researchers to focus on developing a culturally sensitive CBT protocol (Hinton & Patel, 2017).

In Argentina, this discussion regarding the adaptation of CBT treatments has not led to systematic research.

Here we will describe relevant research in the development of a culturally sensitive model of CBT for Argentina.

Alicia Facio has conducted research that focuses on culturally sensitive treatment intervention, in order to increase the connection between clients and therapists. She analyzed psychological differences between adolescents from Argentina compared to other countries, specifically from North America (Facio, 2006; Facio et al., 2017).

Based on her experience as a CBT clinician and her empirical findings, Facio proposes ideas that should be incorporated by local CBT therapists (Facio, 2017). Her suggestions are supported by results of her research, which include personality test data from psychometric and longitudinal tests on the socio-emotional development of young Argentines, and studies related to psychological differences between the Argentine and American community adult population.

Based on the work carried out by Oyserman et al. (2002), Facio points out that people from most Latin American countries, including Argentina, score higher in both individualism and collectivism than Americans of European decent. Another work by Facio et al. (2017) proposes that familism (for example, almost half of 19-year-olds believed that family responsibilities should be more important than personal projects) is central when thinking about the worldview of young people in the local context and therefore when developing CBT interventions.

She concluded that the interpersonal distance between therapists and patients is closer in the Argentine population, compared with the United States. Further, she proposed the utility of emotional metaphors over rational discussions, depending on the characteristics of the population (Facio, 2017).

The first author of this chapter has investigated the cultural characteristics of CBT treatments in the local context and in the adaptation of CBT treatments in a hospital population suffering from psychogenic non-epileptic seizures (Korman, 2016; Korman et al., 2014; Saizar et al., 2013. Korman et al., 2017). The first of

these works have analyzed and described some of the characteristics of CBT therapists in Argentina (Korman & Sarudiansky, 2018). They conducted a qualitative approach using semi-structured interviews to gain an in-depth and contextual understanding of the perspectives of 15 CBT therapists about their practice. Three key characteristics were identified from the analysis of the interviews. The valuation of psychotherapy and local idiosyncrasy make CBT treatments widely used for various problems (not necessarily mental disorders); treatments are more extensive than suggested treatment guidelines, while psychotherapists themselves are regular consumers of psychotherapy. The specifics of CBT in Argentina are related to the association between psychotherapy and self-improvement, which is characteristic of the impact of psychoanalysis in the Argentinean context.

Another project, which began in 2014, is adapting CBT interventions to treat hospital populations, specifically those with psychogenic non-epileptic seizures. Further, this group has carried out a qualitative analysis of native populations that influence the understanding of the diagnosis by identifying explanatory models and prototypes. Folk explanations were common to all participants (magic, witchcraft, energetic causes) and psychosocial explanatory models were different from the results of previous studies because these studies indicate that most patients support somatic explanations. Patients also use folk explanations related to traditional medicine, which highlights the interpersonal aspects of the disease (Sarudiansky et al., 2017). Now the researchers are developing the adaptation of a CBT treatment for this population based on the data collected. For the adaptation they are working in collaboration with Lorna Myers, Ph.D., one of the CBT references in this topic.

More research is required in order to further adapt CBT for Argentinean populations. CBT should not be a one-size-fits-all approach and we need to understand the best way to adapt it.

So far, we believe that this is one of the most important outstanding deficits that the CBT has in Argentina: The systematic research on the adaptation of treatments to the cultural characteristics of the population that will receive them.

## Research on CBT in Argentina

In this section, the research related to CBT developed in Argentina will be reviewed. Most of the studies to be discussed were funded by private economical means; some received grants from universities or government institutions. Nevertheless, the financial incentives to conduct psychotherapy research in Argentina is usually quite low, and subsequently, there are few professionals dedicated to research full-time. For example, annual research subsidies range from about 1000 USD to 3000 USD, depending on the type of research project. From a review of the literature, it appears that most of the current psychotherapy research has focused on patients with moderate–to-high socioeconomic status, while research in psychotherapy in public hospitals, where a large number of patients are concentrated and represent the most vulnerable populations, is very scarce.

Many of the CBT trainers have done research in the development and adaptation of inventories (Belloch & Fernández-Álvarez, 2004; Olaz et al., 2009, 2014; Rutsztein et al., 2004, 2010, 2013). There are few CBT treatments that have been investigated in the local context.

We will discuss two types of investigations: evaluations of clinical interventions and studies pertaining to the characteristics of CBT therapists.

Regarding the clinical evaluations in CBT, the works of the group directed by Eduardo Keegan that has evaluated the efficacy and clinical utility of two variants of CBT in Argentine patients diagnosed with compulsive disorders (Biglieri et al., 2007). This same researcher has developed a brief cognitive behavioral intervention for maladaptive perfectionism in students (Arana & Keegan, 2016; Arana et al., 2017).

Fabián Olaz is evaluating the results of a mindfulness training and a protocol based on the ACT-Matrix (F. Olaz, personal communication, July 6, 2017) while Anna Rovella and her group have adapted clinical tools for the treatment of generalized anxiety disorder (GAD; González et al., 2002; Herrera et al., 2006; Rovella et al., 2011). Her research group is currently adapting instruments for assessing emotional deregulation (Rivarola & Rovella, 2015; Villa Fadón et al., 2015), psychological flexibility in patients treated with dialysis, experiential acceptance, and thoughts and emotions, based on Adrian Wells' metacognitive theory.

Daniel Bogiaizian, from the Argentine Association of Anxiety Disorders (AATA), is currently researching smoking cessation treatments that use CBT, for individuals with anxiety disorders (Bogiaizian et al., 2017).

Regarding the CBT therapist characteristics, the first author of this chapter (GK) has researched the perceptions of CBT in Argentina (Korman et al., 2015; Korman, 2016). The third author of this chapter (CG) has evaluated the way in which psychological and psychopharmacological treatments are combined in Argentina, and how clinicians adhere to evidence-based treatment guidelines (Fabrissin et al., 2014; Garay & Korman, 2008a, b; Garay, 2016). Andres Roussos has researched how patients perceive change during psychotherapeutic treatments, including CBT treatments (Roussos, 2013; Etchebarne et al., 2016). Sara Baringoltz leads a research team in investigating the role of recreation in CBT therapists. Baringoltz and colleagues have published several books on the topic (Baringoltz, 2000; Baringoltz & Levy, 2007, 2012). The preliminary results they have found is that therapists do not achieve what they suggest to their patients (R. Wilner, personal communication, August 6, 2018).

At the Northwestern Association of Cognitive Therapy, Dante Tolosa is conducting research on the inclusion of CBT in everyday life. He is currently focusing on the therapeutic companion (Tolosa, 2015, 2016), an assistant for mental health professionals included in different mental health laws in Argentina. The object of a therapeutic companion is to accompany the patient in carrying out the tasks proposed by the CBT therapist.

CBT research in Argentina is in its infancy; however, it will continue to develop, specifically within the local context.

## CBT with Special Populations in Argentina

CBT in Argentina is still developing, for this reason this section will explore where the attention might be needed.

Although, as we have mentioned, there are research studies and treatments based on CBT for children, the application of interventions in specific contexts is still a pending issue. Currently, there are no formal regulations in which evidence-based clinical developments are implemented into the institutional context. This is problematic for at-risk individuals of lower socioeconomic status, as public hospitals do not implement CBT practices. Public hospitals may be the only opportunity for vulnerable populations to obtain mental health treatments; however, the interventions used are not evidence-based.

Further, despite the recommendations of international researchers and the broad anthropological trajectory in Argentina, there are still no guidelines for the effective implementation of CBT for individuals from native communities.

## Summary

Scientific development in Argentina has been systematically affected by recurrent economic crises, as well as by political instability. Despite this, in psychotherapy, Argentina continues to have several researchers interested in producing knowledge and developing therapeutic strategies, in order to improve the mental health of the local population.

Since its origins, CBT has been based on scientific research, which supports its use and has gained a positive reputation in the mental health field (Korman, 2013). In Argentina, the development of CBT has had distinct features. The adaptation of CBT in Argentina has more to do with psychotherapists' perception of psychoanalytic outcomes as negative and looking for alternative treatments. Nevertheless, the wider acceptance of CBT is also associated with the evidence of the clinical efficacy, which is supported by randomized and controlled studies. Also, the emphasis in CBT on "effective treatments" and "clinical research" has drawn clinical psychology closer to psychiatry and pharmacology. Paradoxically, in Argentina, to date, no randomized controlled trial has been developed to evaluate the efficacy of CBT. Research in psychotherapy in Argentina is quite recent, and there is a lack of funding to carry out these studies.

Despite this deficit, CBT has been spreading in Argentina since the 1980s. There are several ways to explain this phenomenon. First, it may be related to the low stigma of psychotherapy in Argentina. Psychotherapy is not only associated with mental disorders but also with an improvement in quality of life and with self-acceptance. This public perception allows individuals, including public and political figures, to talk freely about their psychotherapy interventions. Further, the mandatory medical plan provides several psychotherapy sessions at no cost to the

individual, so many people have access to affordable mental health services. This context may facilitate a good reception for new models of psychotherapy, like CBT. CBT might also have gained popularity in Argentina due to the modern cultural factors which focus on personal wellbeing and self-care.

In this context, many institutions that advocate for and practice CBT have been developed; however, this growth has mostly been in the private sector. In public universities, the popularity of CBT began more recently, after 1990. This might be associated with political factors and with a hegemonic presence of Lacanian psychoanalysis in this sector.

Finally, CBT research has been conducted in the last several decades, despite scarce funding. Many of the research projects outlined in this chapter were funded through private support. Nevertheless, there is a lack of evidence of specific outcomes on psychotherapy in Argentina. It is necessary that the investigation of psychotherapy begin to provide information about the specific characteristics of the Argentine context, including cultural factors, such as culturally appropriate framing of cognitive behavioral techniques, assessing and addressing key local complaints such as somatic symptoms, and spirit possession, and incorporating these factors to promote recovery and resilience. The authors believe that special attention should be paid to the population served in public hospitals, given that these individuals are considered the most vulnerable and to a large extent are not included in local research investigations. The challenge will be to start conducting research in the most vulnerable populations with an emphasis on the development of a culturally adapted model of CBT for Argentina.

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# Chapter 4
# Cognitive Behavioral Therapy in Australia


**Michael Kyrios, Ross Menzies, and Nikolaos Kazantzis**

## Overview of Australia

Australia is the world's sixth largest country by area, the world's thirteenth largest economy (heritage.org) but with a population of approximately 26 million (abs.gov.au) it does not rank in the top 50 as for population. The Commonwealth of Australia is comprised of the Australian continent, the island of Tasmania, and a number of smaller islands (https://www.cia.gov/the-world-factbook/countries/australia/). The country is highly urbanized with most population centres located on the eastern seaboard. Prior to the arrival of Dutch explorers in the seventeenth century, Indigenous Australians inhabited the continent (Clarkson et al., 2017). In 1770, Great Britain claimed the East Coast and named it New South Wales and a penal colony was set up. As the population of Australia grew, additional colonies were set up, and in January 1901, the six colonies formed the Commonwealth of Australia. Australia has six states and ten territories and has a democratic political system. Of note, immigrants account for 30% of the population (abs.gov.au).

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## History of Psychotherapy in Australia

Australia has been a loyal and reliable advocate in the science, practice, dissemination, and upscaling of cognitive behavior therapy (CBT). The science underpinning CBT in Australia has been grounded on experimental psychology from the 1950s onwards, while its dissemination has been advanced by the advent of accredited clinical psychology training in the scientist-practitioner model, with both research and practice supported by resilient professional bodies that have also stressed the importance of a strong evidence base to clinical practice. Furthermore, the upscaling and dissemination of CBT throughout health, mental health, community, and educational settings has been supported by public policy that gives particular prominence to a strong evidence base.

The best example of this in recent years was the embedding and, hence, upscaling of CBT into the Australian national health system through the provision of government rebates for CBT when treating mental health disorders. The following sections detail the significant factors and events that have impacted the development and dissemination of CBT in Australia.

### *Researchers and Universities Providing the Evidence Base*

Despite an early focus on army, school and inpatient psychiatric contexts, and a history characterised by psychoanalytic theory and psychotherapy, the focus of Australian mental health practice has transferred to primary care and community settings and cognitive behavioral interventions in recent decades (Byrne & Reinhart, 1990). Through that journey, Australian universities and, specifically, psychology departments have been particularly influential in the provision of research findings on human behavior.

In their social history of behavior modification in Australia, Winkler and Krasner (1987) outline that, reflecting Australia's colonial history, psychology in Australian universities grew out of philosophy, with the first professors coming from Britain with roots in the intellectual philosophies of nineteenth century Britain. Winkler and Krasner further identified the University of Melbourne Psychology Department of the early 1950s as the birth place of Australian behavior therapy. In support, Lovibond (1993) outlines that the initial force at the University of Melbourne came in 1952 and 1953 from a select group of Honours students and staff who aimed to understand behavioral problems by utilising the fundamentals of normal behavior. Spence (2016), on the other hand, emphasizes that a variety of state-based groups of researchers and practitioners across Australia with interests in behavior change emerged somewhat independently.

Notably, seminal research in the 1950s and 1960s on classical conditioning and applications to behavior change brought an initial focus on evidence-based interventions (Winkler & Krasner, 1987). Over time, from the 1950s and 1960s onwards,

universities introduced experimental clinical psychology and evidence-based practice into their programs in clinical and applied psychology, although unlike today it was not required by formal course accreditation standards introduced by the Australian Psychological Society (now independently evaluated by the Australian Psychology Accreditation Council, a standards organization). Interestingly, course subjects highlighting the link between the basic discipline of psychology and clinical practice were not specifically characterized as behavior therapy; rather, they were labelled experimental clinical psychology (Lovibond, 1993), stressing that translational science was at the heart of cognitive-behavior therapy in Australia from the very outset.

In the late 1960s and 1970s, operant conditioning research and applied behavior analysis followed, while the 1970s also saw the advent of clinical psychological research findings being applied to a diverse range of psychological and behavioral problems (Spence, 2016), such as childhood, anxiety, mood, and behavioral disorders and problems. There was a particular uptake of CBT in educational and disability services during this period.

The 1980s and 1990s saw the beginning of the cognitive revolution in Australia. Although it is not possible to pinpoint the specific impetus, it most likely occurred as a result of Aaron T. Beck's theory of psychopathology, research trials, and practice guides such as *Cognitive Therapy of Depression* published in 1979. (La Trobe University, situated in Melbourne, Australia awarded Dr. Beck a Honorary Doctor of Science Degree for his contributions to the profession.) The integration of behavioral and cognitive interventions broadened the focus to a greater range of issues and disorders, including psychosis, and obsessive-compulsive, trauma-related and personality disorders, as well as chronic health conditions. These developments were supported by research on psychopathology, psychosocial determinants of health, and clinical trials. By the 2000s and 2010s, the arrival of a new wave of cognitive and behavioral therapies was making great impact across the board, while randomized control trials were impacting advances in public mental health policy. In particular, digitally delivered CBT interventions were being developed in the hope of upscaling the dissemination of CBT, particularly to those who had little access to specialist clinical services.

Such developments were dependent on the university sector, particularly clinical psychology and public health researchers. Cognitive rehabilitation interventions, post-rational and narrative approaches, acceptance and commitment therapy, dialectical behavior therapy, eye movement desensitization and reprocessing (EMDR) therapy, and mindfulness-based interventions were also spreading rapidly amongst practitioners, although it took a little longer for researchers to take an interest or to be funded for investigating the efficacy of such interventions. By the 2000s, the advent of the third wave of cognitive-behavioral interventions and the positive psychology movement also saw their expansion into the educational, health, primary care, and other domains (Kazantzis et al., 2010). Such advances were supported by the university departments of psychology, education, population health, medicine (especially psychiatry), occupational therapy, social work, and other allied health,

supporting the notion that CBT has now extended its spread and impact into a range of professions and disciplines beyond psychology.

## Relevant Organisations and Regulations

The Australian Psychological Society and the Australian Association of Cognitive Behavior Therapy (AACBT), inclusive of its predecessor the Australian Behavior Modification Association (ABMA), have been particularly influential in the promotion of CBT and CBT-related research. These organisations have provided national and international linkages, provided mentorship and professional practice standards, ethical standards and codes of conduct, and promoted the inclusion of CBT in national health and mental health policies. We focus here on the contributions of the APS and AACBT but acknowledge that many psychologists in Australia hold memberships with partner organizations, such as the Association for Behavioral and Cognitive Therapies (ABCT), The British Association for Behavioral and Cognitive Psychotherapies (BABCP), European Association for Behavioral and Cognitive Therapies (EABCT), the International Association for Cognitive Psychotherapy (IACP), and, more recently, the Association for Contextual Behavioral Science with its emphasis on Acceptance and Commitment Therapy. Australian psychologists have also sought specific accreditation in the practice of CBT via the Academy of Cognitive Therapy, a multidisciplinary certifying organization.

(i) The Australian Psychological Society (APS)

The APS has been a distinct force in the emergence of cognitive behavior therapy in Australia. Its strong ties from the outset with universities and teachers' colleges, and its emphasis on evidence in the training of psychology practitioners, are still reflected in current national accreditation and registration requirements in Australia (Cooke, 2000).

Established in 1944, with 44 members, as the Australian Branch of the British Psychological Society (BPS), members voted to become the independent APS – the organisation coming to fruition in 1966. The APS, with a current membership of around 24,000, has functioned as a national body representing psychologists through state groups, regional branches, a series of divisions representing academic and practitioner arms of the society, and public interest and professional special interest groups. In 2017, the APS voted on a new governance structure, consisting of a representational Board and Council. The APS advocates for the profession and discipline of psychology, publishes three main journals (*Australian Psychologist, Clinical Psychologist,* and *The Australian Journal of Psychology*), holds numerous conferences and a congress, undertakes several activities around the issues of public interest, provides psychology practitioners with evidence-based practice guidelines, runs a training institute (the APS Institute), maintains standards and the professional code of conduct, and participates in course accreditation processes which impact on national professional registration and endorsement.

One of the great achievements of the APS was to directly advocate and succeed in embedding government-funded rebates for evidence-based therapy, and particularly CBT, within the Australian national universal health system (see section below on the policy context in Australia which describes the "Better Access to Mental Health Care" initiative). Through this initiative, consumers have been able to access rebates for CBT services, greatly increasing access, particularly to mental health experts delivering focused psychological interventions such as those embedded within CBT.

The APS has also established excellent linkages and collaborations with other professional groups representing medical practitioners, allied health and mental health, consumers, indigenous health practitioners, and others. For example, the APS Institute, together with the Australian Association of Social Workers and Occupational Therapy Australia, developed the first online training course in CBT for Australian mental health professionals (*CBT Fundamentals: Processes and Techniques in Cognitive Behavior Therapy*), funded by the Australian Government Department of Health and Ageing (DoHA) to support the Better Access to Mental Health Care initiative. The course has now successfully trained over 7000 mental health professional across Australia.

(ii) The Australian Association of Cognitive Behavior Therapy (AACBT)

According to Birnbrauer (1994), the Australian Behavior Modification Association (ABMA), the first official entity aimed at representing behavior modification or behavior therapy in Australia, was set up following an informal meeting of relevant individuals from various states at an APS conference in 1974. Initially led by Victoria in the early 1970s, the ABMA constituted a relatively loose grouping of state branches that were incorporated locally. The recognition of the cognitive revolution in psychology led to a name change for the organization and in 2010 the AACBT was formed as a national body. "Broadly speaking, the AACBT is concerned with the application of behavioral and cognitive sciences to understanding human behavior, developing interventions to enhance the human condition, and promoting the appropriate utilization of these interventions" (King, 2016, p. 266). It is a multidisciplinary association with membership open to psychologists, psychiatrists, teachers, counselors, coaches, occupational therapists, social workers, other tertiary qualified health professionals, and other groups interested in using the cognitive behavioral approach "to help bring about emotional, cognitive, and behavioral change" (King, 2016, p. 266) across all aspects of health care. It is a particularly inclusive organization, attempting to disseminate research findings from all branches of cognitive and behavioral therapy (e.g., behavior therapy, cognitive therapy, CBT, acceptance and commitment therapy, mindfulness-based CBT).

AACBT currently organizes conferences (its first national conference was in 1978, while it has hosted over 40 conferences) and workshops with national and international experts, facilitates local professional development activities, publishes a journal (*Behavior Change*, first published in 1984 by the Victorian Branch), provides professional awards to recognise researchers and practitioners in cognitive behavior research and therapy, and has a national website and social media presence

(e.g. a Facebook page with over 9000 followers in 2016 and now over 12,000; Menzies, 2016), which it uses to update members and followers on news, research, and facilitates professional and networking opportunities. AACBT has established links with the major umbrella organisations representing cognitive and behavioral work internationally (including ABCT, EABCT, Asian Cognitive Behavioral Therapies Association [ACBTA], and IACP), and has representatives on the Committee of the World Congress of Behavioral and Cognitive Therapies. From the outset, ABMA/AACBT demonstrated its intentions for global outreach (see later section on Global Reach), with the Queensland Branch hosting the 4th World Congress of Behavior Therapy on the Gold Coast in 1992 and Melbourne hosting the 8th World Congress of Behavioral and Cognitive Therapies in 2016. Conference proceedings and papers emerged from those conferences (Menzies et al., 2016; Sanders & Halford, 1992) highlighting the quality and range of research in cognitive behavior therapy emanating from Australia and the world.

## *The Policy Context in Australia*

While CBT is practiced mainly by psychologists in Australia, particularly as most clinical psychology postgraduate training programs provide foundational knowledge in CBT (Kazantzis & Munro, 2011), numerous other health and mental health professionals and paraprofessionals are also trained in or practice CBT. This is reflected in the multidisciplinary membership of AACBT and training opportunities provided by the APS Institute. Despite the wide acceptance and practice of CBT, there are currently no formal certification requirements within Australia, although the AACBT has recently introduced an accreditation system for members that is similar in its requirements to that of the BABCP. Despite the absence of certification of practitioners in the past, CBT has permeated Australia's nationalized healthcare system that provides specified rebates via the Medicare Benefits Schedule for a wide range of healthcare services, with primary care as a centrepoint. Patients present to their general medical practitioner (GP) and, should more specialised care be required, patients can be referred on. Traditionally, such referrals have been limited to specialist medical practitioners but, in recent years, the importance of a multidisciplinary approach to many health problems has been acknowledged. In particular, the contribution of psychologists and allied health practitioners to mental healthcare has been recognized by policy makers. In 2006, and of particular relevance to mental health and CBT, a national program termed "Better Access to Mental Health Care" was introduced, specifically targeting mental health presentations within primary care.

Better Access allows GPs with specific training to develop mental health plans and refer on for ongoing care which encompasses CBT (Kyrios, 2014). In addition to GPs, referrals can also be made by psychiatrists and paediatricians to generalist and endorsed clinical psychologists or social workers and occupational therapists for rebatable focused psychological treatments based on CBT. While the initial policy

allowed for up to 18 sessions of individual therapy in addition to the same number of group sessions per year, the uptake by the public was so great that budget overspend considerations led the federal government to limit the number of sessions to only up to 10 individual and 10 group sessions per year. The COVID pandemic provided an impetus to increase the number of sessions and to introduce telepsychology sessions. Referrals are initially made for a maximum of 6 sessions with a GP assessment required to determine whether the additional sessions are needed. While the limited number of sessions compromises the quality of care for certain conditions (obsessive compulsive disorder, posttraumatic stress disorder, hoarding disorder, psychosis, etc.), some additional service provision models have been developed that can be accessed through primary care networks and non-government organisations. The bulk of Better Access referrals are to psychologists, with endorsed clinical psychology sessions making up around half of those. (A similar emphasis on CBT exists in New Zealand, though there is a different training and healthcare context, [Kennedy-Merrick et al., 2008]). The impact of CBT and the role of psychologists in particular have also led to impacts in specialist mental healthcare and to health contexts such as rehabilitation, pain, diabetes and cardiac care, migraines and headaches, sleep disorders, etc. Since the advent of Better Access, there have been enormous increases in the number of individuals with a mental disorder receiving CBT and significant decreases in levels of distress, depression and anxiety (Pirkis et al., 2011).

A review of the Medicare Benefits Schedule has been undertaken that may change the funding framework again. While a number of challenges have been identified with respect to unplanned impacts of Better Access on the profession, training courses, and equity (Gilmore et al., 2013), the major point to consider, however, is that CBT was purposely chosen to be the cornerstone of mental health care within primary care in Australia because of its evidence base. Other criticisms of the Australian system include the lack of local CBT certification and, possibly reflected in cost blowouts, the lack of a nationwide stepped care approach to mental healthcare. GPs can make a referral anytime, with no evidence required that the particular professional receiving the referral has specific levels of expertise in CBT.

While almost all clinical psychology programs in Australia are now CBT-based, a large proportion of psychologists maintain an eclectic or psychoanalytic approach to their practice. Furthermore, referrals are generally made without specific reference to the severity of the disorder which, in many international contexts, is linked to the "intensity" of treatment. For instance, in the United Kingdom, a stepped care approach is utilized in the delivery of low- and high-intensity psychological interventions (IAPT, 2012). The UK's Increasing Access to Psychological Therapies (IAPT) program aims to facilitate access to psychological treatment for people with high prevalence mental health disorders (e.g. depression and anxiety) through the provision of four levels of stepped care that are based on guidelines by the National Institute for Health and Care Excellence (NICE), an independent public body providing national guidance and advice aimed at advancing care in the United Kingdom.

Albeit with some significant differences, the IAPT framework has formed the basis for the development of the *beyondblue* New Access program in Australia, a pilot which was exclusively funded by a non-government organisation. To date, a

higher intensity component in stepped care has not been incorporated into New Access. Furthermore, New Access could accept direct self-referral via telephone and social media, rather than following a GP referral. Moreover, New Access training was not overseen by a relevant professional body (i.e. the APS), as it had in the United Kingdom by the British Psychological Society. While Cromarty et al. (2016) reported that initial recovery rates and the economic viability of New Access were promising in a non-independent pilot evaluation, a stepped care framework has not yet been established formally in Australia. Stepped care was particularly important in the success of the United Kingdom's IAPT program where higher reliable recovery rates were associated with a higher average number of therapy sessions, higher step-up rates among individuals who started with low-intensity treatment, larger services, a larger proportion of experienced staff, and NICE recommended treatments (Gyani et al., 2013). Nonetheless, there are moves towards stepped care models in Australia with a number of alternatives being developed, inclusive of the use of digitally delivered CBT.

A salient feature of CBT is its suitability for adaptation into interventions that can be delivered and disseminated via digital means (e.g. online, smartphone apps) in automated, therapist-assisted, or multimodal formats (Bakker et al., 2016). There is now a large body of research supporting the acceptability, feasibility, and efficacy of digital delivery of mental health resources in assessing and using cognitive behavioral principles and strategies to treat psychological disorders (Andersson & Carlbring, 2017), although uptake and engagement fluctuate widely (Fleming et al., 2018). Digitally delivered interventions span the spectrum from those for mental health literacy, help seeking, public health/health promotion, at risk/early intervention, and treatments, either automated self-help or therapist-assisted, for specific symptoms, high prevalence psychological disorders, serious mental illness, and suicide prevention.

The Australian government has invested in the development of digital CBT mental health interventions for high prevalence disorders. Australia has led the great developments over recent years in the online dissemination of CBT, inclusive of the integration of online CBT into the national mental health policy (Australian Government Department of Health and Ageing, 2012). The Australian government's e-mental health strategy (Australian Government Department of Health and Ageing, 2012) has supported the development and maintenance of various online and remote psychological treatment services, while embedding these within the national health and mental health system in a formal capacity and developing staged models of care is the next priority. An online repository of CBT-based mental health interventions has been developed inclusive of a portal (Head-to-Health; see https://headtohealth.gov.au), a website designed to help people with mental health conditions or challenges link to trustworthy online information and resources, most of which are CBT-based. There is ongoing development of such digital supports, inclusive of the further development of quality indicators so that consumers and professionals can differentiate quality products, the training of professionals to incorporate such resources into their work, and the facilitation of

access to such resources to community-based service providers (Reynolds et al., 2015).

## Global Reach of CBT in Australia

A number of international conferences have been held in Australia where CBT has taken a central role. In 2014, the APS hosted the 27th International Congress of Applied Psychology in Melbourne. Within that conference, there were a multitude of CBT researchers presenting keynotes, symposia, and papers. More significantly, as mentioned above, the 1992 World Congress of Behavior Therapy was hosted by the Queensland Branch of ABMA on the Gold Coast and, in 2016, the AACBT hosted the 8th World Congress of Behavioral & Cognitive Therapies in Melbourne. Over 2300 delegates from more than 50 countries attended that event that had been 10 years in the planning. One emphasis was to showcase research from emerging economies and in regions where CBT had not been the dominant treatment modality in the past. The AACBT introduced a free registration scheme for delegates from emerging nations, which saw attendees come to Australia from the Sudan, Congo, Ethiopia, Uganda, Zimbabwe, Nigeria, Sierra Leone, Indonesia, Papua New Guinea, and many other nations. The theme of the 8th WCBCT was "Advances and Innovations in the Behavioral and Cognitive Therapies Across the World" (see Menzies et al., 2016). A second emphasis of the event was to attract delegates from beyond the traditional disciplines of mental health. Applications of the cognitive and behavioral sciences in experimental psychology, clinical psychology, psychiatry, nursing, social work, psychiatry, primary care, and a range of related areas in allied health and health policy were presented. This was in keeping with the multidisciplinary nature of the host organization, the AACBT.

## The Future of CBT in Australia

CBT is currently firmly entrenched within the Australian health and mental health system. Professionals, paraprofessionals, educators and peer supports are using CBT and CBT-based frameworks to: (a) impart information and treatment strategies that empower individuals affected by health and mental health challenges to manage their symptoms and lives and/or (b) to educate youth and adults so as to better manage or prevent difficulties and build resilience. With respect to the latter, the return of CBT at a broader level to primary and secondary educational contexts is an exciting development.

Furthermore, digitally supported CBT has made a significant impact on the broader Australian community. While various models and resources have been developed to help clinicians integrate digitally supported CBT into their practice, few training programs or supervision arrangements support the development of

requisite skills. A part of the future of CBT and its dissemination lies in the development of training programs to facilitate the integration of e-based CBT skills into the arsenal of practitioners. Technological developments will further facilitate the utility of CBT. For instance, technology can facilitate access to individualised content chosen on the basis of client preferences or algorithms that integrate information from structured online assessments. Exposure-based interventions will be advantaged by augmented and virtual reality capabilities. The use of avatars in online programs has already begun (Rehm et al., 2016). With such opportunities come challenges, inclusive of ethical and legal concerns, keeping up with technological advances, developing viable business models to support digital services, and adjusting models of interdisciplinary and professional-peer interactions (Kyrios & Thomas, 2014; Kyrios et al., 2015).

Finally, the role of our Australian CBT professional bodies in supporting developments in emerging nations in our region is only beginning to be explored. The AACBT is playing a significant role in current planning for a World Confederation for Behavioral and Cognitive Therapies. The new organisation has the support of many of the largest international CBT associations and has been developed by the World Congress Committee of the WCBCT. It is a global organisation to represent CBT activities and influence policy making in mental health. One of its aims is to overcome regional barriers and provide support for emerging nations with little current access to specialist CBT services. Australia is well placed to support emerging economies in the Pacific region to gain access to CBT services. This may, of course, critically involve the use of e-therapies described above. CBT has not only had a golden past in Australia but Australian CBT researchers and practitioners will continue to impact globally.

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# Chapter 5
# Cognitive Behavioral Therapy in Bangladesh


**Nabila Tarannum Khan**

## Overview of Bangladesh

Bangladesh is a densely populated, low-lying, mainly riverine country located in South Asia with a coastline of 580 km (360 mi) on the northern littoral of the Bay of Bengal. (World Population review, 2018). The current population of Bangladesh is 166.37 million people (World Population review, 2018), making it the 9th most populous country in the world. The country has a population density of 1115.62 people per square kilometer (2889.45/square mile), which ranks 10th in the world (World Population review, 2018).

Bangladesh is a fertile land, which got its independence from Pakistan in 1971, Bangladesh was originally called East Bengal, when it was under the British rule from 1757 to 1947 and became part of British India. In 1947, East Bengal and West Pakistan separated from India and formed the new country of Pakistan. East Bengal was renamed East Pakistan in 1955 (Mookherjee, Nayanika, 2009).

Bangladesh is the third largest Muslim populated country. Muslims constitute over 90% of the population, while Hindus constitute 8.5% and the remaining population constitutes approximately 1% (Official Census Results, 2011). Urbanization has brought its own set of problems pertaining to mental health and well-being. The range of disorders and deviancies associated with urbanization is enormous and includes psychoses, depression, sociopathy, substance abuse, alcoholism, crime, delinquency, vandalism, family disintegration, and alienation (Trivedi et al., 2008).

Bangladesh has also many socio-economic problems contributing to the causation of mental disorders. Poverty, unemployment, rapid urbanization, and rising trends of substance abuse are among the common factors contributing to mental disorders (WHO, 2018a, b).

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## Mental Health Prevalence in Bangladesh

The prevalence rate of mental disorders within Bangladesh is quite variable with ranges from 6.5% to 31.0% among adults and from 13.4% to 22.9% among children (Hossain et al., 2014a, b). While an awareness regarding mental health disorders exists at community level, there is also a negative attitude toward the treatment of those affected and treatment is not a priority in health care delivery within Bangladesh. Mental health services are concentrated around tertiary care hospitals in big cities and are mostly absent in primary care (Hossain et al., 2014a, b). The first national survey on mental health conducted in 2003–2005 demonstrated that 16.1 % of the adult population had some form of mental disorder and that the prevalence of mental disorders was higher among women (19%) than men (12.9%) (welfare WMoHaf, 2007).

Another study reported an overall prevalence of mental disorders among 12.2% of respondents and here as well more females than males were affected (13.9% vs. 10.2%) (Karim et al., 2006). A rural community–based study showed an overall prevalence of psychiatric disorders as 16.5%; notably, half of the sufferers had depressive disorders (8%) and a third had anxiety disorders (5%) (Monawar Hosain et al., 2007). On the other hand, another study on females in a rural setting reported 16.4% had mental disorders with depression being the single most common disorder (8.9%) (Ara et al., 2001).

A study in Bangladesh showed that women had a higher psychiatric morbidity than men, with a sex ratio of 2:1 for mental disorders and 3:1 for suicide (Ministry of Health and Family Welfare, 1999).

Mathers (2008) considered mental disorders as constituting a major public health problem and contributing to 13% of the global burden of disease as measured by disability-adjusted life years. As low- and middle-income countries have a higher burden of mental disorders than economically developed countries (Bass et al), it is important to identify difficulties earlier both from a developmental perspective and at the earliest onset of the disorder so that proper assessment can be conducted to both prevent and treat mental health problems.

Psychiatric and psychogenic disorders such as depression, anxiety, obsessive-compulsive disorder, and psychophysiological disorders are among those most commonly reported in Bangladesh. Further, the prevalence of mental disorders was much higher in overcrowded urban communities than in rural ones, and also much higher among the poor.

Typically, in developed countries mental health problems are treated with a multidisciplinary approaches, where psychiatrists, clinical psychologists, psychotherapists, psychiatric nurses, and social workers all provide necessary support in collaboration (Royal college of Psychiatrists, 2018). However, in Bangladesh the mental health sector is dominated by doctors and psychiatrists. This may be due to the historical perception of the practice of psychology and the negative stigma and connotations connected to it as well as the assumption that only medicine could cure all elements including psychological.

By contrast with developed countries, the only scientific intervention for psychological problems were through psychiatric drugs in Bangladesh, until the clinical psychology department in Dhaka University was founded in 1997. From that time, this newly developed team of psychological professionals has struggled to establish new non-pharmacologic approaches to treatment; and after some initial resistance, they built people's confidence in the field of mental health in Bangladesh (Islam & Biswas, 2015). It is clear that within the broader health sector, mental health has fewer facilities and beds. For example, beds in mental hospitals account for only 8% of the total number of hospital beds. On the other hand, there are no beds earmarked for the mentally ill in forensic units across the country. Consequently, fewer mentally ill patients receive services in various institutional facilities. Only 26% of service users in outpatient facilities are mentally ill. Similarly, the mentally ill constitute only 4.2% of the patients served in inpatient units.

Bangladesh also has a small number of community care facilities for patients with mental disorders. National Institute of Mental Health in Dhaka is the only national level tertiary care mental health treatment and research facility in the country (Choudhury et al. 2006). Bangladesh has only one mental hospital that was established in 1957 (WHO, 2008). In 1969 the first outdoor clinic for the mentally ill was opened at the Dhaka Medical College in the capital Dhaka. Later in 1981, the National Institute of Mental Health (NIMH) was established to provide training on mental health to primary care physicians and health workers. In addition, a few NGOs are also involved in mental health in the country, primarily focusing on treatment and rehabilitation.

## History of Psychotherapy in Bangladesh

After the partition of the Indian subcontinent, psychology was thought of as a branch of philosophy. In 1959 the Universities of Karachi, Panzab, Rajshahi offered M.A. in psychology. They had courses required for teachers, trainers, sociology students, and social welfare workers. That time Dacca, now known as Dhaka, also opened a child psychology program to women graduate students. In 1950, Pakistan psychology started changing because of the influence of foreign-trained psychologists and the growing recognition as a separate discipline. However, old philosophical concepts remained in the traditional-bound Pakistan.

The oldest laboratories are in Pakistan and Dhaka. They have apparatus for experiment on sensation, association reaction time, learning, etc.

In 1964 there was no national psychological association, but there were approximately 250 teachers of psychology, though one was reported and planned. No psychological journals were published in Pakistan. Psychological papers were published in periodicals such as the *Pakistan Journal of Philosophy*, *Pakistan Journal of Science*, *Punjab Educational Journal*, *and the Proceedings of the Pakistan Philosophical Congress.* That time an outstanding psychologist, S.M.H. Zaidi, of the University of Karachi, frequently contributed to the American psychological journals.

The study of the discipline of psychology started in 1921 (British era), at Dhaka University in the Department of Philosophy. Psychology as a separate discipline was started first Rajshahi University in 1956 and at Dhaka University in 1965. In the early 1960s, at the University of Rajshahi, Karachi and Sind started to develop for modern laboratories and had been initiated for some research on perception, learning and motivation. During this time, applied psychology in education, medicine, and industry was underdeveloped. As such, a class of clinical psychologists were growing and the prospected growth of psychology in Pakistan appeared to be closely linked with the needs and demands of a new nation.

There is no documentation work done in the perspective of history of psychotherapy. Much of the history described below comes from a series of personal interviews with M. Rahman, professor of clinical psychology, the University of Dhaka. The first psychotherapist in this land (Bangladesh was East Pakistan at that time) was Professor Mofassel Uddin Ahmed (called M.U. Ahmed) who became known for his psychotherapeutic clinic, at Azimpur, Dhaka, during the 1960s and 1970s. His initial approach to psychotherapy was hypnotherapy. Later he adopted autosuggestion and meditation as his methods of intervention, which he used to call "Medistic Psychotherapy." Reportedly, he used to do a lot free association in his psychotherapeutic sessions give suggestions to his clients for healing their various types of psychological difficulties. Prof. M. U. Ahmed became very successful in his therapeutic work and, therefore, became popular among his clients. Psychiatrists who valued psychotherapy in mental healing referred cases to Prof. M.U. Ahmed. He became the first president of Bangladesh Psychological Association. He was also elected President of the Bangladesh Mental Health Association, where there were prominent psychiatrists, psychologists, and social workers. This relationship is the key to the successful development of therapy in Bangladesh. Clients were now given the opportunity to express their emotions and encouraged to take responsibility for their own action and to work out solutions to his problems through appropriate suggestion and advice.

During this time, Bangladesh was immersed in spirituality and supernatural ideas about mind and mental illnesses. As a result, it was common practice of the people of Bangladesh to visit spiritual leaders or faith healers for their day-to-day stress, personal distress, or even for mental illness. In the 1970s, the number of psychiatrists was very few (estimates are fewer than 10 nationally), and the primary approach to treatment was consistent with the medical model of psychiatry.

The development of counseling skills in Bangladesh owes much to Professor Dr. M. K. Ali who worked as a director of the Counselling and Guidance Centre at the Teacher-Student Centre of Dhaka University. Dr. Ali practiced Rogerian client-centered therapy. Here he would conduct counseling /psychotherapy through non-directive approach to local and foreign students as well as to the teachers of the university. Dr. Ali was also a very good counselling skills trainer, as he conducted a counseling course for 15 psychologists and psychiatrists organized through Dr. Hamida Akhter Begum's CPSRT (Centre for Psycho-Social Research and Training) during December 1992 and January 1993, at the institute of education and research (IER) at Dhaka University. As a result of this training, one of the psychotherapists

in attendance started his own clinic, Counselling Centre, Jigatola, Dhaka, that followed the client-centered approach as taught by Professor Mohammad Mahmudur Rahman.

The development of cognitive behavior therapy (CBT) in Bangladesh is often linked to the work of psychologist Mr. Rumiz Uddin Ahmed. The first CBT (cognitive behavior therapy) clinic in Bangladesh was established by Mr. Uddin Ahmed, a psychology graduate from Rajshahi University. He developed this clinic (Ahmed Psychotherapy Centre) in the early 1990s, which was situated at the Green Road of Dhaka City, and he was associated with the Society for the Care and Education of the Mentally Retarded Children in Bangladesh (SCE M R, B). This society was originally started by Professor Dr. Sultana Sarwatara Zaman. SCEMR, B which later was renamed as Society for the Welfare of the Intellectually disabled in Bangladesh (SWID, Bangladesh). Mr. Ramij Uddin Ahmed got his training in CBT in a European country.

From a careful review of historical records, it is also found that Mrs. Farida Begum who was a sychology graduate from Dhaka University and who also used to work as a psychologist at SCEMR, B (later named as SWID, Bangladesh) got her training in behavior therapy in a European country, and started her practice in behavior therapy in children in Dhaka.

One of the more important steps toward the development of psychotherapy in Bangladesh occurred in 1993 when psychiatrists under the leadership of Dr. Anwara Begum, Dr. M. Nazmul Ahsan, and Dr. M. S.T. Mullick edited a manual: "Mental health: A manual for primary care physicians." This was developed with support from the Institute of Mental Health and Research, Dhaka, Bangladesh, where they presented a very common sense suggestive approach to psychotherapy.

Another important development was when Professor Mohammad Mahmudur Rahman started his psychotherapy clinic, called Monobikash (meaning mental development) Clinic on 1st October, 1993, in Dhaka, where he initially started a client-centered approach to psychotherapy, having been trained from Professor Dr. M. K. Ali. In 1997, Professor Rahman received his postdoctoral training in clinical psychology, in Springfield Hospital, London, UK, for 9 months, where he got supervised clinical practice experience in CBT, as part of post-graduate clinical psychology training project at the Department of Psychology at Dhaka University. After his return from London, UK, at the end of 1997, he joined the clinical psychology training course at Dhaka University as an associate professor and he also started to practice CBT in his Monobikash Clinic.

On an institutional level, CBT in Bangladesh started its journey in 1995–1996 at the University of Dhaka within a professional course called "Clinical Psychology" through active support by a group of British clinical psychologists (Rahman, personal communication). Besides clinical practices and other activities, researchers from this professional and academic branch attempted various research approaches focusing on mental health and cognitive behavior therapy. With more than 20 years of existence, this professional certification course of clinical psychology shares the institutional history of CBT.

To formalize the training of clinical psychologists in Bangladesh, in 1995 an initial proposal of three years of training in clinical psychology was made through an educational link program between University College – London and the University of Dhaka (Powell et al., 2014). While the program was considered to be a long and expensive one, it was considered to be an important step to produce clinical psychologists with the training required to carry the profession forward and meet the mental health needs of people in Bangladesh. The funding for this program was approved by the Overseas Development Administration (ODA) of the UK on Oct 7, 1996 and was managed by the British Council. The central aims of this initiative were: (1) to alleviate poverty and disadvantage associated with mental health; (2) to ensure sustainability of psychological services in Bangladesh; and (3) to respond to developing needs, emergency needs, and Bangladesh government initiatives in respect of poverty and mental illness. To develop this exchange program, there were 26 visits from UK professionals to Bangladesh and 8 visits were of professionals from Bangladesh to the United Kingdom (Powell et al., 2014).

At the start of the program, there were two theoretical teachers and one was trained as a clinical supervisor in clinical psychology.

As of July 2018, 215 students had completed their MSc degrees and the total number of clinical psychologists with their master's and M. Phil degrees in clinical psychology is 60. Most of these professionals are CBT-practitioners in Bangladesh or abroad. At present, many more psychotherapy clinics are now established in both government and private institutions, where graduates of clinical psychology practice CBT on a variety of clients.

## Current Regulations Regarding Psychotherapy Provision

To promote the professional interests of clinical psychologists and to ensure their quality of training and service standard, a professional body named Bangladesh Clinical Psychology Association (BCPA) was formed on 26 October, 1999. BCPA has changed its name and became Bangladesh Clinical Psychology Society (BCPS) on 23rd February, 2010.

BCPS is the voice of the clinical psychology in Bangladesh and aims to promote and advance mental health within the context of refining psychosocial well-being and scientific knowledge. BCPS offers support for professional training, research, and education as well as encouraging and ensuring the highest standards of effective, efficient, and ethical practice of its members. BCPS is also a socially responsible organization that aims to ensure that psychology is respected and considered in a dignified manner by the policy makers in different national emergent issues (Biennial Report, 2016).

BCPS and Dr. Graham Powel, a British Clinical Psychologist and previous President of British Psychological Society (BPS), have been jointly handling all the training and professional practice challenges by aligning with the United Nations (UN) and WHO framework of reducing the treatment-need gap in Mental Health

(mhGAP). A mhGAP forum was set up by WHO in 2013, at which time they adopted the WHO *Comprehensive Mental Health Action Plan, 2013–2020* of which Bangladesh is a part.

## Professional and Cognitive Behavior Therapy Organizations

The main institute of CBT practitioners in Bangladesh is the Department of Clinical Psychology at the University of Dhaka. Established in 1997, it is the only one of its kind in Bangladesh that offers postgraduate studies, training, and research in clinical psychology (CBT practitioners) based on international standards and principles. The total number of CBT practitioners are 196 (BCPS, Biennial Report, 2016).

BCPS has taken some initiatives to provide training in CBT and offers counseling courses, workshops, and seminars (Binnaual Report, 2016). As an example, they may offer trainings for clinical psychologists and other professionals to enhance their knowledge and experiences as well as engage in continuous professional development. BCPS also offers training for ethical issues and code of conducts for CBT practitioners as well as other mental health professionals, which was developed by BCPS by following the British Psychological Society's 2006 code of ethics and conduct.

The Association of Therapeutic Counselors, Bangladesh (ATCB) was founded in June 2010; it is a national and non-profitable organization dedicated to the enhancement of the counseling profession and offers better training in this field. The ATCB is directed by the Psychiatry Department of Bangabandhu Sheikh Mujib Medical University (BSMMU) which is the only medical university of the country. The program offers a six-month diploma (short course) based on CBT certificate course content for anyone who is willing to deliver mental health services to community people.

**Training Opportunities in CBT** The major training providers in Bangladesh for cognitive behavior therapy are the Department of Clinical Psychology and the Department of Educational and Counseling Psychology, University of Dhaka, the Psychiatry Department of the Bangabandhu Sheikh Mujib Medical University (BSMMU), and a few private mental health organizations based on capital only. The type and form of training courses in CBT in Bangladesh vary in content of CBT, the length of the course, and the recipient of the training by different organizations and department of the country. These will be summarized below.

1. Department of Clinical Psychology, University of Dhaka: This training course is designed for three years of post-graduate training where one year (first year master's degree) is focused on CBT for adult population, two years for (M.Phil degree), the second year is for CBT for child and adolescents and special populations (like geriatric, children with autism), and the last year of the course is for research in CBT and different mental health areas.

2. Diploma course, Psychiatry Department, BSMMU: The course was initiated by the Department of Psychiatry of a medical university where professionals can participate on a full-time basis for six months and they take courses and complete a placement at the psychiatry department. At the beginning of this offering, anyone from any academic background could participate in this training. However, at present, it is limited to doctors, psychology, and social workers.
3. Department of Educational and Counseling Psychology, University of Dhaka (DECP): This department also offers a three-year postgraduate training program which mainly follows the transactional analysis model where CBT training is also arranged for the students in varied lengths and content.

Private mental health organizations: There are a few private organizations who provide CBT training for mental health practitioners, in varied lengths from 3 to 15 days and the content is focused on CBT. Examples of such organizations are:

- Harmony, A Mental Health Support Center, Banani, Dhaka. (https://www.facebook.com/pg/HarmonyAMentalHealthSupportCenter/about/?ref=page_internal) and
- Charlotta House at Bashundhara R/A, Dhaka, Centre for Mental Health and Care,Bangladesh (CMCH,B) at New Airport Road, Dhaka, Bangladesh (https://www.facebook.com/pg/cmhcbd/about/?ref=page_internal).

While they are not very large organizations, they usually offer training on CBT, different treatment approaches of CBT, CBT for different disorders, etc.

At the beginning of the development of training programs for CBT in Bangladesh, CBT trainers were UK experts in CBT who served as the resource persons of the link program of initiation of the Department of Clinical Psychology, University of Dhaka. The next generation of CBT trainers were pioneers of the Department of Clinical Psychology, University of Dhaka. Finally, the training could be conducted by the faculty members and alumni members of the Department of Clinical Psychology, University of Dhaka. Other organizations, specifically the DECP, utilize international affiliations and receive varied lengths of CBT training from international experts on an infrequent basis. The BSMMU also utilize their faculty members and senior practitioners who have CBT training from the Department of Clinical Psychology, University of Dhaka.

The clinical placement and CBT practice for a CBT trainee is an integral element of the training. Current placements for CBT training in Bangladesh include the National Institute of Mental Health; the Psychiatry Department, Bangabandhu Sheikh Mujib Medical University (BSMMU); the Psychiatry Department, Dhaka Medical College Hospital; and the Psychiatry Department, Mitford Hospital for both adult and child population. Besides this, there are some special placements that utilize CBT for more specialized populations like BIRDEM for diabetic and other health conditions (www.dab-bd.org/sub-page.php?sub_category=22), Community-health Rehabilitation Education and Awareness (CREA) for substance dependence( http://www.creasociety.org/web_admin/page/program-/Substance-Abuse), neuro-developmental centers for neuropsychology placement, National Cancer Institute,

Asthma Center, Palliative Department of Hospital and Autism and Special School for Special Children, and National Trauma Counseling Center for Trauma Victims. In all of these placements, CBT is being practiced by the trainee clinical psychologists, under the supervision of the Department of Clinical Psychology, University of Dhaka.

To further the training in CBT for practitioners, since 2013 the Nasirullah Psychotherapy Unit, a component of the Department of Clinical Psychology, University of Dhaka, usually arranges continuous professional development (CPD) trainings for the advancement of current practices and skills of CBT practitioners in Bangladesh. CBT training to promote clinical practice for working with specific populations like with child and adolescents, substance dependence, suicidal assessment and management, and neuropsychology is offered. Further, examples of CPD training topics include reflexivity in CBT therapists, ethical standard in clinical practice, mindfulness as a clinical tool, and dialectical behavior therapy (DBT).

One of the major challenges of providing CBT training in Bangladesh are the lack of standard training manuals in CBT for Bangladeshi population, availability of accomplished CPD trainers with the knowledge of recent advancements in CBT, the lack of collaborative effort of providing quality training on CBT for different professionals in Bangladesh, and ongoing clinical supervision after the completion of an academic training program.

## CBT with Specific Clinical Populations

At present, CBT is being used for various clinical populations in Bangladesh, including mood disorders, anxiety disorders, depressive disorders, marital distress, anger, childhood disorders, and chronic pain. One clinical area of importance is the application of CBT for dealing with substance abuse disorders. There was evidence for the efficacy of CBT for cannabis dependence, with higher efficacy of multi-session CBT (Dutra et al., 2008). Treatment of these clients in Bangladesh may involve family therapy, DBT, and a CBT-based 12-step model.

For treating head injury and stroke, CBT has been widely used with integrative approaches which are based on CBT in Bangladesh. Khan and Rahman (2011), in their study, used various techniques of CBT with integrative approaches for neuropsychological rehabilitation of patients with head injury.

In recent years, CBT even has been shown to be an effective treatment when added to medications for patients with schizophrenia in Bangladesh. Furthermore, CBT is now one of the psychotherapies taught as a required part of the curriculum in training programs in psychiatry in Bangladesh in BSMMU.

## Adaptation of CBT in Bangladesh

Many of the current psychological approaches and theories are developed based on the majority culture, particularly Euro-American social values (Henrich et al., 2010). As such, scholars have questioned the appropriateness of directly applying these approaches to ethnic minority client groups (Chentsova-Dutton & Tsai, 2010; Cheung, 2012; Franklin et al., 1993). Additionally, despite acknowledging the need for culturally responsive therapies, few of these tailored approaches are used in the field (Bernal et al., 2009). This may not be any more apparent than in Bangladesh as at the time of the writing of this chapter (July 2018). There is no research that has specifically addressed the context of the adaptation of CBT in Bangladesh.

Despite the absence of formal and research-based adaptation, in consideration of the application of CBT in Bangladesh all of the technical terminologies of CBT were translated by the first batch students of clinical psychologists, University of Dhaka, into colloquial language. Secondly, many commonly used CBT worksheets (thought diary, feeling chart, daily activities form, etc.) have been translated into Bengali (the name of the language is Bangla). A collaborative environment is essential to service delivery, as clinicians make sure to abide by their cultural norm of manners and understand how religious perspectives may influence clients. When clinicians and clients from the same culture started working collaboratively with culturally appropriate and accepted behaviors which helps the client to form a positive impression of the therapy and the clinician as well. Though the therapeutic work was originated from western culture, clinicians strive to create a positive expectancy, and this is enhanced by their being aware of what the clinician knows about what the patients think their problem is (Lewis-Fernández & Diaz, 2002; Sue & Sue, 2007). Positive expectancy greatly increases positive outcomes in therapy (Woodhead et al., 2012). Positive expectancy results when patients believe that the treatment will improve the problems that are of most concern to them.

Proverbs and analogies can serve as adaptive cognitive sets to interpret reality that promote positive affect and serve as primers to adaptive functioning (Aviera, 1996; Hyman et al., 2006; Otto, 2000). In Bangladesh, clinicians are also using culture-related stories, metaphors, proverbs, etc. For example a metaphor using “the story of two plants” may be implemented during the course of therapy. Clinicians may tell the story like this:

> *Suppose that there are two plants, one of which we take care of (give water, sunlight) regularly and the other we do not. What will be the end difference between the two plants? One will thrive and one will struggle. The clinician then works with the client to realize the importance of taking care of yourself and thinking differently.*

Using proverbs, cultural stories, and culturally appropriate analogies also helps to promote the patient’s cultural self-esteem as well as the therapeutic alliance by which patients believe that the therapist understands their conditions with their own perspective.

There is a widespread stigma against people with mental illness in Bangladesh. There are many myths and superstitions surrounding the cause and outcome of mental illness. Mental disorders are primarily viewed as a result of being possessed by evil spirits rather than as illnesses that can be treated. Consequently, victims of mental illnesses are most often neglected, subjected to delayed care-seeking and Health and Family Welfare as well as that of a few major NOGs and mental health service providers in Bangladesh (Islam & Biswas, 2015).

Stigma and specific stigma-related beliefs can be reduced by psycho-education about mental health disorders.

Progressive muscular relaxation (PMR) has been regularly integrated within CBT in Bangladesh to reduce somatic symptom (e.g., sensation of feeling flushed in ones face, headache, feelings of steam coming out of your ears). The application of deep breathing and relaxation training helps move the attention away from somatic sensations such as from pain etc.

While there has not been any formal adaptation of CBT in Bangladesh, to further understand the CBT practice and adaptation in Bangladesh, we interviewed 10 CBT practitioners, who have been practicing CBT between 15 and 23 years. Below is our summary of these interviews.

## Clinicians' Experience in CBT Adaptation in Bangladesh

### *Conceptualization of CBT in Bangladesh*

All interviewees reported that CBT is a very easy-to-administer therapy and it is also found very suitable for use in Bangladesh. CBT is universally conceptualized as a thought-feeling-behavior model, where our thinking influences our feelings, feelings influence behavior, and then a physical reaction may be specifically activated by a situation. Most of them (9 of 10) conceptualize CBT as the connection between thought, emotion, and behavior.

## CBT Framework in CBT Practice

Interviewees indicated that the cognitive triad (such as in case of depression) from cognitive behavior therapy and can be useful to establish initial rapport with clients. They also reported that it helps both clients and therapists to prepare for further clinical work based on cognitive behavior therapy philosophy and principles. All clinicians reported using the 5-factor model of CBT.

## Experiences While Doing CBT Practice in Bangladesh

Some clinicians (5 of 10) reported that emotional clients may benefit from an opportunity to vent about their problems rather than work on cognition and behavior. While an important part of CBT, all of them reported believing that clients don't want to do homework and that for some of them it is challenging because of finding the time to do in the context of the daily functions of life. One clinician reported that it can be challenging when clients want an expedient result and another commented that clients want a quick-fix akin to a medical treatment approach.

One clinician reported that, for example, if a child/adolescent client's belief is that "his/her mother don't love her," they would not ask for the evidence about that belief. They were more likely to address this creatively by drawing a hole and keep a person in the hole. Asking, "if you are in trouble and fall down inside a big hole, who will come first to rescue you?" young clients can see their parents would be and this approach may lead to a cognitive change more easily.

Again, overall, all clinicians reported that client's feedbacks are very positive after receiving CBT. One clinician reported that after receiving the treatment, at the time of termination one of his/her clients with personality disorder reported, "Actually I know everything about thoughts, feelings, and behavior, but you know better and this helps to keep on track."

## Common Challenges During CBT Practice

Some interviewees responded that when clients are very emotional, sometime it is very difficult to structure the session according to a CBT model. One clinician responded that when the presenting problem is not emotional but more of a real life problem (e.g., loss of job), CBT may not be the preferred treatment approach. It is not working and it only help to ventilate client. Another clinician reported that for some clients when they experience an excessive amount of anxiety or depression, they may warrant medication initially to promote stability and that efforts may focus on using behavior therapy for changing behavior initially, prior to the client engaging in CBT with a focus on their emotion and thinking.

## Adaption in the Practice of CBT

As CBT only has a 20-year history in Bangladesh, interviewees reported that adaptation has been done informally. Some expressed a desire for the development of manuals to contextualize CBT for the general and specific clinical population. Some mentioned that the articulation of the CBT concept and construct is important as a way of adaptation. For the adaptation two clinicians reported that it would be

helpful to create a checklist that would be completed before the administration of CBT. Content can be reviewed to guide them clinically and then research may help establish this as a clinical guideline.

## CBT is Suitable in Bangladesh

Among the 10 interviewees, two clinicians indicated that they think that CBT is a very user-friendly method and it is easily administered with an eclectic form for many clients. One clinician communicated that CBT is not suitable for all age groups of clients and for emotional problems (ending of a relationship, loss of significant family member, etc.)

In sum, to make CBT more culturally grounded and sensitive in Bangladesh it is important to develop contextually sensitive CBT by addressing locally emphasized somatic symptoms and syndromes; modifying catastrophic cognitions, including local metaphors and proverbs in treatment; examining CBT techniques to local practices; and making efforts to incorporate aspects of local religious and healing traditions (Hinton et al., 2012).

## Research on CBT in Bangladesh

In Bangldesh, CBT researchers are mainly postgraduate students (M.S.; M. Phil; and Ph. D) of the Department of Clinical Psychology, University of Dhaka. Along with them there are also a number of other students and professionals doing CBT studies in Bangladesh who are psychiatrists working in government medical offices and educational and counseling psychologists from the Department of Educational and Counseling Psychology, University of Dhaka, who are doing research in mental health in Bangladesh.

At first glance, CBT researches in Bangladesh appear to focus on the following areas:

1. Efficacy and effectiveness studies in CBT in different psychiatric disorders and mental health conditions (Deeba & Rahman, 2012; Jasmin & Deeba, 2017; Mozumder, 2007)
2. Efficacy and effectiveness studies in the treatment of different health diseases and health conditions (Khan & Rahman, 2011; Khatun, & Begum, 2009)
3. Scale adaptation and development of measures of cognitive-behavioral phenomena from a Bangladesh perspective (Jerin et al., 2014; Mozumder & Begum, 2005)
4. Identifying core beliefs and cognitive distortions among different psychiatric patients (Mozumder & Haque, 2015)

5. Examining the efficacy of specific techniques from CBT as they are linked to specific psychiatric population or patients with sepcial mental health and health conditions (Hossain et al.)
6. An understanding of CBT as it relates to different mental health and socio-cultural issues (Gaffar & Deeba, 2017)
7. Exploring and understanding cognitive-behavioral phenomena in Bangladesh context on substance dependance and self harm among adolescents (Azad, 2006; Khatun et al., 2015; Mozumder & Begum, 2007)

The research methods were used with CBT as they relate to the above-mentioned themes were quite variable and differed as a function of research study questions as well as the purpose of the research and considerations of the practicalilties of conducting research in the field. A majority of the approaches were utilized to cover both quantitative and qualitative in nature. Specific study types identified were descriptive, correlational, quasi-experimental, experiemental, phenomenological, grounded, and exploratory qualitative study design. The assessment tools and measurements used for collecting data were quite varied and consisted of observational methods, completion of psychometric scales and rating scales, self-report, and standardized questionnaires and checklists.

Early on, researchers emphasished the adaptation and development of psychometric tools to apply while practicing CBT. These include measures such as Depression Scale, Anxiety Scale, and OCD Scale. Early research also examined the role and effectiveness of CBT in treating different mental health conditions and psychiatric disorders. Some of the research also examined the role of CBT in the treatment of specific health issues (e.g., treating psychological problems among stroke patients). Again, as the field of CBT is really in its early stages in Bangladesh, it is quite impressive that researchers were able to to assess and treat people with different psychological problems such as trauma survivors, rape victims, and students (Deeba & Mozumder, 2006; Deeba & Rapee, 2015).

Research then began to move to more comparative and efficacy studies on CBT for different health diseases and conditions, such as diabetes, hypertention, cancer, and asthma. At the same time, efforts to focus on assessing and providing CBT to special area of people like those who have experienced acid violence, rape victims, trauma survivors, and those with substance use or dependance issues. Additionally, during this stage of research development, CBT researchers have shifted their efforts from outcome studies to exploratory qualitative studies on human congnition and behavioral aspects. These include but not limited to understanding cognitive distortions and suicidal behavior from a Bangladesh perspective.

The current trend of CBT researchers in Bangladesh has a greater focus on conducting both qualitative and quantitative studies in mental health, psychiatry, and health conditions within the Bangladesh context. This research involves clinical work in both traditional research settings and examination of CBT in more natural and community-based settings. Examples involve application of CBT following after a natural disaster with treatment occurring in the community.

## CBT with Special Populations in Bangladesh

While there are a number of applications of CBT throughout Bangladesh, we highlight below some specific populations that have a need for intervention where CBT has been used.

## Refugees

According to the WHO (2018a, b), since August 25, 2017 an estimated 693,000 Rohingya (Indo-Aryan peoples from the Rakhine State of Myanmar) have crossed over from Myanmar into Cox's Bazar, Bangladesh, joining approximately 212,500 others who had fled in earlier waves of displacement. There have been 7885 new arrivals since January 2018.

This influx of refugees has led to observations that conflict and social tension are rising within multiple contexts in Bangladesh. Conflict is seen within the camps among the Rohingya, between Rohingya and host community, as well as inter-community tensions, including at the household level, outside the camps. Both in 2017 and 2018 there have been high-profile killings of camp community leaders as part of factional infighting in the Rohingya community (WHO, 2018a, b). The psychological impacts of displacement continue to affect large numbers in the Rohingya community. Fifteen agencies and actors are providing mental health and psychosocial support services (MHPSS) to the affected population, and there is an urgent need for more investment particularly in psychiatric care (WHO, 2018a, b). The more common mental health problems associated with refugee populations and asylum seekers include post-traumatic stress disorder (PTSD), major depression, generalized anxiety, panic attacks, adjustment disorder, and somatization. In one study within the refugee community, most patients in primary care with mental health problems present with physical complaints, which can lead to under-recognition and treatment of common mental disorders (Kirmayer, 2001).

Patients with depression or anxiety sometimes focus on physical symptoms or use culture-specific bodily idioms to express distress (Kirmayer, 2001. Medically unexplained symptoms, particularly pain, fatigue, and gastrointestinal and genitourinary symptoms, are common in the community and in primary care (Kirmayer et al. 2004). The Rohingya/Myanmar population in Cox's Bazar and in Ukhiya are highly vulnerable, having fled conflict and experienced severe traumas, as well as they developed some mental health problems including the number of traumas, adaptation difficulties, the loss of culture and support, it can be quite difficult for refugees to survive. The Ministry of Women and Child Affairs (2018), Multi Sectoral Programme on Violence against Women (MSPVAW) established a program on One-Stop crisis Cell (OSCC) and Regional Trauma Counselling Centre(RTCC), and established 10 Mental Health Service Centeres (MHSC) by which they are providing psycho-social counselling to the women and children victims of violence.

Here, ten clinical psychologists who are CBT practitioners are working and conducting individual psychotherapy, group therapy, and family therapy. The most common mental health issues reported among the refugees are sufferings from violence, excessive anxiety and worry, palpitations, shortness of breath, agitation, acute stress, recurrent nightmares, difficulty with sleep, low mood, lack of appetite, and lack of self-care.

The graduates from the Department of Clinical Psychology, University of Dhaka, are working with refugee community and clinicians reported using a range of common techniques of CBT including: ventilation, psycho-education, breathing relaxation, mind distraction, graded task technique, problem-solving approaches, evaluation of the pros and cons of a situation, collection of a positive data log , and trauma-focused CBT. A systematic review of 10 randomized controlled trials on treatment of refugees with mental health problems found some promise in CBT and argued that there is a need for adapting treatments to the local cultural context (Crumlish & Rourke, 2010).

## Clients with HIV

Self or internal stigma is a daily reality and continuous strike in the mind of people living with HIV/AIDS (PLWHAs). As Bangladesh owns collectivistic family nature, as a result not only the HIV positive individual is neglected but also their family members suffer the negligence of the society. Consequently, PLWHAs hide their status to avoid social criticism (Sultana, 2014). They often will have unhealthy thoughts related to their contraction of the disease and believe that it's their fault and they blame themselves. As a result of their negative thinking along with the lack of societal support, they may isolate themselves and avoid social gatherings which may further have a negative impact on their mental health. Often they develop negative ideas about self, others, and their future.

According to surveys conducted using People Living with HIV Stigma Index, instances of stigma and discrimination exact profound psychological costs, resulting in feelings of guilt, shame and suicidal thoughts (UNAIDS, 2013).While there is not much research on clinical work with HIV positive clients in Bangladesh, applied various techniques of CBT (i.e., Psychoeducation, Assertiveness training, problem-solving skill training, cognitive restructuring techniques etc). and reported positive changes among the HIV-clients.

## Acid Survivor Clients

Acid attack has become an unfortunately common phenomenon in Bangladesh. A vast majority of attacks happen in rural areas and the victims are attacked at night, acid thrown through open windows. he experience can be quite traumatic

physically, psychologically and socially and acid victims often suffer from various types of mental health disorders. Shahid and Begum (2005) assessed the mental health problems of acid burn survivors and the need for psychological services for them. The authors reported a number of psychological problems experienced by victims including anxiety, depression, helplessness, worry, tearfulness, worthlessness, sleeping problems, low appetite, suicidal ideation, aggressive behavior, and social withdrawal. In consideration of treatment and psychological management of acid burn survivors they reported that various techniques of CBT such as psychoeducation, distraction, distancing, problem-solving approach, the use of a pros and cons technique, breathing relaxation, progressive muscular relaxation (PMR), assertiveness training, problem-solving skill training, and cognitive restructuring techniques, which showed positive changes in emotional, cognitive, and behavioral areas among the acid burn survivors.

## Working with Children

The World Health Organization (2001) reported that regardless of cultural or political boundaries, 20% of all children worldwide are suffering from serious emotional and behavioral disorders. Different studies showed that there are fewer differences between the prevalence of mental health problems among the children and adolescents of developing and developing countries (Begum, 1995). Behavior disorders are also a common health concern in Bangladesh. Rabbani and Hossain (1999) reported that 13.4% of children had behavior disorders (males 20.4%, females 9.9%). In a two-phased survey carried out on over 10,000 children aged 2–9, Islam (1999) reported that the prevalence rates of severe and mild mental retardation were 0.6% and 1.4%, respectively. This survey also found that mild mental retardation was strongly and significantly associated with low socioeconomic status (Islam, 1999). Durkin et al. (1993, 2000) used a structured measure for assessment of 162 flood-affected children who had been diagnosed with behavioral disorders previously. Durkin (2002) also found that an additional 10% had aggressive behavior and 34% had enuresis. There is an increased probability of developing behavioral disorders for those who suffer from chronic illnesses such as diabetes, heart disease and asthma that require timely treatment (Lopez et al., 2008).

Another Bangladeshi study conducted on socially disadvantaged (urban slum) children reported 22.9% had some form of psychiatric disorder with slightly lower prevalence in boys than girls (20.0% in boys and 25.5% in girls) (Jahan et al., 2004). Mullick and Goodman (2001) used the Development and Well- Being Assessment (DAWBA) questionnaire, and previously validated Strengths and Difficulties Questionnaire (SDQ) tools, in their study and found overall prevalence of 15.2% in different settings (rural, urban, and urban slum) with the highest prevalence in the urban slum (19.5%) (Mullick & Goodman, 2005).

Two more recent studies found that 14.6% children have behavioral problems as reported by the parents in rural Bangladesh (Khan et al., 2008) and that the reported

prevalence of mental disorders seen among youth is 18.4% (Rabbani et al., 2009). Access to quality treatment becomes a challenge as the median health expenditure on a Bangladeshi child can be less than $US0.20 especially among poor and rural communities (Patel & Kleinman, 2003).

There are a number of different models to deal the childhood psychiatric disorders. These may involve a direct method or indirect one, and these approaches may also vary according to settings. For example, a dyadic method (1:1 clinical work) and a triadic method (child clients, caregivers or teachers, and the therapist) may be used. In Bangladesh CBT practitioners usually used the triadic method; however, this approach becomes compromised when one party does not participate. Bangladeshi clinical psychologists mainly work clinically based on a behavior therapy model (i.e., Peterson) or a cognitive therapy based on the work of Meichenbaum (1977). Deeba and Rahman (2012) found that behavior therapy is better suited with younger children who are under 5 years of age. They also found that cognitive-ehavior therapy is effective with children of 5 years and above with mental health problem. CBT techniques such as graded assignment and reinforcement are found to be effective for enuresis and depression (Deeba & Rahman (2012). Creative therapy and play therapy are often used as the complimentary techniques to behavior and cognitive therapies with children with different psychological problems (Deeba & Rahman, 2012). Overall, the research has supported the treatment of various disorder of childhood using different techniques of CBT.

## Summary

Overall, while still relatively new in Bangladesh we can see how CBT has been nicely integrated. In Bangladesh, most of the clinical psychologists have knowledge of CBT and where needed practice it within an eclectic framework. Some techniques of CBT are used widely within client-centered and supportive therapy, systemic family therapy, EMDR, narrative therapy, DBT, acceptance and commitment therapy, creative and art therapy, and crisis intervention. Interestingly, while rational emotive ehavior therapy (REBT) is considered one of the earliest forms of CBT, there are no formal trainings in Bangladesh for clinicians to learn REBT; however, some clinicians report using some techniques of REBT that they have learned through professional readings. Presently, a few NGOs are also involved in mental health in the country, primarily focusing on treatment and rehabilitation, where clinical psychologists are also using CBT. The country has only limited resources to provide mental health work, and there is a poor understanding of mental health needs and limited access due to the cost of service provision (Ahmed, 2011; Maulik & Darmstadt, 2007). In Bangladesh, no mental disorder is covered by social insurance, no human rights review body exists to inspect mental health facilities, no specific mental health authority has been established, and there are only limited resources allocated for mental health (WHO, 2008).

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# Chapter 6
# Cognitive Behavioral Therapy in Brazil


**Marilda E. Novaes Lipp, Lucia Novaes Malagris, and Valquiria A. Cintra Tricoli**

## Country: Brazil

Brazil, officially the Federative Republic of Brazil, is the largest country in South America and the fifth largest in the world, in terms of land mass and sixth in population size which, according to the last census, numbers 207.7 million people, with a rate of population growth, between 2016 and 2017, of 0.77%. (IBGE,[1] 2017). The country is situated on the east coast of South America, alongside the Atlantic Ocean. Geographically, it is divided into five regions: north, northeast, center-west, south, and southeast, encompassing 26 states and one federal district.

Ethnically, the Brazilian population comprises native Indians, Portuguese, Africans, and European and Asian immigrants. Currently, the population consists of the following: by race/color: white (49.4%), brown (42.3%), black (7.4%), Asian (0.5%), and Amerindian (0.3%). Per capita income is US$ 8040 per annum (Silva, 2018) and life expectancy is 72.9 years. The currency is called the Real and the political system is democratic, with power being tripartite in nature: Executive, Legislative, and Judiciary.

[1] Brazilian Institute of Geography and Statistics, the agency responsible for the official collection of statistical, geographic, cartographic, geodetic and environmental information.

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As far as education is concerned, today in Brazil, 11.8% of the Brazilian population is illiterate (Freitas, 2018). The percentage of adults who completed secondary education in Brazil is 14%, which already represents a substantial improvement over recent years. In terms of higher education, in the last 10 years the number of people completing university courses has increased from 4.4% to 7.9% (Freitas, 2018), with 122,295 students in graduate courses, of which 76,323 are academic master's, 4008 professional master's, and 41,964 doctorate candidates (Ministry of Education – MEC, 2018).

As Brazil is deemed to be a developing nation, and due to its huge geographical area, it has large, highly developed areas in the fields of science and research while others are still in the process of development. The field of psychology is one of the areas of knowledge that is most highly developed, currently having 314,629 registered psychologists (CFP, 2018a), the vast majority of whom (88%) are female (CRP, 2018) characterizing psychology, in Brazil, as a profession for women. The federal state of São Paulo boasts the highest percentage of psychologists in the country (26.32%), followed by Rio de Janeiro with 11%. There are psychologists scattered all over national territory, around half of whom are located outside the state capitals.

## Access to Mental Health Care in Public and Private Health Care

Although there has been a conspicuous growth in the number of psychotherapists, there are still not enough to satisfy existing demand. According to the World Health Organization (WHO), at least 12% of the Brazilian population, or 23 million people, need some form of mental healthcare, and 3% (five million) suffer from serious, persistent disorders (WHO, 2017). The annual cost to the country of mental illness is R$ 1.4 billion (approximately US$ 375 million[2]). To this, one has to add the cost per treatment for non-communicable, chronic illnesses. Taking into consideration the link between chronic illness, lifestyle, and emotional factors, it is important to highlight recent data published by the WHO (2018), showing that, in the last 10 years, there has been a 26% increase in deaths from non-communicable illnesses in Brazil. The cost to the health service in Brazil, associated with chronic illnesses, amounts to R$ 74 billion (approximately US$ 20 billion) (WHO, 2018). Research from WHO (2018) shows that 9.3% of Brazilian suffer from anxiety disorders and 5.8% has been diagnosed with depression.

Working in public institutions represents something of a challenge for psychologists because there is a tendency to transplant into the public institution the teachings acquired in their private practice training. However, beginning with the clientele, the challenge is already plain to see, as it generally involves people of low

[2] Rate of Exchange employed US$ 1.00 = R$ 3.73 (June 15, 2018)

incomes, referred by another institution, and often unaware of what psychological treatment involves (Dimenstein, 2000, Seidl et al., 2018).

In the quest to understand the situation regarding the work of psychologists in healthcare in Brazil, Almeida and Malagris (2015) conducted a research study with the participation of 125 psychology professionals working in Hospital Psychology. The results showed that the majority of professionals were located in the southeast region of the country, had completed postgraduate courses in the area of health, and were used to attending scientific events in the area. It was found that 70.4% worked in public hospitals and 29.6% in private hospitals.

The study by Almeida (2011) sought to identify the theoretical reference of the clinical psychological interventions of the professionals working in general hospitals in various regions of Brazil. The results indicated that the majority used psychoanalysis (34%), possibly more focused on intrapsychic issues than on prevention and health promotion. In second place came cognitive-behavioral therapy with 26%, followed by brief analytical psychotherapy with 23%, and other theoretical references at 17%.

As for those professionals working with cognitive-behavioral therapy in the public system, it is appropriate to outline a partial overview of some of the regions in terms of their professional insertion, according to information supplied by representatives of the Brazilian Federation of Cognitive Therapy from the federal states in Brazil. Due to Brazil's size, a good many difference can be found with regard to the insertion of the cognitive-behavioral therapist in the national health system, it being important to understand how it works in the various regions in the country.

Brazil's public health service (SUS) was created in 1988 under the Brazilian Federal Constitution. Everyone, adults or children, rich or poor, has the right to look for the services offered by SUS, including psychotherapy; however, it is very difficult to get an appointment due to the high demand it faces. The inclusion of psychologists in the field of healthcare has drawn on professionals using a variety of approaches, including the cognitive-behavioral approach.

It is important to note that not all the regions have cognitive-behavioral therapists working in the SUS and, probably, not all of the experiences of the SUS in Brazil are mentioned here.

Taking into consideration the northern region of Brazil, in the state of Acre, 10 professionals who use the cognitive-behavioral approach were identified in the public health system in the capital city of Rio Branco. Of these, some work in the areas of legal/forensic, school/education, health, and social welfare. In the state of Amapá, at the present time, CBT professionals are limited to the private clinics, and are not part of the public health system. In the state of Rondônia, meanwhile, professionals are included in SUS, the public health system, principally in the Center for Psychosocial Care – Alcohol and Drugs (CAPS AD). In the health units in the state of Amazonas, students may choose whichever psychological approach they desire, including the option of the cognitive-behavioral approach.

In the state of Pará, CBT psychologists can be found in the Multiprofessional Residency Program for the Health of the Elderly as well as in the Centers of Reference and Social Welfare (CRAS). In Tocantins, psychologists in the public

health system have sought specialization in CBT, a fact which has given rise to the approach being included in the area of public health services in the state. Meanwhile, in the state of Maranhão, the clinical and academic contexts are foremost but it is worth emphasizing, with regard to inclusion in the public health system, the presence of CBT psychologists in the SARAH Network of Rehabilitation Hospitals.

In Paraíba, cognitive-behavioral therapists can be found in day clinics in the public health service, in hospitals, clinics, schools, social programs within the Family Health Strategy, in the Family Health Support Center (NASF), and in non-governmental organizations (NGOs). In Piauí, in terms of placement in the public health system, there are psychologists who work with CBT in hospitals and government programs. In the state of Rio Grande do Norte, cognitive-behavioral psychologists work in the University Hospital while in Sergipe, there are only a few psychologists who have CBT specialization working in reference units within the SUS. In the state of Alagoas, there was no evidence of the involvement of CBT psychologists in the health system.

In the center-west region, in the Federal District of Brasília, CBT is present in the multiprofessional residency and in the psychiatric residency of the psychiatric hospital and the subject of CBT is included in the curriculum of these residencies for the resident interns (psychologists and psychiatrists). Today, there are CBT specialists working in the most diverse institutions including NGOs, CAPS universities and general or psychiatric hospitals.

In the southeast region, in the state of Espírito Santo, 14% of psychologists work within the SUS. In Rio de Janeiro, attention is drawn to the placement in the SUS by way of Residency Programs at UFRJ, where professionals using a variety of approaches, including CBT, work. There are also psychologists with CBT instruction in the Federal Hospital of Ipanema and in the State Institute of Diabetes and Endocrinology, in partnership with the Institute of Psychiatry at UFRJ, among others.

## The History of Psychotherapy in Brazil

The initial contributions to the study of psychotherapy in Brazil were provided by doctors. As noted in the review by Camara (2017), the nineteenth century heralded the beginnings of psychotherapy in the country in the form of the hypnotic suggestion method introduced by the doctor Erico Coelho, who had been inspired by the works of Bernheim (1888). The reports of cases of successful treatment of nervous diseases started to inspire psychiatric doctors, primarily in Rio de Janeiro (Fajardo, 1896). The hypnotic suggestion method was not based on psychodynamic theories, but rather it made use of suggestion and persuasion and took the form of a psychotherapy model which may be considered as a precursor of the emergence of behavioral psychotherapy, even before psychoanalysis appeared in the country (Camara, 2017).

The pioneer of psychoanalysis in Brazil was Durval Bellegarde Marcondes (Salim, 2012). A psychiatry graduate at the São Paulo Faculty of Medicine, in 1924,

he introduced the ideas of psychoanalysis into clinical activity in Brazil. The doctrine of *Sigmund Freud* became the subject of scientific activity in Medical Schools. The first work on psychoanalysis written in Portuguese was the 1914 dissertation by *Genserico de Souza Pinto* entitled *Psicanálise: A Sexualidade das Neuroses,*[3] in Rio de Janeiro. Thereafter, psychoanalysis and psychoanalytically oriented psychotherapy have prevailed in Brazil, although many other approaches have also found favor over the years.

When the military dictatorship was established in Brazil (1964–1985), the strong censorship and repression of various topics that were imposed by the regime ended up making it possible for psychotherapy to gain a foothold in Brazil as a place for resistance, particularly for people in the middle to upper classes of the period. Psychotherapy became one of the few places with some privacy for opponents of the regime, as it offered the possibility of the generation of new ways of perceiving the world and living.

Humanistic psychotherapy emerged at the end of the 1960s in various state capital cities in Brazil (Tassinari & Portela, 2002), mainly in Rio de Janeiro and São Paulo and, even today, is still quite active. For a long time, the ideas of Carl Rogers and Freud continued to be the most accepted in various universities and clinical practices.

Considering the historical and philosophical aspects that permeated psychology in the middle of the 19th and 20th centuries, one can understand the epistemological path on which behaviorism settled. Fred Keller was a fundamental character in the development of the experimental analysis of behavior, based on the pioneering study of B. F. Skinner. According to Todorov and Hanna (2010), Fred S. Keller arrived in Brazil in 1961 as a Fulbright Scholar, to teach at the University of São Paulo (USP) for a year. The first center for the training of behavioral analysts, still very productive to this day, was the University of Brasilia (Todorov, 2006) under the direction of Carolina Bori. It was behaviorism that gave the stimulus to the emergence of cognitive-behavioral therapy in Brazil.

Law 4.119 recognized the profession of psychologist on August 27, 1962. At that time, it was noted that the vast majority of psychologists were working in institutions, with only very limited working in private practice (Chaves, 1992).

Since this time, training courses have been established and there has been great expansion in the area. Soares (2010) organizes the history of psychology in the country into seven periods. When Brazil was a colony, studies were produced that emphasized aspects that may be seen as a form of approximation to psychotherapy, as well as studies that acknowledge the value of the environment in the learning process and also the intellectual capacity of women, in order to demonstrate the understanding of the psyche.

In the nineteenth century, higher education courses were developed, books were printed, and institutions were established. One of the factors contributing to the development of psychological thinking in Brazil was that exchange visits began

[3] Psychoanalysis: The sexuality of neuroses

with other countries, particularly France, with a significant influence in the areas of medicine and education. The problems of Brazil in the nineteenth century, which involved exclusionary ideas and practices, social inequality and the exploitation of one class by another, fostered conditions for psychology to be circumscribed as a specific area of knowledge, "thereby gaining the status of an autonomous science" (Antunes, 2012, p. 51).

It was in the period between the end of the nineteenth century and the early 1930s that psychology gained the status of a specific area of knowledge in Brazil. After the so-called Revolution of 1930, there was an expansion in the teaching of psychology, with a greater number of book and journal publications, an increase in research, the establishment of psychology associations, conferences and the expansion of the field of activity of psychology in education for the organization of work and clinical practice. New social relations required up-to-date understanding and practices, particularly with regard to education and psychology. As a result of these demands, psychology has moved forward in its development and in the strengthening of its practice. From the 1960s to the 1980s, with the backdrop of the struggle to democratize the country, psychology that focused on the problems of the population, underlining social engagement, experienced strong development, extending its areas of involvement. New fields of intervention in psychology emerged, such as: community, hospital and legal psychology. Criticisms were leveled against professional practice and the replication of knowledge from other countries (Antunes, 2012).

The understanding of psychology has expanded over time with the creation of postgraduate courses and the area became stronger with the organization of the professional category of psychologists. By the end of the 1970s, clinical psychologists were starting to be integrated into the public health institutions in Brazil. This integration of clinical psychologists into public institutions was leveraged not only by the economic crisis of the time, which resulted in a reduction in private psychological care, but also by the critical view of the time that psychology was not focusing on the demands of Brazilian society (Pires, & Braga, 2009).

## Historical Advances of CBT in Brazil

The following data are based on the few articles published in Brazil (Rangé et al., 2007; Falcone et al., 2012; Neufeld & Affonso, 2013; Neufeld et al., 2015) and on statements obtained from the various professionals who have contributed to the growth of cognitive therapy in Brazil. Use was also made of surveys conducted by the presidents of the State Associations of Cognitive Therapy as well as state representatives from the Brazilian Cognitive Therapy Federation (FBTC). However, it should be understood that this review does not include all of the professionals working with CBT in Brazil, nor all the training or specialization courses in Brazil, as they are too numerous to mention.

Studies show that CBT's roots in Brazil can indeed be traced back to the use of behavior therapy (Range et al., 2007). One of the first attempts at integrating cognitive and behavior models was made in the early 1970s in São Paulo when Raquel Rodrigues Kerbauy and Luiz Otávio de Seixas Queiroz invited Michael Mahoney to São Paulo to teach a course on "cognitive behavior modification." However, it was only in the late 1980s and early 1990s that the movement began to integrate cognitive and behavioral models, both in Sao Paulo and in Rio de Janeiro.

In 1985, the creation of the *Ambulatório de Ansiedade do Instituto de Psiquiatria do Hospital das Clínicas da FMUSP* (AMBAN) in the city of São Paulo and the Stress Management Center (*Centro Psicológico de Controle do Stress* – CPCS, now called *Instituto de Psicologia e Controle do Stress*), in Campinas, São Paulo, marked the spread of interest in the interactive model of cognitive behavior therapy. The creation of the CPCS came from the contacts that Marilda Novaes Lipp, its founder, had established with the work of Michael Mahoney and Donald Meichenbaum. Today, the IPCS has at its disposal a team of highly trained psychologists and has qualified 610 psychologists and psychiatrists as postgraduate specialists in cognitive-behavioral therapy.

The foundation of AMBAN emerged as a result of the interest of some psychiatrists, led by Francisco Lotufo Neto in further studies of anxiety disorders. At about the same time, the Medical School of São José do Rio Preto (FAMERP) hired psychologists Maria Cristina Miyazaki and Neide Miceli Domingos to work in the pediatric ward where they applied cognitive behavior principles, thus contributing to the advancement of CBT in the area of health.

From the 1990s, several cognitive professionals from Rio de Janeiro, such as Eliane Falcone, Bernard Rangé, Lucia Novaes Malagris, Paula Ventura, Helene Shinohara, Monique Bertrand and also Denise Amorim Rodrigues, Maria Alice Castro and Carlos Eduardo Goulart Brito, among others, began the expansion of cognitive therapies at the university level and in undergraduate courses. Today, these professionals are still striving to expand the horizons of CBT.

In 1997, Paul Knapp and Melanie Ogliari Pereira brought in professionals from the *Beck Institute* for training in cognitive therapy in Porto Alegre and São Paulo. This program was a milestone in the history of cognitive therapies in Brazil. In 1997, the Brazilian Cognitive Therapy Society (SBTC) was founded, now known as the Brazilian Cognitive Therapy Federation (FBTC), with Paulo Knapp as its first president.

The last few years have shown an increased growth and a prevalence of cognitive behavioral use in Brazil, as demonstrated by the large number of postgraduate courses in cognitive behavioral therapy offered in Brazil and the vast number of articles published yearly on CBT in Brazil.

Due to the large geographical size of the country, it is necessary to analyze the development of CBT by region, as its status varies according to the area in which it is practiced.

## History of CBT in the South/Southeast Region

The studies mentioned in the last section show that the pioneers in CBT in Brazil are from the South and Southeast regions, therefore the historical development of CBT began in this geographical area of Brazil; however, nowadays CBT is practiced across all national territory, in varied proportions.

Considering that São Paulo boasts 26.32% of all registered psychologists, followed by Rio de Janeiro with 11%, it is to be expected that the southeast would have a greater number of CBT practitioners, which is indeed the case.

In the state of Espírito Santo, 71% of psychologists have a CBT specialization, predominantly working in clinics using the Beck approach, followed by schema focused therapy, by Jeffrey Young, which is being quite heavily developed at this time. Also used, though to a lesser degree, are acceptance and commitment therapy, functional analytical therapy, dialectical behavior therapy, and mindfulness. Many psychologists work double shifts, in the clinic and in the public health service, with 14% working for SUS and 28% in the hospital environment.

## History of CBT in the Center-West Region

In the state of Mato Grosso do Sul, CBT was introduced by Marta Vieira Vilela around 1990, bringing the teaching of CBT to the Dom Bosco Catholic University, with the support of the Psychological Center for Stress Control which promoted stress control training based on rational emotive behavioral therapy. Presently, there are approximately 300 psychologists working with CBT, using the Beck and Ellis approaches. In the state of Goiás, the most favored line of work is that of Beck, the majority of the professionals working in private clinics.

## History of CBT in the Northeast Region

In the northeast region, the cognitive-behavioral approach began to be disseminated in the city of João Pessoa, in the state of Paraiba. In 1989, the supervision in cognitive-behavioral clinical psychology was implemented in the João Pessoa University Center (UNIPE), becoming the first university in the northeast to offer internships using this approach (Rangé et al., 2007).

In Salvador, cognitive therapy has been popularized in the Federal University of Bahia, where a specialization course in cognitive therapy was established (Rangé et al., 2007).

As for the city of Maceió, in the state of Alagoas, the word about CBT was initially spread, in 2004, by the Alagoas Center for Cognitive Psychotherapy (NAPC). The greatest demand for CBT professionals is in private clinics; however, it has

been implemented also in school psychology. The Beck approach prevails, but there are already a number of psychologists who work with REBT, schema therapy, and dialectical behavior therapy.

In the state of Maranhão, activities under the cognitive-behavioral umbrella began in 2007. The number of cognitive-behavioral therapists has been augmented by many practicing, qualified psychologists. CBT's academic/scientific trajectory in Maranhão refers to one of the founding members of the FBTC, the lecturer Ricardo Franklin Ferreira who, on entering the Department of Psychology at the Federal University of Maranhão in 2009, was established as the first cognitivist educator at the university.

The first professionals to work with the approach in Aracaju were Neuraci Araújo, Pablo Rubino, Alexandre Raad, and the students of the first class of the Postgraduate Course in Cognitive-Behavioral Therapy who concluded their specialization in 2007. Prior to this, a few professionals operated on a self-taught basis. In private practice, many professionals exist who claim they work within CBT. These number over 400, however, only half have taken the specialization course. The Beck approach is the one most frequently used, and schema therapy is hardly used by the professionals. Professional interest in the approach has been increasing every year.

Cognitive-behavioral therapy started to be used in the state of Piauí in 1998, by the psychologist João Damasceno. CBT in Piauí is used by professionals in clinics, public and private hospitals, companies, and government programs. The professionals subscribe to different modalities, such as Beck, REBT, Young, but the Beck model is the one most frequently employed, being the benchmark for the vast majority of therapists in this Brazilian state.

Other cognitive therapy centers have sprung up in the cities of the northeast region through the initiative of a number of professionals who have worked to disseminate the approach: Benéria Donato, Eleonardo Rodrigues, and Rodrigo Lopes da Silveira (Range et al., 2007), to name but a few.

## History of CBT in the Northern Region

In the northern region of Brazil, cognitive-behavioral therapy is still being implemented, by way of specialization and training courses.

The specialization course in Manaus, the capital city of the state of Amazonas, came about with psychiatrists Mauricio Hayasida, Jorge Alberto dos Anjos, and Ana Maria Coelho Marques, as well as the psychologist Nazaré Ma. de A. Hayasida, in 2004. After this, the first class graduated in the Martha Falcão school (FMF), under the coordination of Paulo Knapp. In subsequent years, a further six classes graduated, coordinated by other colleagues from the FMF institution itself.

In the state of Tocantins, Lucilene Prado e Silva was the first cognitive-behavioral psychotherapist to offer appointments in her practice in Palmas, in 2002. In 2011, the Institute of Behavioral Therapy (ITC) was inaugurated, the first clinic in the state to have psychologists specializing in cognitive-behavioral therapy.

In the state of Pará, up to around 15 years ago, cognitive-behavioral therapy was practically unknown. In 2006, CBT started to be introduced into the psychology course at the Federal University of Pará (UFPA). The involvement of Hilma Khoury on a variety of projects, collaborating in the Anxiety and Depression Day Clinic project (AMBAD) (2006–2010), and as coordinator in the project entitled Cognitive-Behavioral Intervention applied to the Health of the Elderly provided the opportunity to acquire an understanding of and undertake training in CBT. Recently, the number of psychologist professionals adopting CBT in their clinical work has grown, in the consulting offices, hospitals, and Centers of Reference and Social Welfare (CRAS), particularly in the cities of Belém and Santarém, but also in other municipalities within the state of Pará.

In 1997, in the city of Natal, in the state of Rio Grande do Norte, Maurilton Morais, a psychiatrist, lecturing at the Federal University of Rio Grande do Norte (UFRN), along with other professionals from the city, promoted events of short duration in the area. At this time, a CBT training course was initiated. In 2004, the first CBT internship class began, in the same university, as part of the psychology course. There are currently several CBT professionals in the College Hospital of the Federal University of Rio Grande do Norte and in psychology care sectors. More and more professionals working in private clinics and health insurance plans are using this approach.

Cognitive therapy came to the Federal University of Rondônia (UNIR) in 2009/2010 with the first medical professionals to be hired having graduated in the area. The most frequently used model is that of Beck. Treatment is conducted primarily in private and training clinics. The first specialization course was offered in the capital city in 2011 and was extended to other locations in the state in 2014. At the vanguard of this movement, in the consulting offices of Géssica Borges Bergamini, the first short-duration training course in CBT was held and the Rondonia Cognitive Therapy Study Group was initiated.

In the state of Acre, cognitive-behavioral therapy as a course subject and practice in the internship program began in 2010. The line developed by Beck is the one most used (both academically and in practice), but some therapists are also using rational emotive behavioral therapy and schema therapy.

## Current Regulations Regarding Psychotherapy Provision

The Federal Council of Psychology (CFP) was created in 1973, and in 1975 it approved the Code of Ethics of Psychologists in Brazil, which was replaced by a new code in 1976, brought up-to-date in 2005 (CFP, 2005).

The CFP is the entity that regulates, directs, and monitors the psychologist's professional practice across the whole of Brazil. In accordance with these functions, the CFP performs a periodic assessment of the psychological tests which may only be used with its approval. All approved tests are reevaluated every 15 years.

In addition, the CFP decides which practices may or may not be used by the psychologist. It is only permitted to link or associate the title of psychologist and/or professional practice with psychological techniques or practices already acknowledged as appropriate to the psychologist and which agree with the scientific criteria established in the field of psychology.

As far as the use of the internet is concerned, the CFP reformulated the use of information technology for offering online psychological services, in Resolution no. 11/2018 of May 2018 (CFP, 2018b) which authorizes online psychological consultations and treatment, personnel selection processes, psychological assessment, and technical supervision of other psychology professionals and students. There is no restriction on the number of online sessions. Online treatment is prohibited for victims of violence and traumatic events. Psychologists interested in offering online therapy must register with the Regional Council of Psychology and request authorization from the entity to conduct their treatment online, or be liable to disciplinary action in the absence of this validation.

## Professional and Cognitive Behavior Therapy Organizations

The major impulse for the establishment of CBT as the therapeutic approach of choice was the creation of the Brazilian Federation of Cognitive Therapies (*Federação Brasileira de Terapias Cognitivas* - FBTC) in 1997. The FBTC is the national association for those who dedicate themselves to working in any of the cognitive and behavioral therapy modes. It has 3369 members and eight affiliated state associations. FBTC offers certification for therapists who pass the appropriate examinations. Today there are 181 certified psychologists in CBT in Brazil. FBTC also publishes the *Revista Brasileira de Terapias Cognitivas* {RBTC} (Brazilian Journal for Cognitive Therapies). The RBTC publishes most articles in cognitive therapy in Brazil.

The scope of the FBTC is national, in which affiliated associations (ATCs) are present in ten states. In those states where associations are yet to be formed, there are 18 delegates and 13 vice-delegates who are striving for the promotion and implementation of CBT in clinics, hospitals, and faculties.

The FBTC was founded in the city of Porto Alegre, in the southern region of the country, every year promoting an international event with guests from the United States, Canada, and a variety of European countries, thereby ensuring that the latest in CBT theory and practice is communicated to the psychologists involved in it.

The first ATC was founded in 2005, in Rio de Janeiro, with Helene Shinohara its first president. It is the most active of all the ATCs, its membership including several lecturers from public and private universities, disseminating the study of CBT amongst their graduate and postgraduate students.

The Association of Cognitive Therapy of the State of Paraná (ATCPR), was founded in 2006. In 2007, in partnership with the Psychiatry Society of Paraná

(SPP) the first CBT Training Course of Paraná took place. The basic focus was that of Beck.

A landmark event for the ATCPR was the first edition of the International Workshop, in 2010, with the theme "Cognitive-Behavioral Therapy with children and adolescents" run by Paul Stallard. Renato Maiato Caminha, Valquíria Aparecida Cintra Tricoli and Adriana Selene Zanonato all participated in the event. In 2015, the Cognitive Therapy Association of Rio Grande do Norte was formed under the presidency of Neuciane Gomes and in 2007, to provide continuity to the development of cognitive therapy in the state, the Alagoas Association of Cognitive Therapy (ATC-AL) was founded. The newest state association is that of São Paulo formed by Neide Micelli Domingos as its first president.

## Training Opportunities in CBT

In Rio de Janeiro, CBT is included in the graduation curricula of several universities, including the following institutions: Federal University of Rio de Janeiro (UFRJ), State University of Rio de Janeiro (UERJ), Estácio de Sá, Celso Lisboa, Pontifical Catholic University of Rio de Janeiro (PUC-RJ), among others. It can be found in specialized postgraduate courses in the theses and dissertations on the approach. It is also used in the public health service (SUS), in private clinics, and in hospitals. The modality most used is based on Beck and on third-generation cognitive therapy theories. Due to the treatment being available in a variety of settings, CBT is sought after by patients with various types of complaints and by different social classes. At the present time, we are seeing the emergence of sexual cognitive therapy. Residents of the Multiprofessional Residency Programs in Women's and Family Health, at the Federal University of Rio de Janeiro (UFRJ), are attending CBT courses in the area of health psychology offered in the Institute of Psychology's Postgraduate Program in Psychology.

In the state of São Paulo, CBT is regularly practiced in private clinics, hospitals, university clinics, and in the public health service (SUS). The São Paulo ATC was recently founded under the presidency and vice-presidency of Neide Micelle Domingos and Roseli Lage de Oliveira, respectively. There is a large number of specialization courses in São Paulo, with a diversity of theoretical approaches under the umbrella of CBT, such as courses which have adopted Beck, some follow Ellis, schema theory, constructivism, among others. One of the CBT representatives in the state of Sao Paulo is Valquíria Tricoli, who heads up a care clinic primarily for adolescents. Among other courses, there is a rational emotive behavior therapy (REBT) clinic in São Paulo, the Specialized Treatment Clinic (CTES), dedicated to treating alcoholism, and the Veda Cognitive Therapy Center is offering an REBT course run by the Albert Ellis Institute, among others. A strong current within CBT is the constructivist approach, represented by work on impulse disorder by Cristiano Nabuco de Abreu, of the Institute of Psychiatry of the São Paulo Faculty of Medicine. In faculties within the state of São Paulo, CBT is gaining acceptance with the

contributions by Carmen Beatriz Neufeld at the University of São Paulo (USP) in the city of Ribeirao Preto, and Alessandra Marquez at UNIP; however, the majority of CBT training derives from specialization courses.

At the present time, there is an online course in cognitive-behavioral therapy organized by Cristiano Nabucco, in São Paulo, and Marco Calegaro, in Santa Catarina, and also by the publisher Artmed Panamericana, which is offering learning opportunities without the physical presence of the student. The same publisher is also offering a refresher course in CBT organized by Carmen Beatriz Neufeld, Eliane Falcone, and Bernard Rangé.

In the state of São Paulo, which boasts the highest concentration of psychologists in Brazil, there is an increasing number of professionals with CBT specialization. In Campinas, a city in upstate São Paulo, the Institute of Psychology and Stress Control (IPCS) has a large group of cognitive-behavioral therapists, many of which have already received FBTC certification. This institute also has units in several cities, including São Paulo, Recife, Uberlandia, Cuiabá, Rio de Janeiro and Niterói. The IPCS offers the only specialization course in Brazil that focuses on rational emotive behavioral therapy (REBT); therefore, the number of psychologists working with this approach is higher in the state of São Paulo than anywhere else in Brazil. IPCS has already prepared over 600 psychologists specializing in REBT. Their students, former and current, are scattered all over Brazil, pioneering this theoretical instruction.

The state of Paraná had its initial contact with cognitive-behavioral therapy outside the university seats of learning, in two distinct groups and moments in time, which would subsequently come to be unified. In the city of Cascavel, in 2003, the first Further Training Course took place, entitled "Bases of Cognitive Therapy," one of the first in the state. In 2005, in Curitiba, another city in the same state, the Pontifical Catholic University of Paraná (PUCPR), through the Institute of Prevention and Treatment of Drugs of the Health Alliance (IPAD – PUCPR Santa Casa) promoted the course "Foundations of Cognitive-Behavioral Therapy."

In Florianópolis, in the state of Santa Catarina, important CBT activity has been evidenced by Marco Calegaro, promoting specialization courses in the area. In Porto Alegre, we should highlight the work of Ricardo Wainer in schema therapy and Wilson Vieira Melo, with dialectical behavior therapy.

CBT began to evolve in Espírito Santo within the last five years, during which time the first CBT course was created in the state capital of Vitória.

In the state of Goiás, three private universities offer courses in CBT, but the federal university does not follow this practice. There are three specialization courses in the state. The most favored line of work is that of Beck, the majority of the professionals working in private clinics, very few occupying positions in hospitals or the public health service.

In Aracaju, in the state of Sergipe, on an academic level, cognitive-behavioral therapy started to be included in the curriculum of the Tiradentes University (UNIT) with a self-taught lecturer who was offering internships supervising with this approach. It is currently included in the course curriculum at UNIT and at Estácio de Sá.

In the state of Tocantins, the ITC, together with the school *Cognitiva Scientia*, started, in 2017, the first specialization in cognitive therapy in the state, with 25 places occupied by psychologists and psychiatrists from the public network in the municipality.

Cognitive therapy came to the Federal University of Rondônia (UNIR) in 2009/2010 with the first medical professionals to be hired having graduated in the area. In other scenarios, CBT training has begun in private faculties through the placement of new lecturers from other states. Today, all the private colleges have CBT subjects in their curricula, although the full professors rarely have specific training in the area. Currently, big strides are being made with qualification and in the master's program in psychology, which is undertaking a line of research that focuses on studies using the cognitive approach.

In the state of Acre, cognitive-behavioral therapy as a course subject and practice in the internship program began in 2010. Currently, three of the four institutions that offer the Psychology course include the approach in the theoretical and practical development of their students. Two of these institutions run postgraduate courses in the area.

## CBT with Specific Clinical Populations

The profile of patients seeking CBT professionals is one of a diverse economic class, predominantly individuals or families who are looking for help with Anxiety Disorders, which affect 9.3% of Brazilians, or Depression, with an incidence of 5.8% in the country. It is estimated that at least 23 million Brazilians (12% of the population) require some form of mental healthcare and approximately five million Brazilians (3% of the population) suffer from grave and persistent mental disorders (WHO, 2017).

There has also been a big demand for treatment for emotional stress, which has an incidence of around 35% in the general population. Other reasons for people turning towards psychotherapy include obsessive-compulsive disorder, anger, marital problems and relationship issues. Qualification programs are available for lifestyle change, obesity and anti-smoking. The number of parents seeking CBT treatment for their children has been increasing as they become aware that CBT is brief and effective.

The vast majority of psychotherapy treatments are conducted in private clinics, paid for by the clients themselves, which means that the majority belong to the higher socioeconomic classes. Recently, it was prescribed that private health plans should carry the cost of some of the psychotherapy sessions of their associates. In general, it is required that doctors refer their patients to the psychologist with a limit of around 12 sessions, although some more expensive health plans permit a higher number of psychotherapy sessions. On the plus side, some companies are beginning to make arrangements with CBT psychologists for treatment for their employees.

People who cannot afford the expense of psychotherapy may be able to receive treatment in university clinics where the students provide therapy under the supervision of their teachers. Alternatively, they can get assistance from Brazil's public health service (SUS). Brazil's public health service has three levels of healthcare (primary – low complexity; secondary – medium complexity, and tertiary – high complexity). Psychology has contributed at various levels and in various settings, one of which is the Psychosocial Care Center (CAPS). In CAPS, individuals are treated with the aim of achieving reintegration into the family and society, consisting of a multiprofessional team that includes psychologists, some of them working within the cognitive framework.

All states in Brazil offer some type of help for mental disorders, and CBT is gaining preference. For example, in the state of Mato Grosso do Sul, six out of every 10 people benefiting from state health plans seek cognitive therapy for the treatment of various types of disorder and other difficulties of life.

## Adaptation of CBT in Brazil

While CBT is fully accepted and embraced in some countries, in other countries this may not be the case. Linguistic aspects, for example, and the way in which the performance of tasks is requested, either as homework or during the sessions, require modification. In addition, the form of feedback on the concepts of the case, the form of presentation and implementation of techniques, accountability for performance, do not always help the patient to be committed if the therapist rigidly follows the original proposal of the authors. Some of the concepts that are part of the theoretical base and which are applied in the therapy, for cultural motives, merit further attention. Take for example the belief studied by Albert Ellis in Rational Emotive Therapy (Ellis, 1980) that "it is necessary to have love and approval by all of the significant people in your life." It is known that this belief relates to a lack of assertiveness or, in other words, the difficulty of fighting for your rights and of self-affirmation. Clinical experience demonstrates the very frequent presence of this belief among patients. Working with assertiveness in Brazil needs to be adapted to cultural aspects, as Brazilians, being a Latin people, have emotional peculiarities that need to be considered. Therefore, it is essential that the use of social skills training techniques such as assertiveness training considers the context in which the individual is situated in order to avoid the intervention creating problems for the patient instead of helping him/her with their interpersonal relationships.

Another aspect to be taken into consideration when applying CBT in Brazil is that it is often very difficult for some patients to stick to their homework as a psychotherapeutic strategy. It is thought that this has to do with cultural aspects, since the term "homework" appears to remind them of something they used to do when at school. Thus, they may feel infantilized and, consequently, reluctant to do it. So, the term needs to be tailored, using a word appropriate to the case in question.

One of the adaptations which is most obviously needed is the one related to the level of education. Clinical experience has shown that, for these patients, it is necessary to offer therapeutic activities, at home or otherwise, using symbols. For instance, Camera, Hirata, and Malagris (2016) proposed an adaptation of psychotherapy materials used in the cognitive-behavioral treatment of the more frequent anxiety disorders in adults, for a Brazilian population considered to be absolutely or functionally illiterate. The idea for the proposal came from the authors' experiences with patients in the Brazilian public health service (SUS) who are usually people of a low educational and economic level. This experience showed that many patients were not doing their homework or even the tasks to be performed during the sessions, because they had difficulty in understanding them. Add to this the economic difficulties which obliged them to work long hours did not allow them to introduce into their lives yet another task in their already overburdened daily routine.

With the materials produced, it was sought to avoid as much as possible the use of words, opting instead for symbols, figures, and drawings. One CBT strategy for which adaptation was sought in the study in question was the Daily Record of Dysfunctional Thoughts (DRDT). So-called *emojis* were used as the basis, figures created in the 1990s by computer scientist Shigetaka Kurita at NTT DoCoMo, a Japanese cell phone company (Hern, 2015). This resource was selected due to the great variety of situations, thoughts, behaviors, and emotions that can be expressed using figures, without the need to use letters or words.

For the recording itself, it was decided that the *emojis* would be printed on adhesive paper so that they could be detached and glued in the corresponding columns, facilitating the patient's active role. As far as the psychoeducation material on the cognitive model is concerned, the *emojis* were also used, for the most part, so that the patient could gain a clear understanding of the fundamental concepts for treatment.

The recording was also adapted for exposure to situations causing anxiety by creating a hierarchy of situations to which the patients should be gradually exposed. Some *emojis* were used with facial expressions, ordered in such a way that they would represent the levels of anxiety, on a scale from 0 to 10. These figures were placed above the image of a ladder, making it easier to understand the grading of levels of anxiety.

Another technique that focuses on the treatment of anxiety for which adaptation was proposed was the Diaphragm Breathing technique. The material was planned so that the client, when viewing the figures, could reproduce the same movements, thus making it easier to carry out the technique.

Lipp (1984) formulated a treatment model entitled "Stress Control Training (SCT)" which has been extensively employed in research studies, in individual and group therapy sessions in Brazil. It is an intervention method which aims to modify lifestyle and which has been very well accepted as it adapts well to the culture of the Brazilian population. SCT was developed based on research and the author's clinical experience and involves intervention on four pillars: relaxation and deep

breathing techniques, guidance on diet to combat stress, instruction on the importance of regular physical exercise, and, lastly, cognitive-behavioral techniques. Lipp created information material appropriate to people with stress in such a way that it facilitates commitment and change. The materials produced cover all the pillars and are written in clear, objective language. SCT is given over 15 weekly sessions where each session has a specific objective focusing on the base pillars.

One resource that has been increasingly developed in Brazil are the so-called "flashcards." There are various kinds, some directed toward the child population, others for teenagers and adults. They are really quite creative intervention methods that have been very well received by the Brazilian population. The flashcards encompass: social skills (Rodrigues, & Folquitto, 2015), attitudes (Lipp & Benzoni, 2015), emotions (Caminha & Caminha, 2014), problems (Lopes & Lopes, 2018), and thoughts (Caminha & Caminha, 2012). The decks comprise groups of cards that aim to work the patients' skills in a creative, playful and interactive manner, in order to facilitate comprehension, diligence and change.

Another adaptation which is usually quite fruitful in helping with adherence to treatment and which has been widely used in Brazil is the use of metaphor and parables. Rangel (2004) offers 150 parables that present teachings that can be adapted for psychotherapy in harmony with CBT strategies. The parables are useful resources for the Brazilian population, whether for patients with comprehension difficulties in the reading of more formal psychoeducation material, or whether for those who are resistant to the therapeutic process.

One other resource that is customarily employed in Brazil to facilitate the understanding of CBT concepts and adherence to treatment are movies that deal with characteristics, applications, and therapeutic effects. This resource is consistent with international literature, according to a review conducted by Oliva, Vianna and Neto (2010) on the use of cinema therapy as a psychotherapy intervention. With regard to the teaching of CBT in Brazil, the analysis of movies has also proved to be very useful, as can be observed in Landeira-Fernandez and Cheniaux (2009) in their book entitled "*Cinema e Loucura*"[4] in which mental disorders are discussed based on commercial films. The ludic aspect and the humor usually help with adherence in the case of many patients in Brazil, perhaps due to cultural factors.

In any case, understanding the culture, the context in which the patient lives, his/her level of education, the ability to comprehend, these are aspects fundamental to the success of the therapy. In Brazil, the therapist clearly needs to be creative and maintain common sense when adapting techniques to facilitate adherence to treatment and for the success of the therapy.

[4] Cinema and madness

## Research on CBT in Brazil

A survey of CBT articles published in Brazil between 2010 and 2018 demonstrates the need for greater incentives for studies in this area. There is one scientific journal, the *Brazilian Journal of Cognitive Therapy* (RBTC), published by the Brazilian Federation of Cognitive Therapy, which is specifically designed to present topics focusing on the cognitive-behavioral approach. In the period mentioned above, with regard to studies conducted in Brazil, the RBTC published articles ranging from case studies and literature reviews to theoretical research, although still a very small number for a country with a significant prevalence of cognitive-behavioral therapists.

Among the publications found of clinical cases, considering those that have been most frequently accessed, the work by Frassetto and Bakos (2010) should be mentioned, involving the treatment of a child with phonological disorder related to family conflict and marital separation, performed with a focus on the therapeutic alliance and the cognitive and behavioral techniques of CBT. There is also the work of Oliveira (2011), the objective of which was to develop problem resolution skills to control anxiety. Another report on a clinical case was conducted by Justo, Matos and Lipp (2015), concerning a CBT intervention on a 35-year-old woman suffering from serious symptoms of obsessive-compulsive behavior. In addition, Assumpção, Neufeld and Teodoro (2016) presented a case report of a patient with a diagnosis of diabetes, mild symptoms of depression and burnout, treated in 2015 and 2016. This study represented the phases and stages through which patients go to achieve modification of behavior.

Also, in the field of the practical application of CBT, the study by Basso and Wainer (2011) into grief and sudden loss must be mentioned, with its specification of the essential aspects of CBT in managing this grief. Then there is the article by Barletta (2011) presenting the definition and characterization of conduct disorder and oppositional defiant disorder, and questions concerning evaluation, and the training of parents, children and teenagers. The article penned by Simone performs a review of the main CBT-based techniques that focus on behavior modification, which serve as support to the therapy with patients suffering from attention deficit disorder or hyperactivity.

In the area of conceptualization, the work of Neufeld and Cavenage (2010) proposes the systematization of the process of cognitive conceptualization based on the literature, clinical practice, and supervision in the training of cognitive-behavioral therapists. This study discusses a review of the literature concerning cognitive case conceptualization and the challenges with regard to clinical care. There is also the publication by Pereira and Penido (2010) on the theoretical and practical applicability of cognitive-behavioral therapy in hospital psychology. Data were presented in respect of studies that analyze the influence of the cognitive processes on individuals' health behavior and illnesses, as well as several cognitive-behavioral techniques employed in private practice that can be applied for the understanding and management of health problems.

Several works reviewing the literature were also published in this period, such as that of Veras (2010), who conducted a survey into the development of body image in contemporary western culture and into the workings of the cognitive-behavioral therapeutic process used with the aim of improving the perception that the individual has of him/herself. Another article, by Carneiro and Keith (2016), presented a narrative review of the evidence and applicability of different cognitive-behavioral techniques in the treatment of mood disorders, such as traditional cognitive-behavioral theory, the theory of behavioral activation, mindfulness, and online instruments.

As for those works that propose innovation, the study of Santana and Lopes (2016) may be singled out. The aim of this study was to build a psychoeducational tool for cognitive distortions linked to the experience of cancer, through the adaptation of J. Beck's "coping cards" technique, identifying cognitive distortions and psychoeducating cancer patients by neutralizing beliefs that act on the restructuring of distorted thoughts.

The review of the studies presented here is purely an illustration of the type of work that is being published and does not, therefore, fully represent all publications in this area.

## CBT with Special Populations in Brazil

### *CBT in Cardiology: WOMEN with Cardiovascular Disease*

The studies of Lessa and Bastos (1983) and Lotufo (2007), among others, show that the prevalence of cerebrovascular diseases and coronary disease in Brazilian women aged between 45 and 64 is higher than for women in other countries, with 40% of coronary events in women leading to death. It is estimated that modifiable risk factors contribute to this alarming picture. In this way, special attention has been paid to women with risk factors for cardiovascular disease. The Brazilian government, through its public health system, has made available centers for the prevention and treatment of risk factors in women, including offering participation in cognitive-behavioral group therapy. In the private sector, the focus of cognitive-behavioral therapy has been on studies with women with metabolic syndromes, which represent greater cardiac risk. These studies are aimed, primarily, at the prevention of premature death by modifying life habits, and the reduction in levels of depression and anxiety, facilitated by cognitive-behavioral therapy (Lipp, 2007; Malagris, & Lipp, 2014).

### *CBT with Pregnant Teenagers*

Another population receiving more attention from the programs of cognitive-behavioral therapy is adolescent females. Data obtained in 2011 show that the country saw 533,103 births in girls aged between 15 and 19, and 27,785 for girls aged between 10 and 14. It should also be stressed that 30% of females who become pregnant in their teenage years end up having another child within a year.

Data published by the Ministry of Health showed a total of 274 pregnancy-related deaths in teenagers in that year. In addition to the deaths of the mothers, it can be seen that infant death is more common in children born to teenagers under 15 years of age, when compared to women aged between 25 and 29 (Santos, 2018). Accordingly, several universities have been providing programs of assistance to this population, among them the State University of Campinas (Unicamp) in the Women's Hospital (CAISM) which offers specialized care to pregnant girls in its Adolescent Pre-Natal Outpatient Clinic (PNA). In an initiative which is a first for the country, a group of PNA professionals providing this care have been involved in activities that include the creation of an open group to provide guidance to these girls about human and reproductive rights, as well as research studies to inform our understanding of this section of the population (Brasil Escola, 2018). Cognitive-behavioral therapy is one of the services offered.

Although CBT is seen to be useful with the special groups mentioned above, its use must be extended to other needy populations, such as the elderly, people suffering from cancer, homoparental families, among others, that are not yet receiving the attention of CBT. It is the private clinics which are providing CBT to these populations.

## Conclusion

CBT is expanding in Brazil at astonishing speed, there being numerous specialization courses in cognitive therapy, and some universities have already included the CBT approach in their graduation curricula. The FBTC and its respective state associations, as well as their regional representatives, are exerting a fundamental role in the development of CBT at a national level, promoting opportunities for contact with professionals from various corners of the globe, instructing and encouraging their associate members. Several master's and doctoral dissertations have been published on CBT, demonstrating the scientific interest in the area. Psychologists working with CBT provide their services in private clinics, hospitals, the SUS and within universities.

The approach postulated by Beck is the one most frequently used, while in Sao Paulo one can find a substantial number of followers of REBT. CBT is primarily sought after by individuals with a higher level of education, but it is also establishing a foothold in the SUS where care is given to the less well-off. CBT is used with

children, adults, and couples, although it is mostly adults who seek this form of treatment. The most frequent complaints are anxiety, depression, anger, and stress. One of the greatest difficulties that a cognitive-behavioral therapist faces is getting their patients to perform the homework asked of them. Few manage to stick to these tasks and therapists often have to use their imagination to devise tasks that are appropriate to the culture and which have the greatest probability of being carried out.

Although CBT is quickly evolving, much still needs to be done, both in the sense of including CBT subjects in the graduation curricula of the universities, and also the geographical distribution of practitioners of CBT, since in some regions there is a marked shortage of CBT professionals.

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# Chapter 7
# Cognitive Behavioral Therapy in Canada


**Amanda Fernandez, Keith S. Dobson, and Martin Drapeau**

## An Overview of Canada

Canada is a geographically and demographically diverse country. It is the second largest country in the world and covers roughly ten million square kilometres. Canada is bordered by the Pacific Ocean, the Atlantic Ocean, and the Arctic Ocean; and it also shares the longest undefended border in the world with the United States along the south and northwest (Alaskal) of the country. Canada has varied landscapes, including the Rocky Mountains, prairie grasslands, arctic tundra, and various different types of forest regions. Canada is divided into 10 provinces and three northern territories; each province and territory has its own capital city where the parliament for the province or territory can be found. The capital city of all of Canada, however, is Ottawa, which is located in the central province of Ontario. Canada's population lives mostly in central Canada (i.e., the provinces of Ontario and Quebec). The next densest provinces are the west coast province of British Columbia, and its neighbour prairie province of Alberta. Most people in Canada live relatively close to the southern border, and the northern territories of the country are sparsely populated.

Canada has three founding groups: First Nations, French, and British. The First Nations people are indigenous individuals whose ancestors lived in Canada before the arrival of European settlers. There are over 600 First Nations groups in Canada. Although many First Nations individuals live in cities across Canada, First Nations peoples also reside in tracts of land called reserves that were created by treaties with the Canadian government for the exclusive use of First Nation peoples. Such

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reserves have their own administrative and political structures, but also adhere to Canadian law. French Canadians are largely decedents from the French colonists who settled predominantly in Quebec and the Atlantic region, although small pockets of French speaking communities exist across Canada. English Canadians were originally and for the most part decedents from settlers who came from the countries comprising Great Britain. An early war between France and England for supremacy in the lands that became Canada was settled when the English forces defeated the French, but the recognition of two founding nations has always been a part of the Canadian context. As a result of the British defeat of the French, Canada adopted a Constitutional Monarchy as its parliamentary system, and it is a British Commonwealth Nation. Although Canada was created in 1867, it was only in 1992 that it patriated its own constitution and Charter of Rights and Freedoms from England, as recently as 2006, the Canadian Parliament recognized Quebeckers (Québécois) as a nation within Canada, comprised of individuals who maintain a unique identity, culture, and language.

Canada has mostly grown through the influx of immigration from a diverse number of countries. In 2016, over one-fifth (21.9%) of the Canadian population reported they were foreign born and, at some point, had been a landed immigrant or permanent resident in Canada (Statistics Canada, 2016a). In addition, close to half (48.1%) of those who identified as foreign-born were born in Asia and the Middle East, 8.5% reported being born in Africa, and 27.7% reported being born in Europe. Given Canada's history and continued growth of a diverse population, Canada is recognized as a bilingual country with English and French as its two official languages. In 2016, 17.9% of Canada's population identified themselves a bilingual in English and French, although the majority of the bilingual population is concentrated in Quebec, New Brunswick, and Ontario. It was also reported that despite recent increases in immigrants from countries where English and French are not their mother tongue, 93.2% of immigrants reported they were able to conduct a conversation in either English or French (Statistics Canada, 2016b).

Canada's political system largely reflects British political institutions and traditions. The federal government employs a parliamentary system, and although Canada has its own constitution (repatriated in only 1982), it is still a constitutional monarchy and has both an elected parliament, an appointed senate, and a governor-general, who is the British monarch's representative in Canada. Federal legislation is not proclaimed until it is signed by the governor-general. Laws derive from both Canadian statutes and British (and Canadian) common law, with the exception of Quebec where both common and civil law systems are in effect. Canada's federal government is responsible to national and international affairs (e.g., military, coastal protection, currency regulations, foreign policy). In contrast, provincial and territorial governments have their own elected premier and legislature, and jurisdiction regarding domains such as health care, social services, and education. Most relevant to this chapter, control over the training and licensing of health care professionals is a provincial matter, and while there are commonalities across many provinces and territories in Canada, there are also notable differences in some domains.

Overall, Canada's large geographical area, political structure, and diverse immigration create a rich population comprised of diverse peoples, cultures, and ways of life that supports Canada's multicultural ideals. As is discussed in the following sections, this diversity has also contributed to variability in mental health services.

## A Brief History of Psychology in Canada

Applied psychology in Canada can be traced back to the early twentieth century (Nelson et al., 2007). Some of the earliest Canadian psychology programs and practitioners were associated with and relied on American institutions such as the American Psychological Association (APA), as there was no national psychological association in Canada until 1939. Therefore, the earliest development of psychological practices in Canada paralleled those in the United States and was substantially influenced by literature from the United States, as well as Europe (Adair et al., 1996; Brock, 2013; Domene & Robinder, 2013). The early development of psychology in Canada largely related to research, theory, and pedagogy. In fact, the Canadian Psychological Association (CPA) originally opposed the development of applied psychological services to the public, with a strong debate as to whether it was premature for psychology to offer services, whether applied domains had relevance in a scientific discipline, and therefore, whether such services could be considered legitimate (Adair et al., 1996; Ritchie & Sabourin, 1992). In support of such concerns, the Canadian Psychiatric Association had taken a position in the 1950s that diagnosis and psychotherapy were medical activities, and could constitute risks to patient populations if shared with other professions such as psychology.

Despite the lack of support by the CPA to develop applied psychological services, professional services flourished in Canada. Psychologists in applied settings began to develop their own infrastructures that did not belong to the national association. Provincial associations related to professional interests were founded, with the first provincial association being the Ontario Psychological Association (OPA) established in 1948 (Ritchie & Sabourin, 1992). As the desirability of legal recognition grew for professional psychology, so did the development of provincial regulatory bodies. Between 1960 and 1991 all of Canada's provinces enacted statutes governing psychology. The resulting regulatory bodies began to define their own eligibility criteria, as well as create and maintain their own standards of practice. Some of these provincial associations initially became affiliated with APA, as the CPA did not support psychology as a service profession until the 1970's (Adair et al., 1996; Ritchie & Sabourin, 1992). Indeed, CPA did not adopt a national standard for training doctoral level psychologists until 1982.

During the 1970s, the CPA began to shift its framework toward an inclusion of professional psychology and include provincial representation within its structure. This inclusion proved to be difficult due to the continued importance placed on academic as opposed to professional considerations in most universities (Ritchie & Sabourin, 1992). It was not until the provincial and regulatory bodies developed the

Council of Provincial Associations of Psychologists (CPAP) in the 1980s that sufficient pressure was placed on the CPA to reform. Furthermore, while CPA asserted itself to be a bilingual association, it was dominated by English- speaking Canadians, and as such, many French-speaking professional psychologists did not participate in the CPA (Ritchie & Sabourin, 1992). Although professional psychology is still provincially regulated, provincial and territorial associations are all members of CPAP, which works in collaboration with CPA to ensure provincial and territorial professional psychology concerns are considered. All provincial and territorial associations are also affiliated with the CPA's Practice Directorate which coordinates, supports, and facilitates advocacy across Canada. Psychology is now a major healthcare profession in both private and public (hospitals, schools, veteran affairs) settings. Numerous designations in psychology, such as clinical, counselling, and health psychology, make up the broader group of professional psychology.

Medical services are regulated in Canada largely at the provincial and territorial levels. All physicians are regulated by local colleges, but there are national training standards. All physicians, including specialists such as psychiatrists, are also publicly funded, and are eligible to bill for reimbursement for their services directly to the jurisdiction(s) in which they work, using established fee schedules. As some variability began to emerge across provincial and territorial systems in health care (e.g., which services were covered or elective; transportability of health care across provincial boundaries), the Canada Health Act (CHA) was established in 1984 with a stated objective to protect, promote, and restore the physical and mental wellbeing of residents of Canada and to facilitate reasonable access to health services without financial or other barriers (Canada Health Act, section 3, 1984). The CHA defines insured health services as hospital services, physician services, and surgical-dental services (Sect. 2), and specifies that services covered under the act can extend to health practitioners other than dentists and physicians for services that overlap (Peachy et al., 2013). Current provincial legislature further acknowledges that psychotherapy can be practiced by a diverse range of professionals, including psychiatric nurses and clinical social workers, among others (Domene & Robinder, 2013). Despite the provincial regulation of psychology, there is an increasing overlap in scopes of practice among professional groups in the mental health community.

A recent development in the landscape of mental health is that there is less emphasis on the provision of mental health services in hospital and acute care facilities and more on community-based mental health care (Owens et al., 2013; Peachy et al., 2013). Unfortunately, affordable and appropriate community resources are not always available (Peachy et al., 2013). For example, psychologists are often employed in hospitals and other provincially operated facilities, but no Canadian jurisdiction has included the services of psychologists under their fee-for-service provincial insurance plans and so there is limited access to these services (Dobson, 2002; Peachy et al., 2013). Despite the increasing demand and need for mental health services in Canada, the current health care systems and private insurers are unable to meet this need (Peachy et al., 2013). It was estimated that 20% of Canadians experience mental health problems each year but only one third of these individuals sought and received treatment (Mental Health Commission of Canada,

2012). Thus, the prevalence of untreated mental health related illness or problems may be as high as 14% of the Canadian population. Although psychotherapy has been established as a major health care need within Canada, there is still debate and concern regarding how it should be implemented and what professions should deliver it.

## Current Regulations Regarding Psychotherapy Provision

Psychotherapy is an activity that is practiced by many different professionals in Canada, and it generally falls under provincial jurisdiction, As such, the Canadian government and health care legislature does not require a standard curriculum or mandatory set of skills. Such a curriculum has however been established through the Canadian Medical Association and medical specialities such as psychiatry. The psychology CPA has also set a national recommended curriculum and associated accreditation standards. The CPA only accredits doctoral level programmes in professional psychology, as their position and recommendations to the field of psychology are to move toward a doctoral level of practice across all provinces and territories (Canadian Psychological Association, 2011a). Although provincial licensing often requires the completion of academic curriculum that aligns with the CPA's standard curriculum, it is not required that an applicant's degree come from a CPA accredited programme. Accreditation of programmes are voluntary, but given its aid in facilitating licensing, it is highly desired. Currently there are 30 accredited doctoral level programmes in Clinical Psychology in Canada, 5 in Counselling Psychology, and 4 in School Psychology.

Despite CPA's attempts to assert doctoral level practice and a standard educational curriculum, there are variations in the licensure process and standards depending on the college or board that regulates the practice of psychology in each province. For example, the minimum degree required for licensure as a psychologist varies. Doctoral level training is required to obtain the title of psychologist in most provinces but some provinces allow licensing at the master's level. Some provinces differentiate the professionals by the title given (e.g., psychological associate for master level practitioners vs. psychologist for doctoral level practitioners, both in Ontario and Manitoba) and/or will also require master's level individuals to obtain additional hours of supervised experience. In addition to educational and supervised experience requirements, all provinces except Quebec[1] require a passing score on the Examination for Professional Practice in Psychology (EPPP) to obtain licensing. The EPPP is a standardized examination created by the Association of State and

[1] The system in Quebec is different as the Ordre des psychologues du Québec, the regulatory body for psychologists in that province, formally accredits university programs in professional psychology. When a student graduates from an accredited program, he or she is deemed to have met the requirements for entry into the profession. Graduates from a non-accredited program are not eligible for licensing.

Provincial Psychology Boards (ASPPB) that assists provincial boards of psychology to evaluate the applicant's knowledge on content areas deemed relevant for competent practice (ASPPB, 2017). An oral examination which examines the applicant's knowledge and judgement in matters of jurisprudence and ethics is often required in addition to the EPPP. The Canadian territories do not currently list the EPPP as a requirement. Further, the Yukon Territory is currently the only area in Canada that has no legislature governing the practice of psychology.

Other professions in addition to psychiatry and psychology engage in psychotherapy practice. Such professions adhere to their own regulatory bodies and provincial licensure requirements. For example, Quebec has separate legislature and regulatory bodies to regulate guidance counselling, psychoeducation, psychology, social work, and marriage/family therapy. Most provinces and territories have established provincial regulatory bodies for social workers, although provincial legislation varies among provinces. In regard to counselling and other psychotherapy providers, only the provinces of Quebec, Ontario, Nova Scotia, and New-Brunswick have legislation in place or maintain regulatory bodies.

One final note about psychotherapy provision is the emphasis on evidence-based practice and continuous professional development. The CPA has recommended the implementation of evidence-based practice, which is defined as the use of the best available research evidence in the context of specific client characteristics, cultural backgrounds, and treatment preferences, to help inform each stage of clinical decision making and service delivery (Canadian Psychological Association, 2012; Dozois et al., 2014). Moreover, evidence-based practice is consistent with the ethical codes and professional standards set forth by the CPA and regulatory bodies, as it entails continually learning from and informing research evidence related to interventions and treatment strategies that are cost-effective, maximize benefit, and minimize risk (Canadian Psychological Association, 2012). Despite the push for evidence-based practice in professional psychology, and the importance placed on continuing education, mandatory continuing education credits are not required in many provinces (Bradley & Drapeau, 2013).

## Professional and Cognitive Behavior Therapy Organizations

Canada has one national cognitive behavioral therapy organization, the Canadian Association of Cognitive Behavioral Therapies/ L'Association Canadienne des thérapies cognitives et comportementales (CACBT/ ACTCC). This association was created and incorporated under the Canada Corporations Act in 2010. CACBT/ ACTCC was developed by a group of Canadian mental health practitioners involved in the professional practice, theory, and scientific endeavours related to CBT. Its organizational goals pertain to the training, advancement of knowledge, advocacy, and professional accreditation in CBT. More specifically, CACBT/ ACTCC

provides a means to disseminate up-to-date information regarding CBT theory and practice and provide CBT training through the organization of conferences, courses, and workshops. CACBT/ ACTCC promotes scientific research in CBT and provides a forum for researchers and practitioners to communicate and decrease the gap between science and practice. Importance is also placed on advocating to the public in order educate and inform them on CBT. CACBT/ ACTCC has created and maintains a certification process in Canada in order to set a standard of practice for skilled cognitive-behavioral therapists.

## Training Opportunities in CBT

At the graduate level, most doctoral programs adhere to a scientist practitioner model, with emphasis placed on both applied skill development and research skills, while terminal master's programs rely more heavily on practice-oriented frameworks. Within the applied graduate level training domains, the most common programs are clinical psychology, educational psychology, and counselling psychology (Adair et al., 1996). As described in an earlier section, many of these programmes voluntarily adhere to the CPA standards of curriculum in order to obtain academic accreditation status within the country. As CPA promotes and recommends the implementation of evidence-based practice and interventions, they have set a requirement for their accredited programmes to include training in evidence-based interventions (Canadian Psychological Association, 2011b). Subsequently, due to CBT's large base of empirical support and, therefore, its inclusion as a significant evidence-based intervention, many graduate level programs offer instruction and training in CBT. In addition, many CPA accredited psychology residency and internship placements across Canada also offer experience working in rotations or with specific populations designated to implementing CBT.

In regard to after-degree opportunities, Canada has multiple training centres that offer workshops, training modules, and certificates that teach the general principles and skills of CBT, as well as the application of CBT to specialized populations. In addition to training centres, many training opportunities for continuing education in CBT are also offered at various universities across Canada, as well as by the CPA. An ongoing list of CBT workshops and training opportunities can often be found on the CACBT/ ACTCC website (http://www.cacbt.ca) . Despite these training opportunities, there is, as of the current writing, no accredited CBT training centre in Canada. Therefore, CACBT/ ACTCC has created a formal certification process in Canada to help consumers navigate which clinicians are credentialed in cognitive behavioral interventions. All health professionals who work in CBT are encouraged to apply.

## CBT with Specific Clinical Populations

Psychotherapy in Canada is a clinical activity for many health care professionals in hospital, community, and private care settings, including psychology. There have hence been a number of national surveys of psychologists who work in different settings. In regard to hospital settings, psychologists have moved away from a traditional mental health focus and now are employed within multidisciplinary teams in somewhat non-traditional specialties (Goodman, 2000; Owens et al., 2013). Specifically, in addition to the traditional hospital units for specific mental health related illnesses, psychologists reported employment in numerous clinics and units traditionally seen as more health related. These units include, but are not limited to, brain injury, pain, sleep disorders, cancer, cardiac, child development, diabetes, eating disorders, emergency, forensic, and neonatal care (Humbke et al., 2004; Owens et al., 2013). Moreover, some psychologists report clinical activities in family practice, gastroenterology, gerontology, neurology, oncology, paediatrics, and rehabilitation (Humbke et al., 2004; Owens et al., 2013). When examining the prevalent treatment orientations of psychologists working in these areas, the most prevalent orientation reported was CBT with 63.5% of respondents indicating they engaged in CBT related services with their clients (Owens et al., 2013).

Additional surveys of registered psychologists in both public and private settings across Canada (e.g., Hunsley et al., 2013) or in specific provinces (e.g., Jaimes et al., 2015) have reported that although the majority of practicing psychologists use a variety of theoretical orientations in their practice, CBT was rated as the most influential for approximately 80% of respondents. In one of these surveys, 62.5% reported work primarily with adults, 12% with older adults, 10.5% with children, 7.6% with adolescents, 5.2% with young adults, 0.8% with couples, 0.7% with families, 0.3% with groups, and 0.3% with organizations (Ionita & Fitzpatrick, 2014). However, surveys that allowed for a selection of more than one primary age population reported a large majority of practitioners provide services to young adult and adult populations, but more than half also provide services to adolescents and older adults (Hunsley et al., 2013). Most psychologists reported providing services for mood and anxiety disorders, as well as intrapersonal issues, interpersonal issues, and adjustment to life stressors. Approximately half of respondents also reported providing services for sexual abuse and trauma, personality disorders, general childhood problems, learning problems, and managing issues related to health, injury, and illness (Hunsley et al., 2013). Overall, CBT in Canada has been adopted as a primary therapeutic orientation in clinical practice across a wide range of ages, psychological disorders, and psychological symptoms related to physical health disorders.

## CBT Adaptations in Canada

Given Canada's ethnically and culturally diverse population, recent efforts have been made to adapt CBT to meet the needs of different cultural groups. This work has taken into account the additional challenges new Canadians face when they try to access psychological services. The Centre for Addiction and Mental Health (CAMH) on Toronto, Ontario has developed manuals and a DVD to help health professionals identify best practices in culturally adapted CBT for new Canadians' needs. The manuals were based on detailed literature reviews, focus groups with individuals in the cultural communities living in the Greater Toronto Area, and interviews with mental health workers who provide services to specific populations. Specific manuals have been created for *Cognitive-Behavioral Therapy for People of Latin American Origin* (Centre for Addiction and Mental Health, 2011a), *Cognitive-Behavioral Therapy for English-Speaking People of Caribbean Origin* (Centre for Addiction and Mental Health, 2011b), and *Cognitive-Behavioral Therapy for French-and/or Creole-Speaking People of Caribbean Origin* (Centre for Addiction and Mental Health, 2011c). Further, they have published *A Cultural Adaptation Model for the Preparation of a Culturally Adapted Cognitive-Behavioral Therapy Manual for Francophone African Population*, and a training DVD *Exploring a Service Model for Canadians of African Descent*. These materials provide information for professionals regarding general background information regarding the population in Canada, proactive outreach strategies, and recommendations for cultural modifications to interventions and tools in CBT. Moreover, the manuals outline how to deliver CBT that incorporates cultural values and aligns more consistently with the context of these populations who live within Canada.

Another recent adaptation of CBT within Canada, although not an inherently Canadian-specific adaptation, is the attempt to digitize treatment. Due to the increased use of smartphones, tablets, and general internet use, psychology in Canada has begun to include electronic and online means to administer psychological services. Access to psychological services remains a silent crisis in Canada (Mental Health Commission of Canada, 2012) and computerized or Internet-based cognitive behavioral therapy, in both therapist assisted or self-guided formats, is viewed as a promising approach to improve access to care (Andersson, 2010; Hadjistavropoulos et al., 2014). Online CBT programs are widely diverse in their content, number and length of sessions, mode of delivery (in-clinic, computer, internet, smartphone app), use of digital media (text, videos, sounds), and level of interaction with a therapist (Lawlor-Savage & Prentice, 2014). However, digital and online CBT programs can be adapted and individualized for specific disorders or symptom presentations (Gratzer & Khalid-Khan 2016; Hadjistavropoulos et al., 2016). Moreover, digital methods to implement CBT have proven to be an efficacious intervention modality (Andersson et al., 2013; Andrews et al., 2010), and in some modalities, with results that are comparable to face-to-face (Cuijpers et al., 2010). Although online modalities of CBT are not widely accessible within the Canadian healthcare system, recent efforts have been made to better understand

how to increase successful implementation within the healthcare setting (Hadjistavropoulos et al., 2014, 2017).

CBT in Canada is generally administered in a manner that is consistent with traditional Beckian cognitive theory (1969) and traditional behavioral interventions. This said, following recent research and etiological models of mental disorders, a focus has begun to shift away from purely disorder-specific frameworks and towards transdiagnostic modalities (e.g., Beck & Haigh, 2014). Transdiagnostic treatments focus on common underlying cognitive and emotion regulation processes across different disorder and use generalized and flexible intervention strategies that can be adapted to a number of different clinical presentations (McEvoy et al., 2009; Norton & Paulas, 2016). As such, recent CBT adaptations and developments have emphasized underlying cognitive mechanisms and processes, rather than specific symptom presentation (Hayes & Hofmann, 2017). In general, such approaches apply similar underlying treatment principles across mental disorders, rather than implement a specific treatment for each disorder (Barlow et al., 2004, 2011). Research suggests that diagnostic-specific and transdiagnostic treatments have comparable efficacy (Barlow et al., 2017).

## Research on CBT in Canada

Canada has contributed a wealth of information concerning the cognitive model, as well as treatment outcome literature for CBT across numerous diagnostic disorders and presentations. Given the constraints of this chapter, the following section provides a brief overview of selected areas of the Canadian contribution to research in the area of CBT.

As one example of research, Canadians have examined aspects of cognitive processes and the cognitive model in relation to a number of anxiety disorders (e.g., Dugas et al., 2007; MacDonald et al., 2013; Mellings & Alden, 2000). Research on major depressive disorder (MDD) in Canada has involved the study of cognitive errors, coping, interpersonal functioning as well as the study of cognitive vulnerability within numerous factors such as negative life events information processing biases to help ascertain the role they may play in depression onset and maintenance (Blake et al., 2016a, 2016b; D'Iuso et al., n.d., 2018; Dozois & Dobson, 2001; Drapeau et al., 2017; Mackrell et al., 2013; McDermott & Dozois, 2015; Sears et al., 2011; Thompson et al., in press, 2018). Further, research on cognition and cognitive models of psychopathology can be observed in a host of other conditions, including bulimia nervosa (Schnitzler et al., 2012), insomnia (Carney et al., 2010), or borderline personality disorder (Keller et al., in press). Other areas of research include process and outcome research in CBT (Antunes-Alves et al., n.d.; Drapeau, 2014).

Several Canadian researchers have focused their efforts on the efficacy of CBT. In the area of generalized anxiety disorder (GAD), CBT that targets intolerance of uncertainty (Dugas et al., 2003; Ladouceur et al., 2000; Torbit & Laposa, 2016),

ways to decrease resistance and various mediators to outcomes in GAD (Hara et al., 2018; Aviram et al., 2016), the relative efficacy of CBT for GAD in comparison to other psychotherapies (Dugas et al., 2009, 2010), the efficacy or mediation processes of the addition of therapy components such as motivational interviewing, to CBT for GAD (Constantino et al., 2017; Westra et al., 2009, 2016), have been studied. Similar patterns of research have been published for social anxiety disorder (SAD) and panic disorder. Some recent examples include severity and symptom outcomes following CBT interventions (Ashbaugh et al., 2007; Koerner et al., 2013; Nowakowski et al., 2016), predictors of improved CBT outcomes (Moscovitch et al., 2012), and the relative efficacy of CBT in comparison to other psychotherapies (Kocovski et al., 2013). Various contributions to CBT research for depression include: measures of change in cognitive factors and coping strategies in response to CBT (Drapeau et al., 2017; Quilty et al., 2014), predictors of improved CBT outcomes (Konarski et al., 2009), outcome of telephone-administered CBT (Lam et al., 2011), and adaptations of CBT to incorporate factors that contribute to the maintenance of depression, such as interpersonal vulnerabilities (Dobson et al., 2014).

Canadian research has also concentrated on CBT for the use of psychosis with a focus on topics such as CBT as an intervention for high risk, early, and prodromal psychosis (Addington et al., 2011; Burns et al., 2014; Lecomte et al., 2008, 2012) and CBT for Schizophrenia (Lecomte et al., 2008). Some examples of research contributions with bulimia nervosa include ways to improve CBT outcomes by facilitating rapid behavior change during initial weeks of treatment (MacDonald et al., 2017) and effectiveness of unguided CBT self-help (Carter et al., 2003). Trauma-focused CBT (TF-CBT) research in Canada has included outcome studies in children (Thornback & Muller, 2015) and effectiveness studies of TF-CBT in community settings (Konanur et al., 2015). A number of studies have examined the effects of comorbidities on CBT outcomes for various psychiatric populations (Asmundson, 2014; Cousineau et al., 2016; Fracalanza et al., 2014; Gros et al., 2011; LeMoult et al., 2014).

Canadian CBT research pertaining to health psychology topics has increased in recent years. Researchers have examined CBT for insomnia (CBTi), including psychological outcomes and efficacy compared to, and in addition to, psychopharmacology (Morin et al., 2009, 2016), mediators and mechanisms of action (Schwartz & Carney, 2012), and outcomes and effectiveness for individual, group, and telephone modalities (Bastien et al., 2004; Théberge-Lapointe et al., 2015). CBTi was also examined as a treatment for individuals who suffered from insomnia secondary to cancer (Garland et al., 2015; Quesnel et al., 2003). Research has also examined CBT in bariatric surgery patients, in order to address psychosocial factors and improve postsurgical outcomes and weight gain (Beaulac & Sandre, 2015), and to assess the feasibility and efficacy of CBT delivered via online or telephone to decrease practical barriers for psychosocial intervention (Cassin et al., 2016; Sockalingam et al., 2017; Zhang et al., 2015). CBT has also recently been researched as an intervention to reduce risk behaviors and increase prevention for human

immunodeficiency virus (HIV) infection in gay and bisexual men (Hart & O'cleirigh, 2014; Smith et al., 2016).

There are also cross-cultural studies that include the use of CBT within different Canadian populations. Specifically, researchers have written about practical and ideological factors that should be considered when administering CBT to Islamic populations (Beshai et al., 2013), an evaluation of factors-related cognitive behavioral theory in an Arab population (Beshai et al., 2012) and comparison of cognitive vulnerability models in Canadian and mainland Chinese adolescents (Auerbach et al., 2010).

A broad area of interest in the professional community is how to increase access to CBT services. As described earlier, online service delivery, such as Internet-delivered cognitive behavioral therapy (iCBT), has been a major area of interest in Canadian research and practice. Canadian researchers have examined the efficacy of iCBT, its practicality, and facilitators and barriers to implement iCBT in the community (Gratzer & Khalid-Khan, 2016; Hadjistavropoulos et al., 2014, 2016, 2017; Edmonds et al., 2018). Telecommunication methods of CBT have been explored as a way to decrease practical barriers and improve access to care (Cassin et al., 2016; Bastien et al., 2004; Lam et al., 2011; Sockalingam et al., 2017).

## CBT with Special Populations in Canada

Canada's population is diverse, as 4.9% of its total population comprised of First Nation, Metis, and Inuit peoples (Statistics Canada, 2016a), and 21.9% of the Canadian population being foreign born (Statistics Canada, 2016a). The remainder of the population, while born in Canada, can trace its roots back to another country(ies), as Canada is largely a land of immigrants. Given the diversity in language, religion, ethnicity, culture, and socio-economic status of Canadians clinicians need to approach their work with a high degree of cultural awareness. Culturally competency can be defined as having a sense of cultural awareness, knowledge, and skills (Sue et al., 2009). Specifically, the culturally competent clinician has knowledge pertaining to the clients cultural and worldview, the ability to intervene in a manner that is culturally sensitive and is sensitive to their own personal values and how these may influence perceptions of the client, their problems, and the therapeutic relationship (Sue et al., 2009).

Research generally confirms that culturally adapted forms of CBT are more effective than non-adapted CBT and that adaptation CBT resulted in positive outcomes (Kohn et al., 2002; Miranda et al., 2003; Rosello & Bernal, 1999). Language adaptations, the availability of materials in the first language, the use of bilingual clinicians, training clinicians in culturally sensitive interpersonal communication styles, and the inclusion of culturally specific content all contribute to better treatment outcomes and lower drop-out rates (Kohn et al., 2002; Miranda et al., 2003). Although culturally adapted CBT manuals for specific populations have started to be developed for Canadian specific populations (see above), more widely

distributed and inclusive manuals still need to be produced to adequately match Canada's diverse population. Canadian health care professionals should consider approaching therapy and CBT in a culturally competent manner in order to facilitate better access to treatment and improved treatment outcomes for those of different culture, language, and socio-economic status.

## Conclusions

Canada is a multicultural country with a history founded in diversity. The political structure of the country allows for differences in the provincial regulation standards and implementation of psychotherapy services. These differences were augmented by the delay in the creation of a national association that could coordinate, facilitate, and support continuity in regulatory practices across the country. Provinces and territories currently differ in their licensing regulations regarding the level of degree required, other licensing requirements, and title given. All provinces and territories except Québec follow the CPA's Code of Ethics to guide everyday practice, develop specific codes of conduct, and assist in adjudicating complaints against professionals. Québec-based psychologists adhere to their own code of ethics developed by their governing body, the OPQ. In general, the ethical codes across the country are relatively consistent in their tenets of Respect for the Dignity of Persons and Peoples, Responsible Caring, Integrity in Relationships, and Responsibility to Society. Although psychotherapy provision across the country promotes the use of evidence-based practice, there is little regulation in place to enforce this aspiration. Regarding CBT specifically, Canada has a number of training opportunities implemented within CPA accredited academic institution for doctoral studies and internships. There are also a number of private companies that offer CBT workshops and training seminars. However, there is no accredited CBT institution in Canada, so psychological professionals can only submit an application to the CACBT/ ACTCC to become certified as a therapist competent in delivering CBT.

CBT is used in a wide variety of clinical settings and populations. The majority of psychologists surveyed in Canada have reported the use of CBT as their primary treatment modality. The populations that these individuals work with range from traditional psychiatric populations (e.g., mood and anxiety disorders) to non-traditional mental health related concerns within physical health populations (e.g., sleep disorders and cancer). Canadian mental health initiatives have begun to examine and develop culturally adapted CBT interventions for specific populations within Canada, although these efforts are only just beginning. CBT practitioners need to make personal attempts to develop culturally competent services.

Canadians have been prolific in their contribution to research on CBT, and a wealth of Canadian literature exists for cognitive processes associated to psychopathology, as well as various treatment outcome studies, efficacy studies, moderator and mediator studies, and studies that examine CBT delivery modalities. Recent research has focused on implementing CBT in a way that reduces cost and barriers

to accessing care, while maximizing treatment access and outcome. Some research areas and community initiatives have involved the use of the Internet or telecommunication to deliver CBT. Although these initiatives appear promising, they are still not widely available to the population. Overall, professional psychology and mental health services in Canada is a growing need in the population. Twenty percent of Canadians experience mental health problems each year but an estimated 14% do not receive treatment (Mental Health Commission of Canada, 2012; Peachy et al., 2013). Future efforts within the profession involve exploring how to improve access to evidence-based psychological services.

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# Chapter 8
# Cognitive Behavioral Therapy in the Caribbean


**Guerda Nicolas, Monique McKenny, and Natacha Janac**

## Overview of the Caribbean Region

The word Caribbean evokes an array of images, most noticeably beautiful white sand beaches, lush landscapes, and diverse and vibrant cultures. Thus, it is no surprise that the region has been deemed as one of the top tourist destinations welcoming people from all over the world. However, there is much more to the region beyond its tourist attractions. Over the years, the word Caribbean has been described in varied ways, primarily geographically and politically. However, scholars have suggested that the region is best defined in four main ways: geographically, politically, economically, and linguistically (Amuleru-Marshall, 2013; Premdas, 1996). The Caribbean region was named by Christopher Columbus after the Caribs – an ethnic group that resided in the Lesser Antilles and part of South America during the conquest America by the Spaniards (Wilson, 1997). Geographically, the region is comprised mostly of a number of islands that surround the Caribbean Sea. On the northern side, the region is bordered by the Gulf of Mexico, Straits of Florida, and the Northern Atlantic Ocean. On the south side, the region consists of the coastline of South America.

Politically, the region is defined by two main economic groups, the Caribbean Community and Common Market (CARICOM), and the Association of Caribbean States (ACS). CARICOM, created in 1973 and comprised of 15 nations, which aims to promote economic integration and economic prosperities among its member nations. On the other hand, the ACS, created in 1994 consisting of 25 members, aims at developing better trading, tourism, and disaster responses among the

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different countries. Collectively, these two entities seek to enhance the economic vitality of the countries in the region.

It is estimated that there are over 700 islands comprising the Caribbean, highlighting the different cultural and linguistic groups existing in the region. Linguistically, the Caribbean region is comprised of a mosaic of languages linked to the different countries' colonized pasts. The languages spoken in the different nations of the Caribbean are reflective of the different ethnic groups that comprise the people of the region. Among the array of different ethnic cultures in the region commonly known groups include the Afro-Caribbean, European, Indo-Caribbean, Latino Hispanic (Spanish, Portuguese, Mestizo, Mulatto, Pardo, and Zambo), Chinese, Jewish, Arab, Amerindian, etc. (Hillman & D'agostino, 2009). Consequently, there is an array of languages spoken throughout the region and including but not limited to, Spanish, English, French, Dutch, Haitian Kreyol, French Creoles, English Creoles, Caribbean Hindustani, Papiamento, and many others (Engerman, 2000; Hillman & D'agostino, 2003; Palmie et al., 2011). Collectively, the different cultures and languages speak to the diversity of the region and must be a central component as we develop psychologies in the region.

Furthermore, the development of psychotherapies mandates an understanding of the social-political history of these Caribbean nations. Currently, the majority of Caribbean nations can either be described as independent or dependent. With the exception of Cuba, all of the Caribbean nations consist of two or more political parties, and their governing method can be traced back to their colonial roots. Haiti rewrote its rich social-political history when it became the first Black republic of the world and the first in the Western Hemisphere to abolish slavery by breaking free from France on January 1, 1804. Some other nations continue to be dependent territories of France, the Netherlands, the United States, and the United Kingdom. Table 8.1 provides a list of the independent countries while Table 8.2 highlights those who are dependent nations. Cuba has the largest population followed by the Dominican Republic and Haiti while the top three countries with the highest GDPs are Bahamas, Barbados, and Belize. Knowing such history and context are very important as we examine the type of psychotherapies that are most effective for the different cultural groups in the region given that sociopolitical factors play a large role in shaping the lives of the individuals in these countries, the trainings received by mental health professionals, and the licensure regulations.

## History of Psychotherapy in the Region

The history of independent and dependent countries highlighted in Tables 8.1 and 8.2 are reflective of the developmental history of psychotherapy in the region. While space does not afford a thorough overview of such history in this chapter, we invite the readers to look at the work of Hickling (2005) and Hickling and Gibson (2005) for a more thorough overview of the history of therapy in the region. In this section,

**Table 8.1** Chronological list for independence of Caribbean countries

| Country | Date of independence | Previous colony |
|---|---|---|
| Haiti | 01 January 1804 | France |
| Dominican Republic | 27 February 1844 | Haiti |
| Cuba | 20 May 1902 | Spain |
| Jamaica | 06 August 1962 | United Kingdom |
| Trinidad and Tobago | 31 August 1962 | United Kingdom |
| Guyana | 26 May 1966 | United Kingdom |
| Barbados | 30 November 1966 | United Kingdom |
| The Bahamas | 10 July 1973 | United Kingdom |
| Grenada | 07 February 1974 | United Kingdom |
| Grenada | 25 November 1975 | The Netherlands |
| Dominica | 03 November 1978 | United Kingdom |
| Saint Lucia | 22 February 1979 | United Kingdom |
| St. Vincent and the Grenadines | 27 October 1979 | United Kingdom |
| Belize | 21 September 1981 | United Kingdom |
| Antigua and Barbuda | 01 November 1981 | United Kingdom |
| St. Kitts and Nevis | 19 September 1983 | United Kingdom |

**Table 8.2** The breakdown for dependent Caribbean countries

| Dependent on France | Dependent on the Netherlands | Dependent on the United States | Dependent on the United Kingdom |
|---|---|---|---|
| Guadeloupe | Aruba | Puerto Rico | Anguilla |
| Martinique | Bonaire | United States Virgin Islands | Bermuda |
| Saint Barthelemy (St Bart's) | Curaçao | | British |
| Saint Martin | Saint Maarten | | Virgin Islands, |
| | Saba | | Cayman Islands |
| | Saint Eustatius | | Montserrat |
| | | | Turks & Caicos Islands. |

we provide a general overview of psychotherapy in the region and then provide some examples of specific countries as illustrations.

Overall, the history of psychotherapy in the region can be traced back to the 1850s with the rise of psychiatric institutions known as "madhouses" aimed at secluding mentally ill individuals form society (Hickling, 2005; Hickling & Gibson, 2005). Specifically, the introduction of the Mental Health Laws originally produced by the British colonial government and later revamped to the Mental Health Act first introduced in Trinidad and Tobago around 1975 sparked the development of mental health in the region (Hickling & Gibson, 2005). Through the recommendations by The Pan American Health Organization (PAHO) and the University of West Indies, the first psychiatric hospital units for inpatient and outpatients care was established at Jamaica University Hospital in 1965 (Hickling & Gibson, 2005). Thus, it can be

said that most mental health treatments programs in the region are imported from Western societies. Specifically, the theoretical models used, the treatment approaches, and measures used to assess effectiveness are often those developed and utilized outside of the region and imported to the various countries, particularly those who are English dominant.

Nevertheless, the development of mental health programs can be observed throughout the region. For example, in Jamaica, home of one of the largest psychological associations in the region, Jamaican Psychological Society (JamPsych), the development of psychology is widespread in public schools with individuals occupying positions such as guidance counselors, school counselors, and child development (Omuleru-Marshall, 2013). Additionally, practitioners are available in community mental health clinics, with a small subset developing an independent practice of their work (Maino, 2015). In Barbados, there is a high level of support for the field at the University of West Indies as well as an increasing demand for more trained mental health clinicians at the undergraduate level (Maynard, 2013a, b). While the number of programs is growing in the region, there are limited practicum and internship sites available for students (Maino, 2015).

In Trinidad, another English dominant country in the region, the use of varieties of therapeutic approaches, including cognitive behavioral, is practiced widely. For example, Hutchinson (2015) recently wrote a book chapter illustrating the use of rational emotive therapy working with a young woman presented with suicidal behavior relating to depressive and anxiety symptoms. Hutchinson concludes the chapter with an endorsement of the "use of rational emotive behavior therapy to overcome deep-seated beliefs about inadequacy and low self-worth that consequently impaired the client's interpersonal relationships and social skills" (Hutchinson, 2015, p. 149). In contrast to these English-dominant countries, Haiti, a French-speaking country in the region, has a relatively short history of the development of mental health in the country. In Haiti, the late 1980s mark the development of counseling practices, and the development of psychiatric hospitals was erected in the mid-1950s (Nicolas et al., 2012). Thus, while there is progress in the development of training programs in the Caribbean, more efforts are needed in developing graduate-level training as well as practicum and internship sites for these individuals.

The lack of advance graduate-level training in the Caribbean has led many professionals to obtain their advanced degrees outside of the region. For example, the University of the Virgin Islands is one of the few doctoral-level psychology training programs in the region. Such a practice may lead to an increase in brain drain of professionals from the region as well as returning professionals importing approaches and theories learned from outside of the region into their practices, underscoring the cultural validity challenges of these models in the region. Recently, there has been a call for a more indigenous approach in the development of the treatment curriculum as well as approaches used in the region to integrate the cultural and social-political realities of the people of such diverse nations. In a recent article by one of the pioneers in the field, Sutherland (2011) highlighted the various

limitations of Western psychology theory, research, and treatment approaches among English-speaking African descent people in the region. Specifically, she argues that:

> …in view of the adaptations that some people of African descent have made to slavery, colonialism, and more contemporary forms of cultural intrusions, it is argued that when necessary, notwithstanding Western psychology's limitations, Caribbean psychologists should reconstruct mainstream psychology to address the psychological needs of these Caribbean people…. (p. 1175)

She highlights the importance of moving beyond the commonly prescribed theories and interventions to an integration of an "African-centered and constructionist viewpoint" when working with individuals of African descent residing in the region.

In summary, it is clear that some progress have been made in the region to build a psychology platform predominantly in the English-speaking countries in the region. Nevertheless there is more to be done in ensuring advance-level training throughout the region, integration of culture and indigenous cultural elements in treatment, and building a research-based documenting what works and for whom.

## Current Regulations Regarding Psychotherapy Provision in the Region

The evolution of psychology within the region is a complex one as there are countries that have long-standing history of providing psychological care and while others are only now developing a system. As such the regulations of psychotherapy in the region varies from country to country. While some countries are regulated by a legislative arm of the county, others are regulated by the field of psychology itself. Further, differences are seen in terms of which branches of government regulate the practive of psychotherapy as some countries are regulated by the Minister of Health (i.e., Guyana & Cuba) while others are governed and regulated by the Minister of Education (i.e. Haiti). Understanding the different standards and regulations in the various countries and territories within the Caribbean is an important and necessary step in establishing a professional practice in any country in the region. For example, in Jamaica, the licensure of all practicing psychologists and counselors is granted and overseen by the Council of Professions Allied to Medicine (CPAM) (formerly called the Council of Professions Supplementary to Medicine) who also handle all matters related to ethical concerns and continuing education units. CPAM also oversees the mandates for nutritionists, dieticians, audiologists, medical technologists, chiropodists, and physiotherapists, to name a few. Recently, the integration of psychologists for consideration for licensure through CPAM was advocated for and won by the Jamaican Psychological Association. This advancement allows the president of the association to serve as one of the members of the legislative body for CPAM, further ensuring the inclusion of psychologists in developing professional standards and practice in health policy.

Lastly, after decades of advocacy work in 2016, that Virgin Islands Governor, Kenneth Mapp, signed the bill to create the first Board of Virgin Islands Licensed Counselors and Examiners. Prior to this bill, psychologists in the US territorial country could only obtain a business license to practice and treat mental health clients but not obtain a professional license to practice. Thus, while practioners were providing mental health services to clients, many did so without an official licensure nor any regulatory body overseeing their practice. Collectively, these examples illustrate the diversity that exists in the different countries within the region and must be considered as we develop more professional practices in the Caribbean. All of this is also directly linked to the type of mental health policy that exists in the various countries in the region. In a recent study on 16 English-speaking territories of the region, the WHO found that:

> Thirty-five percent of the countries (i.e., six) have a mental health policy, and in five of the six countries, the policy is less than five years old. For mental health plan, 35% of the countries and territories (i.e., six countries) have a plan, and five out of the six countries have produced it during the last five years. Only three countries (i.e., Jamaica, Suriname and Turks and Caicos) have both a policy and a plan. The other countries (i.e., Anguilla, Barbados, Belize, Montserrat, St Lucia and Trinidad and Tobago) either have a policy or a plan. (WHO, 2011)

It is clear that more consistency and uniformity are needed in addressing the regulations and professionalization of psychology and psychological practices in the region. Through the creation of the Caribbean Alliance of National Psychological Association (CANPA) in 2013, a new permanent committee, referred to as the "professional practice standards" was established to "explore harmonizing and catalyzing systems of legal regulation of psychology across the wider Caribbean region" (CANPA, 2013). This committee is chaired by the current president of the association and individuals representing the various countries in the region and will begin its work by focusing on the CARICOM countries given existent agreements regarding economic are already in place. The work of this committee will be significant and help serve as a stepping point from which consistent regulations and standards can be recreated, monitored, and revised.

## Professional and Cognitive Behavior Therapy Organizations

Under the umbrella of CANPA are numerous other professional organizations throughout the Caribbean region. Although not specific to CBT, professional organizations like the Puerto Rican Psychological Association, Association of Virgin Island Psychologists, Haitian Association of Psychologists, Cuban Society of Psychology, and the Jamaican Psychological Society facilitate a community that serves mental health practitioners, researchers, and consultants throughout the region. These organizations are predominantly comprised of pratitioners who embodied a number of different theoretical orientions and treatment modalities. Neverthless, it is important to highlight the longstanding history and significant

contributions that these organizations made in the development of psychology in the region. Each of these organizations and the numerous other psychological associations in the Caribbean are united in advancing the study and practice of psychology in the region while also distinct in addressing the unique needs of their country's population. This is achieved through the promotion of mental health awareness, the dissemination of psychology in the region, and the biennial meetings for their members. Biennal meetings are held at various locations throughout the region with prior hosting cities including Jamaica, Haiti, Suriname, and Bahamas. These conferences are attending by psychologists and health allied from our member's associations and other countries in the region, the US/Canada, Europe, and Africa. For example, the 2018 conference in Kingston consists of over 300 registrants comprising of over 25 different countries.

Along with CANPA and other professional organizations, the Caribbean Journal in Psychology also unites scholars in the region to serve as a forum for the dissemination of research relevant to Caribbean cultures. Similarly, the Latin American and Caribbean Health Sciences Literature Database was established in 1982 by the World Health Organization to encourage and compile literature related to health, including mental health, pertaining to Latin American and Caribbean populations across various academic journals.

Currently, there are no organizations based within the Caribbean solely focused on the region and cognitive behavioral therapy. While there are professional psychologists who study Caribbean populations within the Association of Cognitive and Behavioral Therapies, the growing use of cognitive behavioral therapy among Caribbean populations suggests that professional organizations specific to CBT and Caribbean clients in areas of research and practice are likely forthcoming.

## Training Opportunities in CBT in the Region

Given the lack of professional organizations focused on CBT in the Caribbean, training opportunities for this orientation are limited. There are a few CBT training opportunities through annual conferences hosted by countries psychological association and the biennial at the Caribbean Regional Conference of Psychology. Currently, there are six undergraduate programs in psychology, at least five postgraduate training programs in counseling psychology, and two postgraduate programs in clinical psychology. All of the programs are 2 years in duration and generally comprised of coursework, practicum placements, and a research project/thesis. As previously mentioned, independent practice is not currently licensed or legislated in any of the islands. A master's degree is usually sufficient to practice as a psychologist in the Caribbean, and there are no known psychotherapy training programs outside of academia (Moodley et al., 2013).

As CBT becomes more prevalent in the Caribbean, more training opportunities are gradually becoming available. This is illustrated in one particular emerging program, Caribbean Correctional Training hosted by The National LEAD (Leadership,

Esteem, Ability, & Discipline) Institute in the Bahamas (Lead Institute, 2018). The Caribbean Correctional Training program trains professionals to use CBT within the criminal justice system. Drawing on the tenets of CBT, the Caribbean Correctional Training is helping inmates in the Caribbean to make https://www.thenationalleadinstitute.org/connections between their feelings, thoughts, and actions in order to reduce criminal behaviors. Although there is an annual conference by the institute where this program is highlighted, there is no published research on the program and its effectiveness.

## CBT with Specific Clinical Populations in the Region

When researching the use of cognitive behavioral interventions with different populations, it is very important to distinguish existing literature focusing on treatments with Caribbean individuals living outside of the region from those on people living in the region (Rathod et al., 2010). Specifically, for Caribbean people, there is a significant difference between those residing in the region and those outside of the region who may have a history of assimilation and acculturation. The experience of immigration and later acculturation can influence the effectiveness of treatment. In addition, looking at the existing literature, it is unclear if the treatments implemented were culturally validated for use with the population. Thus, a more robust understanding of both the etiology of mental illness and the specific treatments that are culturally appropriate for such ailments are needed for the region. While limited in scope, below is a summary of some of the published articles on the use of CBT among clinical populations living in the region.

The existing published literature on the use of CBT in the Caribbean have centered on anger management among prison offenders (Hutchinson et al., 2017) and depression among Puerto Ricans (Bernal et al., 2009). For example, currently in Trinidad, family therapy and cognitive behavior therapy are becoming two of the most frequently used forms of treatments being implemented by clinicians of various clinical training background for a variety of clinical issues. In a recent study using a controlled clinical trial study with 85 offenders in prison in Trinidad, Hutchinson and colleagues tested out a 12-week anger management program at two time intervals. Although there is no evidence that the intervention used was culturally validated, they found that the CBT anger intervention program yielded an increase in coping skills for the intervention group and such increase was maintained at 4 months of follow-up. Similar results are observed with other clinical populations in Trinidad.

As mentioned earlier, in their book, *International Counseling: Case Studies Handbook*, Hutchinson et al. (2015) presented the case of Oliva to illustrate the effectiveness of rational emotive behavior therapy to treat depression and suicidal symptoms of the client through improving the client's self-worth her interpersonal relationships and social skills.

The largest body of research focusing on the use of CBT in the Caribbean centers on the cultural adaptation process and treatment effectiveness trials among Puerto Ricans youths and adults living in Puerto (Rosselló et al., 2012). Studies after studies focusing on the use of culturally adapted CBT among depressed (Parra-Cardona et al., 2017) Puerto Ricans consistently demonstrated the effectiveness of the treatment in treating depression symptoms, a gain that is maintained several months posttreatment.

## Adaptation of CBT in the Region

The universality of CBT across different cultural groups have been the subject of much debate over the past two decades (Cameron & Telfer, 2004). The conclusion of such debates is that while CBT is effective, culturally adapting it for different cultural groups leads to more effectiveness and more sustainable changes over time (Parra-Cardona et al., 2017). At this point, it can be concluded that while the adaptation of the use of CBT for various clinical populations in the Caribbean has been successful for some populations, namely, Puerto Ricans, it has been questionable for others. The large body of research on the cultural adaptation of CBT comes out of Puerto Rico by Guillermo Bernal and his colleagues (Rosselló et al., 2012). Irrespective of the age of the population and type of clinical issues, Bernal and colleagues have consistently demonstrated that when culturally adapted, CBT can be efficacious for Puerto Ricans living in the country. Through their intervention work, Bernal and colleagues put forth a model, the ecological validity model, aimed at equipping researchers and clinicians with the tools to effectively culturally adapt treatments for use with different ethnic groups. Specifically, the model consists of eight dimensions (language, persons, metaphors, content, concepts, goals, methods, and context) that professionals can use to develop or adapt culturally sensitive treatments for specific ethnic minority groups. While the use of this model has been limited to developing treatments for Puerto Ricans and Haitians (Nicolas et al., 2009), it is a promising model that can be explored for the adaptation of treatment for different cultural groups.

It is important to note that while the adaptation of treatments such as CBT has been normed over the past couple of decades, currently there is an ongoing discussion among colleagues in the Caribbean of the utility of such a process. Specifically, clinicians and researchers questioned the validity of culturally adapting treatments as opposed to the indigenous treatments created intentionally from development to address the unique cultural, historical, and linguistic needs of the region. At each meeting of the Caribbean Regional Conference of Psychology (CRCP), a preconference workshop has been offered on the development of culturally informed treatments in the region. This workshop is usually followed by plenary speakers presenting on such a topic as well. Inevitably, the conversation often ends with participants questioning the process of cultural adaptation and calling for more treatment development that integrates cultural healing practices of the diverse population in the region.

## Research on CBT and Caribbean Populations

Illuminating the need for adaptation, there are high dropout rates for Caribbeans in CBT interventions and research generally (Rathod et al., 2005). Much of the existing literature on cognitive behavioral therapy among Caribbean populations focuses on Caribbean individuals who have immigrated from their home country. Scholars have examined the ways that CBT and mental health services generally can be adapted for Caribbean American youth (Schwartz, 2009) and adults (Waldron, 2003), British Caribbean populations (Edge, 2013), as well as Caribbean Canadian persons (Chaze et al., 2015). Particularly, the Center for Mental Health and Citizenship and Immigration Canada National Offices, developed and distributed a manual to "enhance the effectiveness" of CBT for English-speaking Caribbean people living in Canada (McKenzie et al., 2011). This illuminates the recognized need in research and policy to address the unique immigration experience of this population and develop careful adaptation in order to make CBT relevant to the life experiences of Caribbean immigrants. Among these is (Bernal et al., 1995) emphasis on acculturation in the ecological validity framework, considering the unique life experiences of Caribbean individuals who move from their home country and are later immersed in a new society and culture.

Nevertheless, some of researches conducted with Caribbean individuals focused on CBT centered on severe psychotic disorders including, schizophrenia (Rathod et al., 2010), psychosis (Rathod et al., 2011), and anger management (Hutchinson et al., 2017; Thomas, 2017). Collectively these studies point to the likelihood of researchers and clinicians to mistake cultural practices and differences for psychotic presentations, especially when Western ideals are considered the reference group (Stewart, 2001). Furthermore, ethnically diverse clients are often perceived as much angrier and aggressive than their White European counterparts. With this bias, ethnic minority patients, including Caribbean clients, are more likely to be treated with psychopharmacology instead of psychotherapy treatments like CBT (Willie, 2016). Strength-based literature centered on CBT and Caribbean populations often incorporates spirituality within CBT-based interventions. Scholars have suggested that spirituality is an important strength of Caribbean individuals, families, and communities by contributing to a sense of resilience following negative experiences (Koffman et al., 2008; Nicolas et al., 2014; Taylor & Chatters, 2010). One example of this is illustrated by the work of Wang and colleagues (2016) who found that Haitian youth who had experienced the trauma of restavek (a child sent by his or her parents to work as a domestic servant for a host family due to economic hardship; Kennedy, 2014) and completed 12 sessions of a culturally adapted, spiritually oriented CBT trauma-informed intervention, showed lower PTSD symptoms.

Furthermore, while scholars have begun to explore the role of CBT in research pertaining to the Caribbean, the small amount of empirical research suggests a continued need for more literature to expand the narrative and use of cognitive behavioral therapy in the Caribbean.

## CBT with Special Populations in the Caribbean

The Caribbean culture is deeply rooted in spiritual dimensions, a commonly held perception that mental health problems are caused by spells, curses, spirits, and demons and that mental health issues represent a punishment for wrongful deeds (Laguerre, 1987; Nicolas et al., 2006; Waldron, 2003). At the same time, healing in the Caribbean context may take place within Christian-based religions in the form of faith healing (Moodley et al., 2013), suggesting that people in the region will seek assistance from a variety of different groups of people, beyond a mental health professional. Nevertheless, short-term, evidenced-based, goal-directed psychological therapy like CBT shows promise for the Caribbean culture given financial and other considerations (Moodley et al., 2013). Research by Lefley and Bestman (1977) identified a number of indicators in their work on the types of psychotherapy relevant to the need of Caribbean clients. Lefley and Bestman recommended that effective psychotherapy with the Caribbean population must be problem-oriented and focused on attainable goals. They suggest that therapists should position themselves as the authority figures and adopt a more direct stance to fit client's expectations of being counseled and given advice short term. Although CBT is being utilized more in the Caribbean, it is paramount to understand the effects of factors such as poverty in the help-seeking behaviors of people in the region (Moodley et al., 2013).

## Conclusions and Recommendations

This chapter provided a synopsis of the implementation of CBT treatment in the region. Specifically, the chapter provides a contextual framework of the landscape of the region as understanding such sociopolitical history of the various countries comprising the region is critical in deciding the use of specific interventions for individuals. Moreover, the diversity of culture, languages, and independence/dependencies of the various countries must be an integral part of treatment development in the region. While the use of CBT has been limited to few countries within the region, the adaptation of the treatment for issues such as anger, depression, and anxiety appears to be promising and warrants further investigations. Given the diversity of the region, we caution researchers on the universal use of the theory and treatment without following the appropriate process for cultural adaptation of the treatments for use in the region. Bernal and colleagues' ecological validity model can serve as a wonderful framework from which to begin such work. Doing so will enable us to heed the word of Rich (2001):

> When those who have the power to name and to socially construct reality choose not to see you or hear you, whether you are dark-skinned, old, disabled, female, or speak with a different accent or dialect than theirs, when someone with the authority of a teacher, say describes the world and you are not in it, there is a moment of psychic disequilibrium, as if you looked into a mirror and saw nothing.

Given the importance of providing culturally relevant evidence-based treatments, a rigorous process of validating the use of CBT in the region is necessary. However, prior to doing so a widespread epidemiological study is necessary to understand the specific mental health problems that are more frequent in the region. Such information will enable researchers and clinicians in the region to target specific interventions for specific disorders and develop a process for culturally adapted these interventions for different cultural groups in the regions. Given the widespread use and demonstrated effectiveness of CBT, this is a wonderful foundation for the type of work that we can embark on throughout the region.

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# Chapter 9
# Cognitive Behavioral Therapy in Mainland China


**Jianping Wang, Yirui Wang, Kehan Shen, and Wanjun Li**

## Country Overview

As one of the oldest countries in the world, China has gone through many dynasties in history. Its monarchy came to an end in the early twentieth century. The People's Republic of China was founded in 1949 and adopts a socialist system. China has a land size of 9.6 million square kilometers, and Beijing is its capital city. China has the world's largest population (over 1.4 billion). There are 56 ethnic groups, of which more than 90% are from the Han nationality. The Chinese culture originated from the Yellow River and the Yangtze River basins. China's culture and history have been profoundly influenced by Confucianism. Many religions co-exist in this country such as Buddhism, Taoism, Islam, Catholicism, and Christianity. Since the Open Door Policy in 1987, China's economy has been rapidly developing. It is one of the fastest growing economies in the world, and its economic aggregate is second only to the United States. China is one of the permanent members of the United Nations Security Council and acts as an important member in many international organizations (Wikipedia, 2018).

Although the earliest accounts of psychological disorders and treatments can be traced back to 2000 years ago, China's modern mental health industry did not arise

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until the 1980s (Qian, 2006 ). Despite its rapid growth, there is a large gap in providing high-quality mental health services that meet the public's needs. While the one-month prevalence of any mental disorder in China was 17.5%, only 4.9% patients have received professional help. This may be due to a number of reasons such as lack of mental health professional services, little community-based services, absence of knowledge, and negative attitude toward mental health issues (Phillips et al., 2009). According to Chen et al. (2016), there are currently less than 5000 people who hold the psychotherapist title, and the number of psychotherapists who are actively doing therapy is even smaller. This is apparently far from meeting the mental health needs of the over 1.4 billion population.

## History of Psychotherapy in Mainland China

China's first records of psychotherapy can be traced to Traditional Chinese Medicine. As early as the third century, the Yellow Emperor's Classic on Medicine has included descriptions of psychological issues and treatment suggestions. For example, it was believed that chronic intense Qingzhi (a similar concept to emotion) was the reason that caused Kuang (a similar concept to mania). In the eleventh century, a physician called Zihe Zhang wrote about many interesting mental health cases in his book titled *Ru Men Qin Shi*. For example, he treated a woman who was extremely fearful of loud noises using a method similar to systematic desensitization (Qian, 2006).

Nevertheless, China's modern psychotherapies originated in the West. Freud's works were translated and introduced to the readers in the beginning of the twentieth century. Soon after, behavioral theories and interventions made their way to China. In 1921, the Chinese Psychological Society – the first professional organization – was founded and made its mark in the development and promotion of psychological science. Meanwhile, a few pioneers began to practice psychotherapy. Zan Ding was recognized as the first clinical psychologist in China and opened the first psychology clinic in the 1930s (Guo, 2015). Unfortunately, all psychology practices and research came to a halt during World War II.

After the founding of the People's Republic of China in 1949, psychology was revived. Due to the strong influence of the Soviet Union at the time, the Pavlovian theories became particularly popular in the treatment of mental health illnesses. This trend continued till 1966 when the Cultural Revolution raised its curtains. Thereafter, psychology was deemed "pseudo-science" and all psychology practices were banned. A lot of psychology literature, research data, and equipments were lost or destroyed. Psychology and its practices suffered a serious setback (Guo, 2015).

Psychology re-emerged after China's Open Door Policy in 1978 (Guo, 2015). The founding of the China Association for Mental Health in 1985 and its Psychotherapy and Counseling Sub-committee in 1991 was a milestone in China's psychotherapy and counseling history (Guo, 2015). Following that, various academic and professional organizations were formed. Two academic journals – Chinese Mental Health Journal and Chinese Journal of Clinical Psychology – began

to circulate in 1987 and 1993, respectively. Moreover, the number of conferences and professional training opportunities for psychotherapists and counselors increased substantially (Guo, 2015).

At that time, psychotherapies as well as counseling services were predominately provided in medical settings by psychiatrists who were interested in "talk therapy." It was rare to see those with psychology/counseling backgrounds delivering therapy or counseling (Jiang, 2012). Instead, counselors with psychology/counseling backgrounds found their role in higher education. The first university counseling center in China's history opened in 1985 in the city of Wuhan (Jiang, 2012). As far as we are aware, until around 2010 hospitals and universities were almost the only places where people could access psychotherapies and counseling services mainly due to a lack of qualified counselors and psychotherapists.

The shortage of well-trained providers has consistently been a barrier in the growth of psychotherapy and counseling in China. Dr. Magarete Haas-Wiesegart and Dr. Wenpeng Wan co-developed the German-Chinese Therapist Continuous Training Program in 1996 (Jiang, 2012). This program did not just bring psychotherapy to China but had a historic and long-lasting value as it has trained a number of capable students who are now leading professionals in this field.

China's psychotherapy and counseling industry really began to grow in the twenty-first century when the government became actively involved in the promotion of counseling through the implementation of a series of policies and laws. For example, since 1987 hospitals with a rating of 3A[1] were required to provide counseling services. In our experience, university counseling centers also began to emerge in the late 1980s. Presently, all Chinese universities provide free counseling services to students. In recent years, middle and high schools were also recommended to provide free guidance counseling to students. Between 2001 and 2017 people had the option to take a national counseling examination and gain counseling certificates. Keep in mind that the certificates were not compulsory requirements to begin counseling practice. Moreover, the certification system was cancelled in 2017 with no replacement. Putting aside the inconsistent quality of the services provided by hospitals and university counseling centers and the issues in the accreditation, these policies directly increased public awareness and facilitated the growth of the industry.

Moreover, although it was an unfortunate tragedy, the Sichuan Wenchuan Earthquake in 2008 acted as a catalyst in the process of mental health promotion. It drew people's attention to psychological health and aroused discussions on the media about topics such as trauma, grief and loss, and depression. Volunteers from all over the country with or without previous mental health training made efforts to provide counseling or simply support to those affected by the earthquake. These discussions and efforts contributed to the public education on mental health–related topics and de-stigmatization of counseling and mental health illnesses.

[1] The Chinese health care system classifies hospitals based on a number of medical and research criteria. Hospitals with a rating of 3A are top ranking hospitals, followed by those with 3B, 2A, and 2B ratings.

## Current Regulations Regarding Psychotherapy Provision

The current and first mental health law to regulate the field of psychotherapy and counseling in China came into effect in 2013 – *The Mental Health Law of People's Republic of China 2013*. Its main goal was to protect mental health patients' rights especially those with "severe psychiatric disorders" in psychiatric/medical settings. It has some items relevant to psychotherapy and counseling.

While the intentions of the Law were good, its clauses are vague and difficult to execute (Liu et al., 2013b; Yang, 2013). For example, the Law explicitly separates psychotherapy from counseling, and psychotherapists from counselors. It dictates that counselors can only provide counseling (but not psychotherapy) services to the public and that psychotherapies must be provided by hospital staff at hospitals. However, by its own explanations, the only meaningful differentiation between psychotherapy and counseling is practicing venues; that is, psychotherapies can only be delivered at hospitals, while counseling is conducted outside of hospitals. There is no real difference between counselors and psychotherapists in terms of their levels of competencies or the services they provide.

It is important for a reader to bear in mind that based on this Law, the word "psychotherapist" is an exclusive title for hospital staff members who have passed hospital internal counseling examinations. Community-based providers are called "counselors" and are not permitted to use the title "psychotherapists." An interesting fact is that when a psychotherapist leaves his/her hospital employment, the government will not revoke the title. Yet, s/he is prohibited from delivering psychotherapy outside of the hospital. If this person intends to continue their practice in the community, their legal status will change from a psychotherapist to a counselor and is therefore only permitted to provide counseling but not psychotherapy services; however, the actual services they provide may be practically the same as before. Moreover, the counseling certification system was officially canceled in 2017 with no replacement, meaning that there is currently no system in place to accredit or define counselors.

According to the Law, while psychotherapists and counselors should have the ability to conduct psychological assessments and be familiar with diagnostic criteria, only psychiatrists have the capacity and authority to diagnose psychiatric and psychological disorders. The Law indicates that a psychiatrist should see a patient, conduct an assessment, and make a diagnosis if warranted. Then, the psychiatrist will determine whether the patient will benefit from psychotherapy or counseling and make a recommendation as such. However, as far as we are aware, most clients would prefer to see a counselor rather than a psychiatrist due to severe stigmatization of mental health illnesses in the Chinese culture. This means that clients who come to see counselors typically have not gone through a formal assessment or diagnostic procedure as suggested by the Law. Therefore, it is up to individual counselors to determine whether a psychiatrist needs to be involved for psychiatric evaluation or medication management. Meanwhile, there have been occasions where counselors see patients with diagnosed clinical disorders under the pretense of

counseling, while the patient should be seeing a psychotherapist at the hospital per the Law. Furthermore, one should note that there is no government agency monitoring the execution of these legal requirements.

Another important fact is that the clinical and counseling psychologies as professions are not officially recognized by the governing authorities in China. Given the very small number of psychotherapists in relation to the size of the country, people have to rely on counselors for psychological services (Chen et al., 2016). It is our observation that clients tend to seek counseling for sub-clinical and everyday issues given the present regulatory, professional, and cultural environments.

In the regulation of the field of psychotherapy and counseling, the Chinese government has played a role in setting national counseling exams and issuing counseling certificates. However, it has never undertaken responsibilities such as monitoring quality of practice, setting ethical and professional standards, dealing with client complaints, and sanctioning misconducts. Professional associations such as Chinese Psychological Society Clinical Psychology Registration Committee (CPSCPRC) have stepped up to provide ethical and practical guidelines (Chinese Psychological Society, 2007a), though their guidelines have no legal binding power. The reality is that Chinese counselors are not required to be members of any professional associations and there are no government agencies monitoring their practices, meaning that unethical behaviors and misconducts may receive no consequences. This regulatory vacuum has led to an unmonitored market and has negatively affected the public's confidence in the profession (Liu, 2008; Zhu, 2017).

It is generally agreed that the Law is too vague and confusing, and is thus difficult to enforce in practice (Liu et al., 2013b; Yang, 2013). Given these issues and the strong psychiatric/medical focus of the Law, scholars and legal professionals have been working on developing legislation specific to counseling and psychological treatments. Unfortunately, though a proposal has been made to policymakers, it may take years until a new law is passed. In other words, there are currently no clear or executable legal guidelines on the provision of psychotherapy and counseling, and there is no prediction as to when the situation may change. This leaves the field of psychotherapy and counseling in chaos and is detrimental to the development of metal health profession in China (Liu et al., 2013b).

Despite the lack of clarity in law, counseling has become the largest industry within China's mental health division and continues to grow rapidly. This process was accelerated by the Counselor National Occupational Standards (CNOS) launched by The Ministry of Human Resources and Social Security of the People's Republic of China (MOHRSS) in 2001 (Guo, 2015). The CNOS has made substantial contribution to the promotion of counseling and the de-stigmatization of mental health problems. According to the CNOS (2001), individuals who passed written and oral examinations would receive counseling certificates. However, it did not require any prior counseling/psychology background or training. Anecdotal evidence suggested that people with no prior counseling/psychology training typically took several weeks to a couple of months to pass the exams while maintaining a full-time job. More than 900,000 people became certified counselors over a span of 16 years from 2001 to 2017. However, only 2–3% of the certified counselors were

actively practicing. Additionally, there have been questions and concerns about their competency levels (Chen et al., 2016). Another criticism is that the MOHRSS was only responsible for the examinations and certification and did not regulate counseling practices and counselors' continuing education, resulting in an unmonitored market where clients' rights are not adequately protected by the authorities. It appears that counselors do not receive external monitoring from a legal perspective. Negative reports on certified counselors' unethical (sometime illegal) conducts and poor competencies have weakened the public's confidence on the certification system. As a result, the MOHRSS counselor certification system was officially canceled in 2017 (Zhu, 2017). At present, the government is working on developing a more plausible and effective structure. However, no announcement has been made as to when the new certification system will be put in place. The lack of regulation has caused public confusion and allows unethical behavior unmonitored.

Along with the CNOS, China's National Health Commission launched a psychotherapist occupational title within the hospital system in 2002 (Guo, 2015). Hospital staff members only need to take a written exam to gain the psychotherapist title. There is no oral exam or practicum component for this title. Moreover, previous mental health–related experience or training is not a prerequisite, though many do come from psychiatric, nursing, and psychology training backgrounds. This means that the only hurdle between an absolute layperson and the psychotherapist title is a written exam. This has raised questions about the value of the title and competency levels of the psychotherapists (Zhu, 2017).

## Professional and Cognitive Behavioral Therapy Organizations

Given the lack of clear legislations and policies, psychological associations have provided some guidance in setting ethical and practical standards. For example, CPSCPRC is the most well recognized academic and professional organization in the field of psychotherapy and counseling in China. The CPSCPRC issued two important documents: 'Registration Criteria for Professional Organizations and Individual Practitioners in Clinical and Counseling Psychology' (Chinese Psychological Society, 2007b) and 'Code of Ethics for Counseling and Clinical Practice' (Chinese Psychological Society, 2007a) in 2007. It sets high ethical standards for its members and provides a clear accreditation structure to counselors and counseling facilities. In our view, its registration standards are relatively comparable to those of Western countries. Hence, its membership is held in high regard and is well recognized (Chen et al., 2016). However, only a total of approximately 1000 psychotherapists and counselors have obtained its membership from the year of 2007 to 2017. In this sense, it is fair to speculate that the CPSCPRC has made public limited given the size of the country.

Since 2008, four CBT organizations were founded to promote its research and application in various health sectors in China. These organizations include the CBT Committee of China Association for Mental Health, the CBT Group of Academic Committee of Clinical and Counseling Psychology of China Psychological Society, the CBT Work Group of Psychiatry Division of Chinese Medical Association, and the CBT Work Group of Chinese Psychiatrist Association. Their leadership consists of one head, three deputy heads, and one secretary. Although there are four organizations, there is a significant overlap in their core members. For example, the leaders for the first two CBT organizations are exactly the same. Three of the five leaders take the same roles in the third CBT organization. Except for the secretary, the third and four organizations have the same leaders.

The CBT Committee of China Association for Mental Health, founded in 2014, is known for its active promotion of CBT. It has organized many academic and professional events, e.g., hosting CBT conferences every second year, facilitating short- and long-term CBT trainings, providing counseling services to the public, and liaising with CBT organizations in Asia and globally. The CBT Work Group of Psychiatry Division of Chinese Medical Association and the CBT Work Group of Chinese Psychiatrist Association broadened CBT's influence to the medical system. They specifically focus on training psychiatrists to become CBT therapists and increasing the application of CBT in hospitals and psychiatric institutions.

Compared to mainland China, the training and practice of CBT appears to be relatively popular in Hong Kong. For example, the Institute of Cognitive Therapy headed by Fu Keung Wong, a Professor at the University of Hong Kong, has a strong community influence. The Institute provides a range of psychological services and training and supervision opportunities to the community. CBT in Taiwan, on the other hand, has a strong clinical focus and is mainly used for hospital inpatients. As far as the authors are aware, there is no CBT professional organization in Taiwan.

Though exact statistics cannot be found, readers can gain a rough sense of the popularity of cognitive therapy in mainland China, Hong Kong, and Taiwan. There are currently 935 certified cognitive therapists at the Academy of Cognitive Therapy (ACT) from the United States, among which three were from mainland China, 49 were from Hong Kong, and none was from Taiwan. In addition, Dr. Jianping Wang, the lead author of this chapter, is the only ACT certified fellow in mainland China. This data does not include practitioners with overseas training backgrounds who are currently practicing CBT in China, e.g., the second author of the paper.

Through joined efforts, China has shown a growing international impact in the CBT community. Dr. Ning Zhang, Leader of the four CBT professional organizations mentioned above and Vice-President of Nanjing Brain Hospital, was recently elected to be the President of the Asian Cognitive Behavioral Therapy Association at the 6th CBT Conference in February 2018.

## Training Opportunities in CBT

Compared to 10 years ago, there is a substantial growth in the training and education of CBT in China. However, the quantity and quality of CBT training opportunities are far from ideal. Most of the trainings are short-term courses for no more than three days. A few long-term CBT programs have been developed in the recent years, such as the Chinese-German CBT training program described earlier, the Chinese-American CBT Training, and Dr. Jianping Wang's CBT Continuous Training Program. These programs typically last for 2–3 years, including a total of approximately 20 days of face-to-face training sessions as well as group and individual supervisions. These programs have contributed to enhancing Chinese psychotherapists and counselors' familiarity with CBT, increasing public awareness, and breaking common misconceptions associated with CBT. One criticism is that the programs do not assess participants' knowledge and competency levels. Participants receive attendance certificates only, and there is no way to control the quality of attendees. However, given the low public awareness and interest in CBT, not setting graduation limits may be a necessary compromise at present.

Recently, a couple of universities have begun to offer CBT courses to psychology master-level students within their counseling and psychotherapy programs, such as Beijing University and Beijing Normal University. However, their placement and supervision resources are far from adequate. As far as the authors are aware, most of the university lecturers are researchers and cannot provide counseling/clinical guidance or supervision. For various reasons, recruiting external supervisors can be difficult for universities.

Generally speaking, CBT training resources in China are much more scarce compared to psychoanalysis and psychodynamics which are unquestionably the mainstream therapy approaches utilized in China. In our view, the shortage of CBT supervisors and trainers may be a bottleneck and has greatly limited the opportunity for CBT trainees' continuing education and professional skill development.

## CBT with Specific Clinical Populations

CBT's efficacy is generally recognized by China's mental health industry (Chen et al., 2010). Mental health illness prevention and treatment guidelines (e.g., anxiety, obsessive-compulsive disorder (OCD), eating disorders, sleeping disorders) published in China in recent years have listed CBT as the most recommended therapy approach (Liu et al., 2013a). However, there have been limited CBT applications for specific clinical disorders in China thus far (Sun & Zhang, 2018).

We have summarized the main findings of CBT's efficacy and effectiveness in treating specific clinical disorders in China. From a research perspective, it appears that more outcome studies are conducted with internalizing disorders, specifically

anxiety, than other clinical disorders in China. Huang, Li, and Huang (2013) in a meta-analytic review found that manualized CBT programs alone and CBT combined with medication showed comparable effects in treating OCD. Both CBT and the combined approach were significantly more effective than pharmacotherapy alone. Moreover, participants demonstrated better adherence in the CBT-only condition compared with the other treatment regimes. A brief CBT program for generalized anxiety disorder (GAD) showed comparable effects to those of a combined treatment regime and was significantly more effective than the control (Zhu et al., 2015). Additional research has demonstrated that CBT combined with medication was particularly effective in treating depressive and bipolar disorders and was advantageous in relapse prevention (Jiang et al., 2015). For patients suffering from panic disorder, adding a CBT component to the pharmacological treatment significantly increased adherence rates and reduced relapses of symptoms (Dang & Liu, 2002). CBT combined with medication produced quicker results than CBT alone in treating insomnia. Yet, there was no statistical difference in their long-term effects (Wu et al., 2002).

Research in treating adult attention deficit and hyperactivity disorder (ADHD) with CBT indicated that CBT was an effective psychotherapy approach for managing the core symptoms of ADHD as well as reducing comorbid depression and anxiety. Moreover, group CBT was found to produce better results than individual CBT (Wang & Cai, 2016). While schizophrenia is mainly treated with medication in China, CBT has demonstrated its efficacy in increasing patients' insight, improving quality of life, reducing residual symptoms, and dealing with caregiver stress (Ma et al., 2012, 2013).

Research on the application of CBT in children and adolescents in China is comparatively lacking. An important initiative involves the work of Jianping Wang and her team. They translated and localized an Australian group CBT program named "Cool Kids" that was designed to treat anxiety in adolescents. Research on its efficacy indicated that compared with the controls adolescents who received a 10-week CBT intervention showed significant reduction in anxiety symptoms (Yan et al., 2015).

As discussed above, we believe competent CBT practitioners are greatly lacking in China. In our experience, most counselors and psychotherapists who identify as CBT users do not have a solid understanding of CBT's theories and only have fragmented knowledge of certain CBT techniques. Most counselors and psychotherapists do not have the ability to assess clinical disorders or conduct a solid CBT-driven case conceptualization. They tend to freely combine techniques from various therapy approaches without the guidance of any theoretical framework. Given this, it appears that the number of counselors and psychotherapists who are truly able to follow a CBT treatment model in China is very small, much less tailoring CBT to meet the needs of specific clinical populations.

## Adaptation of CBT in China

In our experience, CBT is typically used in its original (Western) form with little localization. Although it is well recognized that cultural differences play an important role in the way we do counseling and therapy, CBT in China remains at its beginning stage and has not accumulated enough clinical experience and research evidence to support cultural adaptation. The lack of experienced Chinese CBT practitioners as pointed out earlier further hinders the adaptation process. Research generally supports the efficacy of CBT in treating a range of clinical disorders in the Chinese context (Ng & Wong, 2017). Thus, it is reasonable to hypothesize that CBT in its original form is overall well received in China. Nevertheless, we have not been able to find any literature discussing the adaptation of CBT in China except for the Chinese Taoist Cognitive Psychotherapy (CTCP).

The CTCP was created by two psychiatrists – Yalin Zhang and Deseng Yang – in 1998 based on rational-emotive therapy. It incorporates elements from Taoism and teaches clients a 32-character Taoist formula. According to Zhang et al. (2002), CTCP has shown positive effects in treating GAD. Unfortunately, CTCP has not made further progress and is rarely used in practice.

Given that research on cultural adaptations is scarce, we have summed up some of our personal experiences and observations. First, as the development of China's economy, Chinese people have enjoyed better living standards than before. They have become more attentive to their health care needs, although there is a much stronger emphasis on physical health than mental health. The overall level of China's mental health awareness and literacy is quite low. We find that therapy and counseling are often not seen as science or scientific. Most people consider psychological problems as ideological problems and therapy/counseling as ideological work or simply chatting. Oftentimes, Chinese people's expectations of therapy/counseling are quite extreme, for example, counseling equals chatting and therefore is utterly useless, and therapy/counseling should "fix" all the problems within a couple of sessions.

Second, though CBT was also reported to be one of the most frequently used therapy approaches in China (Liu et al., 2013a), our experience is that psychoanalytic and psychodynamic approaches are far more prevalent and popular than CBT. Since the end of the twentieth century we have seen psychoanalysts and psychodynamic therapists from overseas countries providing training programs at low costs and making themselves available for supervision and continuing education. They have trained many psychotherapists/counselors in China including a number of highly influential leaders in this field. To date, in the eyes of the public traditional psychoanalysis almost equates to counseling/therapy, in our experience. Moreover, though statistics cannot be found, our impression is that compared to psychoanalysis and psychodynamics, there are much fewer CBT supervisors, continuing education opportunities, and peer support groups. We believe this has, in turn, limited the interest and growth of CBT in China.

Third, we believe CBT suffers from many misconceptions in China, e.g., being overly "direct," "superficial," and "uninteresting." Many Chinese clients as well as counselors expect therapy/counseling to be indirect, unstructured, and counselor/therapist centered. In our experience, psychotherapists and counselors are typically perceived to be wise and authoritative in the Chinese culture. Clients tend to reply on them to guide, provide solutions, and rescue them from problems. These are in direct contradiction to CBT's client-centered, empowering model. Moreover, due to the current legislative, professional, and cultural environments, many clients turn to counseling for non-clinical or sub-clinical issues. They are more interested in having a series of spiritual, philosophical, abstract discussions that explore "deeper" things. Additionally, many people believe CBT is "easy" and can be self-taught by reading books. Some of them have had little CBT training, and yet claim to be CBT practitioners and provide CBT to clients, resulting in a misrepresentation of CBT to the public.

Fourth, in terms of CBT trainings, Chinese universities typically do not offer CBT courses. Therefore, psychotherapists and counselors often rely on community training programs and workshops to learn CBT. Based on Dr. Jianping Wang's experience and reports from other CBT trainers, feedback from systematic CBT training programs (mentioned above) has been generally positive. Many attendees indicated that CBT has opened new doors to counseling for them and that the structural and scientific nature of CBT makes them feel confident and well-grounded. They also recognize that CBT can produce meaningful changes in a relatively short amount of time. However, the lack of CBT supervisors has often been a problem in their practice. Therefore, we believe that a strong supervisor network is urgently required to support the growth of CBT in China.

Fifth, we have observed some cultural differences in the implementation of CBT. For example, some clients feel uncomfortable about having structures in therapy/counseling. It may take them a couple of sessions to become used to having session agendas. In our personal experience, many Chinese clients tend to view counseling/therapy as a passive progress where they would be analyzed by psychotherapists/counselors and thus are somewhat resistant toward doing homework in CBT. On the other hand, we have noted that some Chinese CBT practitioners can be flexible in their work and accommodate clients' needs as necessary. Nevertheless, without empirical evidence, it is difficult to say whether our observations can be generalized and how much of them can be attributed to cultural differences.

## Research on CBT in China

China's CBT research remains at an early stage. Research in the recent years has particularly focused on clinical populations, e.g., inpatients and outpatients from hospitals. It is generally agreed that CBT is effective in treating a wide range of clinical disorders. A recent meta-analytic review from Hong Kong provided support for the overall efficacy of CBT for Chinese people. It concluded that CBT produced

positive results in treating a range of clinical and life issues, including depression, anxiety, psychosis, addiction, caregiver stress, and dysfunctional thoughts and coping (Ng & Wong, 2017). Randomized controlled trials (RCTs) have shown that CBT and CBT combined with medication were effective in the treatment of depression, anxiety, sleep disorders, eating disorders, and psychotic symptoms (Han et al., 2013; Ren et al., 2016; Yu et al., 2015).

In addition to the empirical evidence mentioned earlier regarding the therapeutic effects of CBT in treating specific clinical disorders for Chinese people, there have been some interesting findings in areas such as psychological interventions for schizophrenia, online therapy, therapeutic effects of CBT for depression and anxiety, and biological basis of CBT. Zhanjiang Li and colleagues developed a manualized CBT program for treating schizophrenia. They created two questionnaires that are valuable to future research including "Irrational Beliefs Questionnaire" and "Symptom Attribution Questionnaire for Schizophrenia (Patient and Caregiver versions)" (Wang et al., 2007).

Li et al. (2017) created the first online CBT platform in China. This platform provided computerized CBT for depression, anxiety, insomnia, and OCD. It was mainly used by young adults who had mild symptoms during the first episode of mental health illnesses. Pre- and post-intervention comparisons lent support to the efficacy of online CBT treatment programs. Ren et al. (2016) designed a RCT and investigated the effects of computerized CBT for depression among Chinese university students and its underlying mechanism. The results demonstrated moderating effects of automatic thoughts and negative appraisal of events in computerized CBT for depression.

Moreover, Wang et al. (2015) identified quality of life as a significant predictor for the effects of group CBT for mild depressive patients. Another study suggested that challenging problematic attributional style using CBT techniques resulted in positive changes in mood and behavior (Wang et al., 2004). Yu et al. (2015) found that positive attention to daily events for the duration of one month significantly reduced symptoms of social anxiety and interpretation biases. Han et al. (2013) adopted the Delphi method and found that clinical interviews, therapeutic alliance, psychoeducation, and relaxation training were the most important CBT techniques in treating GAD.

Lastly, Luo et al. (2011) investigated the neurological changes associated with treating OCD patients with CBT. Functional magnetic resonance imaging results illustrated that following CBT interventions patients showed reduced brain activities in the orbit-frontal cortex. Cao et al. (2017) examined the effects of CBT on the resting state of regional brain function among patients with adult ADHD. The results indicated that CBT not only improved the core symptoms of ADHD, but selectively modulated the regional brain function in the default mode and fronto-parietal networks.

There is a growing number of CBT publications in the past decade (Zhang, 2017). In 2016 a total of 323 papers were published, of which 114 were on CBT, 42 on cognitive therapy, and 167 on behavioral therapy. However, these papers were mostly cases studies, individual reflections, and treatment effect observation reports,

with only a small number of them being empirical studies (Wang et al., 2011). Moreover, many of these empirical studies lack methodological stringency. Because of the large gap in skilled CBT practitioners, there are also concerns over the integrity of proposed CBT interventions. Hence, the study results should be interpreted with caution.

## CBT with Special Populations in China

Few efforts have been made to apply CBT with special populations in China. The first attempt occurred in 2000 by Dr. Jianping Wang and colleagues where they conducted structured psychoeducation and relaxation skills training on Chinese cancer patients. The results indicated that compared with the controls patients who received CBT intervention showed significantly higher quality of life (Wang et al., 2002). Another known effort was in 2015 when China's Forensic Department invited Chinese Psychological Society to conduct a series of counseling/psychotherapy training for their staff members with CBT being one of the training themes. There have been some trials in terms of applying CBT with special populations such as HIV patients (Meade et al., 2010); however, empirical studies are required to investigate their efficacy and effectiveness. Additionally, we have seen counselors with Chinese ethnical backgrounds expressing an interest in learning CBT and promoting CBT among various ethnic groups.

## Summary

CBT as a counseling and therapeutic approach in China is still young. Generally speaking, it is relatively well received by the community. CBT has gained growing evidence supporting its use for Chinese people. The CBT professional organizations have largely contributed to the promotion of CBT and the training of CBT users. However, CBT development is faced with a number of challenges. The lack of qualified CBT practitioners and supervisors in China has substantially hindered its research, education, practice, and as such limiting its community. The low public awareness and professional influence, in turn, restrict the expansion of the CBT community. In order to change this, Chinese CBT community needs to be creative in its delivery of training and lay emphasis on the localization of treatment programs. More efforts and resources dedicated to breaking the stereotypes of counseling and psychotherapy and to the education and training of CBT practitioners would be beneficial. Furthermore, we believe it is also important that CBT becomes an essential component of clinical psychology and counseling programs at a university level. Despite the challenges, we have strong hope that CBT will continue to grow in China and become an indispensable part of China's mental health education and practice.

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# Chapter 10
# Cognitive Behavioral Therapy in Colombia


**Maria Teresa Paredes**

## About Colombia

The terms multicultural, plural, and diverse are a good way to think about Colombia, its geography, and its people.

Colombia, which is named in honor of Cristobal Colon, is a democratic republic located northwest of South America. Its current population exceeds 49 million people, and its official language is Spanish, but there are also more than 68 different native languages according to the last government census. These languages are protected by the government under the rights and native languages protection law (República de Colombia, 2013).

Its geographical position provides it with sea access from the Pacific and Caribbean Ocean. Also with the Andes Mountains that split into three branches when they get to Colombia, this is why it has five different thermal floors and a wide variety of climates that creates six diverse regions: the Andes region, the Amazon region, the Caribbean region, the Orinoquia region, the Pacific region, and the Insular region. This diversity is also what makes this territory one of the places with the most biodiversity of the planet. It is the country with the most variety of species of flora and fauna per square kilometer in the planet, and it is the most diverse country in terms of birds and orchids on the planet (TodaColombia, 2018). Its topography has kept some regions isolated which allows Colombia to have cultural variety. Colombia's economic development depends on agricultural production and its trading. It is also likely that its diversity is one of the key points that doesn't make a peaceful coexistence between its people easy.

Colombia is a country that inherited from the nineteenth century a clear difficulty in making political agreements, generating internal wars since its independence in 1810 (Borja, 2015). However, there are no doubts that the most important historical

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drama in Colombia during the last 60 years has been the internal armed conflict that started during the period named "The Violence" and finally with the creation of different armed guerrilla groups, with the largest group being "Fuerzas Armadas Revolucionaria de Colombia (FARC) (armed revolutionary forces of Colombia)." This caused strong and negative consequences on all transparency, equity, human rights, and governance indicators. Fighting poverty and advances in education in terms of quality and coverage has been the biggest obstacle for human development in Colombia. This chronic situation facilitated the existence of corruption in general and other delinquency organizations such as paramilitarism and drug cartels. In order to combat these problems, the state has invested over the years four times more in defense that in education or health (Dinero, 2017; Programa de las Naciones Unidas para el Desarrollo, 2018), and it is also a well-known truth that all Colombians have been affected in one way or another by this internal conflict (Arias Trujillo, 2011).

It is true that different governments tried to reach to a peace treaty with the guerrillas, but it was only until August 2012 that the national government and FARC made a public agreement to end the conflict and discuss some key points for a stable peace. On September 26, 2016, President Juan Manuel Santos signed the peace agreement that was supported by different international organizations and countries all over the world.

There are many challenges and hope today in Colombia, and most efforts are toward diminishing inequity and mitigate material and psychosocial havocs of war in more than eight million victims (Reportes, 2020). There are now different programs supported by the government with the objective of helping these victims. Also, it was in 2015 that for the first time in the history of Colombia the budget for education was higher than the one for defense, and this tendency continued in the following years. Today Colombia is presented as a stronger, dynamic, and confident country that is leaving behind a burden of almost a century of violence caused by ideological differences. The reality of Colombia can be succinctly expressed by the following phrase from the writer Iván Olano Duque: "The Colombian tragedy is not new; what it is new and refreshing is the awareness of this tragedy, the fertility of the moment and the aspiration for a real transformation (Duque, 2018)."

## History of Psychotherapy in the Country

Psychology was introduced to Colombia mainly through medicine. In the magazine "Revista médica de Bogota (medical magazine of Bogota)" in the year of 1888, the first publication about hypnotism was made by Doctor Proto Gómez; even though he was a specialist in ophthalmology, he worked as a doctor in the asylum of San Diego en Bogota (Roselli, 1964). Other publications about psychology were made later by other doctors, but what started the study of psychiatric and psychological disciplines was the opening of the studies on mental pathology in the medical department of the National University in 1916 (Villar, 1965). These studies only

prospered for a year because there were no hospitals offering services related to mental health. They stopped the course and restarted it 10 years later, it took 10 years in order to start again this time permanently. At that moment the bases that psychology needed to settle in Colombia were already there. It is important to notice too that it was in the beginning in the twentieth century where tests became very popular, Colombia was not a stranger to Binet-Simon, Spearman factor G-, Terman Ck-, Thurstone; all these tests were used since 1940 in the physiology lab of the medicine department of the National University under the supervision of doctor Alfonso Esguerra Gómez, a man who had a remarkable interest for psychology. It was in this department where systematic studies based on tests started along with studies to prepare the staff for the admission of students into the different departments of that university (Boring, 1978). The road to professional psychology in Colombia was built during the first half of the twentieth century, with the influence of the historical moment and in accordance with what was happening in Europe and the United States in these disciplines. The rush to classify people as apt or not for specific studies and jobs caused many doctors and psychologists in Colombia to center their attention on the application of these tests.

In 1948 Mercedes Rodriga was appointed in charge of both psychotechnics and the institute of applied psychology. She was a psychologist from Spain who recently arrived to Colombia. The rector of the university, Doctor Agustín Nieto Caballero, supported her hiring to the just created section. She was eager, enthusiastic, and responsible not only for the initiatives related to the progress of the organization and the selection of appropriate studies but also about communicating that enthusiasm to some people that joined in her work and created a group of professors that were in charge of the first study plan, with a lot a medical content. Only Mercedes Rodrigo and José García Madrir had studied and trained in psychology.

The role of Mercedes Rodrigo (1891–1982), a Spanish psychologist born in Madrid, is key to the beginning of psychology in Colombia. She arrived in Bogota in 1939, just before the Spanish Civil War, and as other intellectuals, she abandoned her country never to return. She studied in Switzerland in the School of Educational Sciences of the Rousseau Institute, directed by E. Caparéde, who in 1920 founded the International Association of Applied Psychology. He who would turn out to be without a doubt the European figure with the most influence to her (Bozal & Gil, 2011). Afterward she initiated her studies in Ginebra University where she got her psychology diploma in 1923. Mercedes collaborated with Caparéde in the psychology lab of the university, where she did practices in special education in “La Mansión de los Niños” and pedagogical practices in centers related to Rousseau Institute, and also in the cabinet of professional orientation (Bozal & Gil, 2011). She was prolific and tireless in her work in her own country from 1923 to 1939, which was the year where she arrived in Bogota.

Under her direction in the section of psychotechnics with the responsibility of psychological evaluation, she expanded the demand of these services to other departments and also to institutions and companies out of the university. Isolated courses, trainings, and updates on psychology started to be offered, with most of the attendees were doctors. In 1946, Mercedes Rodrigo created the course of medical

psychology, and from the compilation of the different courses, the university published "Introduction to Psychological Studies" in 1949 (Bozal & Gil, 2011; de Psicología, 1998).

It is on November 20, 1947, that the Agreement Number 231 was released. Its content can be found on the register # 44 signed by Rector Gerardo Molina, which clearly states: "Article 1. Expand, starting on January 1 of 1948 the department of psychotechnics of the university, which from now on will be called "Institute of applied psychology of the National University (de Psicología, 1998)." This was the first program of professional studies in psychology in Colombia, and it had five sections: section of infancy and adolescence, university section, research section, teaching section, and the last that would become the first faculty of psychology in Latin America. And in 1966 it turns into the Department of Psychology of the Faculty of Human Sciences (Roselli, 1964; Villar, 1965; Bozal & Gil, 2011; Ardila, 1993). This is not intended to be a comprehensive list of all people meaningful to psychology in Colombia at the beginning. But it is important to mention some important Colombian figures for their conviction and their contribution to psychology including Doctor Agustín López Caballero, Doctor Alfonso Esguerra, Doctor Luis López de Mesa, and Doctor Álvaro Villar Gaviria. Gaviria was also an important figure of psychoanalysis in Colombia (Blanco, 1999; Ardila, 1969).

Political difficulties reached Mercedes Rodrigo quickly and her recently created institute of psychology. Some sectors in the country criticized psychological tests and the selection of university applicants using the method. The problem was taken to the congress who decided to expel Mercedes Rodrigo from the country. She lived in Puerto Rico until she died in 1982 (Villar, 1965; Bozal & Gil, 2011; Silva, 2007).

In 1948, the Institute of Applied Psychology started to formally train psychotherapists in psychoanalysis supported by two doctors affiliated with the psychoanalytic society of Paris, Doctor Arturo Lizarazo and José Francisco Socarras and also Hernán Quijada. They created the group of psychoanalytical studies in 1956 that in 1961 turned into the Colombian Association of Psychoanalysis that still exists.

During the 1950s and 1960s, two psychology programs existed: the one from National University and one from Javeriana University in Bogota. But after 1970, according to the National System of Graduate Information of the Ministry of Education, more than 35 psychology programs have been created, 78 specializations, 54 master's degrees, and 12 PhD programs around the whole country.

There are many outstanding Colombian psychologists both nationally and internationally, but it is important to mention in the history of psychology in Colombia. Rubén Ardila is an outstanding student from the National University. In the beginning of the 1970s, he dedicated his life tenaciously to the consolidation of psychology in Colombia and Latin America. As a student he criticized the quality of the information he was getting since most of his professors were psychiatrists and psychoanalysts. He argued that he did not understand psychology as a profession. He turned out to be the only student who never believed in psychoanalysis. "Freud and his theories never convinced me." "I was quite critical and sometimes too harsh about everything that sounded like psychoanalysis." "It was natural for me to be like that since psychology is a scientific factual discipline, it only accept as true

statements with empirical research in a level that psychoanalysis cannot offer (autobiography of Rubén Ardila. Page 68).” He studied experimental psychology at the University of Nebraska and when he returned to Colombia and Latin America. His work in the diffusion of behavioral therapy had a huge impact, since it helped psychologists to work on their profession with autonomy, using experimental technology to deal with clinical problems, an approach unknown to psychiatry.

Since 2005 the “Rubén Ardila” Award to Scientific Research in Psychology was given by the foundation for the advance of psychology to psychologists who have been outstanding for their scientific research in psychology. In 1975 he founded the Latin American Association of Analysis and Behavioral Modification (ALAMOC) and the Colombian Society of Psychologists in 1978 (SOCOPSI). He has received multiple mentions including the Award for Distinguished Contributions to the International Advancement in Psychology, given in 2007 by the American Psychological Association.

## Actual Regulations for Providing Psychotherapy

Even though the Institute of Applied Psychology (IPA) from the National University graduated the first Licentiates in psychology in 1952, no legislation existed about the exercise of the profession, with the aggravating factor that therapeutic activities could only be performed by doctors (Peña-Correal, 2007). It is by the initiative of the very psychologists in the 1970s, organized under the Colombian Federation of Psychology lead by Rubén Ardila, who made it possible to the promote a law in the congress to regulate and legalize psychology as a profession. The project suffered many difficulties and modifications in order for it to be approved, and only after more than 10 years, in December of 1983, it turned into a law (Ley 58 de 1983, 1983). Only until then the formal conditions are established in order to exercise psychology as a profession. Since this time the National Professional Council became the highest authority for the profession, with representation in the health ministry, the Colombian Institute for Evaluation and Education, the Ministry of Education, psychology departments, and professional organizations.

The omissions and imperfections of the law in 1983 caused the fusion of diverse psychology associations to create the Colombian School of Psychologists in 2004, which is responsible for the elaboration and promotion of Law 1090. It was not until September 2006 that the Ministry of Social Protection promoted Law 1090 that regulates the exercise of psychology as a profession and dictates the deontological and bioethical code that creates the deontological and bioethical tribunals.

Other dispositions for the exercise of the profession relate to disciplinary processes. This law gives public functions to the Colombian School of Psychologists and makes it responsible for the accreditation of academic formation, formalized by the expedition of the professional psychologist card that is government regulated (Quiénes somos?, 2003).

## Professional Organizations in Cognitive Behavioral Therapy

Colombia is a country with little tradition with professional organizations, and there are only three active associations:

- The "Latin American Association of Behavioral Analysis and Modification and Cognitive Behavioral Therapy (ALAMOC)" founded in 1975 in Bogota. Its objective is focused on associating Latin American professionals interested in "the promotions, the encouragement, research, evaluation, accreditation, analysis and study of scientific research and its advancement on cognitive behavioral components that are key to human development and its relation with the process of change and therapeutic processes (Modificacion del Comportamiento y Terapia Cognitiva Conductual, 2014)." ALAMOC is a nonprofit organization, and it is the representative of Latin America in international conferences about cognitive behavioral therapies.
- The "Association of Cognitive Therapy" (ACOTEC) founded in 2002 in Medellin. Its objective is to gather students and professionals interested in strengthening and spreading the ideas and interventions of cognitive behavioral therapies (Eventos, 2013).
- The "Latin American Association of Cognitive Psychotherapy" (ALAPCO) was created in 1999 in Colombia, Chile, Paraguay, Brazil, Peru, Mexico, and Uruguay as an attempt to associate people and associations interested in CBT with the objective of sharing experiences and information while keeping into account cultural characteristics. It intends to favor transcultural research.

## Training Opportunities in Cognitive Behavior Therapy

Even though it has been more than 10 years since Law 1090 of 2006 was approved in Colombia with its objective to regulate professional psychology, there is also Law 1164 of 2007 (Ley 1164 de 2007, 2007) which dictates the requirements for training for all personnel that offer health services; there is little information regarding what a psychologist should know. There is no research about the quality and the impact of a psychologist's training in the professional exercise (Perdomo et al., 2003; Ley 1164 de 2007, 2007).

The undergraduate programs in Colombia structure their curricular content to answer two different sides of psychology: psychology as a science and as a profession (Ley 1164 de 2007, 2007). This is the reason it is a requirement during the last terms to perfect one of the following intervention areas: clinical, social, organizational, or educational. In the case of students who choose to improve their clinical focus, in general, they have to choose from either a psychodynamic, humanist, or cognitive behavioral theory. This experience turns into the first approach to CBT training.

On the other hand, according to the National System of Information in Superior Studies, master's degrees in clinical psychology represent 24% of the total of master's degrees in psychology. They have in their curricular content aspects of theory and practice from cognitive behavioral therapy. It is not possible to specify the degree of clinical supervision in these programs or even if there is some (La educación es de todos, 2020). There is a broad offer of theoretical courses in CBT, offered as specializations and courses with certificate of completion. Some of them are offered or supported by a university.

Since 2004, by the initiative of Doctor Leonor Lega and Maria Teresa Paredes, in collaboration with Doctor Ann Vernon and Doctor Dominic DiMattia, the first primary certificate practicum in Rational Emotive and Cognitive Behavioral Therapy was offered at Javeriana University Cali. This initiative progressed and the "Instituto Albert Ellis de Colombia (Albert Ellis Institute of Colombia)," today AEI Colombia as an Affiliated Training Center of the Albert Ellis Institute in New York. In the following years, it turned into a clear opportunity for theoretical and practical training in CBT, not only for Colombians but also for professional of other nearby countries.

## Cognitive Behavioral Therapy with Specific Populations

In Colombia the law of mental health has existed since 2013, and its objective is to guarantee the rights of mental health to the Colombian population (Ley 1616, 2013). Colombian population was characterized according to its mental health by a descriptive transversal study in 2015 that included the population from the Atlantic, Eastern, Central, and Pacific region, and people from rural and urban areas were taken into account. This broad-reaching study provides information about a myriad of societal aspects as it relates to mental health. More specifically, problems in mental health and behavior, chronic conditions associated with it, violence exposure and mental health, mental health in children, adolescents, adults and elderly people, access to health services, medication use, and the perception of the quality of life among the adult population in Colombia. The study also explored the topic of substance abuse in children, adolescents, and adults (Gómez-Restrepo et al., 2016; García Valencia et al., 2015). The epidemiology aspect of the study had the objective of not only to provide the means to define a public policy on mental health but also to strengthen research on mental health in the country.

According to this study and keeping into account the chronic condition of violence in the country, which has an impact on the mental health of the population, it is important to note that only 51.5% of children between 7 and 11 years old live with their biological parents and 51.1% of the population between 7 and 44 years suffered from some sort of forceful displacement due to violence. Also, researchers conclude that among other things, at least 44.7% of children between 7 and 11 years old require a formal evaluation from a professional of their mental health to determine the existence of a disorder (García Valencia et al., 2015) and that, in the few detected cases, it was stated people started to consume psychoactive substances at

about 11 years old (García Valencia et al., 2015). In children between 11 and 17 years of age, 52.9% are anxious, 19.7% are depressed, and 29.3% are said to have suffered from at least one traumatic event. In the adult population between 18 and 44 years of age, 52.9% present one or more symptoms of anxiety, and 80.2% manifest one to three symptoms of depression. This tendency is also true for the next age group of people. In individuals 45 years old and older, 54.8% present at least one symptom of anxiety and 71.9% one to three symptoms of depression. On the subject of suicide or suicide attempts, the National Institute of Health reports that up to week 52 of 2016, 18,910 cases of suicide or suicide attempts were reported (Gómez-Restrepo et al., 2014), from which 62.7% were women 15 to 19 years old. This problem is somewhat stable since 2015, and there were 4.47% suicide cases per 100,000 people, showing a slow decrease Therefore, it appears that the population suffers mainly from anxiety, depression, post-traumatic stress, and developmental and adaptive problems.

On the other hand, the result of this study was an update on the guidelines, models, and attention programs proposed by the ministry of health. The guidelines strongly suggest the use of cognitive behavioral therapy for individual and group psychotherapy for the most common disorders found in most of the population and also for anxiety, depression, and programs of the health ministry for victims of different kinds of violence, psychotic disorders, schizophrenia, eating disorders, and alcohol, among others. This directive about using CBT on the issues that afflict the population the most is part of the ministry plan started in 2020, which is why more information about its fulfillment is expected soon.

## CBT Adaptation in Colombia

Like other countries, the main references or psychological systems that had impact in Colombia have coexisted despite sometimes irreconcilable epistemological differences. These psychological systems permeate history, culture, and politics among other aspects, and in the same way they transform or adapt by elements that characterize each nation. Another important aspect that is important to acknowledge is that most psychological clinical analysis started in their own moment from the theory developed by Freud and was done by psychoanalytic doctors who were able to practice psychotherapy. Psychology in Colombia was no different, and it is important to acknowledge those elements in the beginning. Even though these days the influence of psychoanalysis is secondary and other models are used in order to explain behavior and human development, this psychological perspective played in its own time a crucial part in the beginning of the development of psychotherapy in Latin America. In 1911 there was a critical review done by Freud himself about the contribution of a Chilean doctor named German Greve and a Peruian named Honorio Delgado about the history of the psychoanalytical movement in Latin America. This frenetic opinion on psychoanalysis resulted in access since 1918 to the first journal of

psychiatry and related disciplines with content from psychoanalytic doctors from all Latin America (Rull & Rull, 2006).

In Colombia as in other Latin American countries, we also had the hegemony of psychoanalysis as psychotherapy influenced by psychiatric doctors. It was only possible to do psychotherapy by people who studied medicine and had training in psychoanalysis. This was particularly true in the beginning of the 1070s. In 1956 the Colombian Society of Psychoanalysis was created, and it is acknowledged worldwide. Back then the role of a psychologist was not well defined, and diagnosis, prevention, and treatment of emotional, mental, and physical diseases were by law exclusively done by doctors trained in psychoanalysis.

As was mentioned in this chapter, Colombian psychologists were initially trained in psychometry and evaluation. They were successful in the application of this area and became renowned in society. However, before the influence of psychoanalysis and the departure of Mercedes Rodrigo from Colombia in 1950, psychoanalysis became dominant in the training of new psychologists, and other theories were abandoned. Experimental psychology was studied only in its theory, and there was no methodology and no lab that could support this theory. Projective tests became very important, and assignments related to clinical psychology, studies of development, and personality were only done with a psychoanalytic orientation.

The psychologists from the 1970s in Colombia were trained as psychotherapists with an emphasis on psychoanalysis, and they could only do their professional practice under the supervision of a trained psychoanalyst doctor. This time was confusing and conflictive for the aspects of academics and practice, and this situation was only solved in 1983 with the 48th law that set a legal basis for psychology in Colombia. However, in 1965, Ardilla published "Behaviorism: Towards a Scientific Psychology" (Ardila, 1965), an article in which it is stated the necessity of another perspective in psychology that includes the scientific method, and it states that the initial dogmatism of the classic behaviorism has been overcome. This publication is the beginning of an enthusiast movement of psychologists who were uncomfortable with the psychoanalytical proposal, but it was only in the beginning of the 1970s that the studies on experimental analysis of behavior lead to the creation of psychology departments with an experimental focus. Courses were created for learning psychology, behavioral analysis, and behavioral therapy, among others. These courses were applauded since they allowed psychologists to act in an autonomous and efficient way. Behavioral therapy turned into the first field of application of this new psychology. These new psychology departments and some new universities worked only on scientific psychology or the experimental study of behavior.

Once more there is conflict between paradigms. Despite the fact that supporters of behavioral analysis were building an identity for psychology and had the objective of improving life for people, they faced strong criticism that focused mainly on problems about freedom, the control of human behavior, and politics among others. This led to the return of dogmatic postures that did not contribute to the advancement of research or the training of new psychologists. However, as time went on, behavioral analysis focused on opening more formal spaces and getting representation on national conferences, magazines, and associations, and step by step it

softened its controversial character which allowed it to advance in the production of academic events.

In the middle of the 1980s, a tendency toward behavioral analysis and mediational behaviorism was set, and in the universities that implemented a behavioral perspective, there was a transition to a new cognitive behavioral focus. Basically, in Colombia, behavioral therapy turned into "cognitive behavioral therapy." Other factors that contributed to a conflict-free transition were the apparition in some universities of research that used classic experimental methodologies, studied cognition from different perspectives, including artificial intelligence, Piaget, mental representations, simulation of psychological processes, Vygotsky, problem solving, or information processing. These labs on cognition were designed to work on basic and applied problems and still exist in most psychology departments. It is a reality that research on cognition and its applications to clinical practice, education, human development, and other areas possess great vitality in Colombia. On the other hand, it is accepted that other cognitive factors take a primordial place in therapy, and we can assure that there is a strong influence of CBT in Colombia (Fernández-Álvarez, 2017; Rull & Rull, 2006; Ardila, 1965; López et al., 2006). In 1992, the first master's degree was developed on principles and techniques for modifying behavior with a basis on a CBT model.

In this decade there is a strong consolidation of CBT, and it was required that psychologists take into account in their practice the diverse cultural, developmental, and political realities. This leads to the adaptation or creation of instruments and methods to validate its practice. This consolidation is still ongoing, and it is a challenge to balance the universality of psychological laws with the particular local and regional culture and thoughts.

## CBT and Research in Colombia

The Colombian Research Pool of Scientific Research and Special Projects Francisco José de Caldas (COLCIENCIAS),was created in 1968 and was ascribed to the National Ministry of Education. It is the entity with the objective of handling resources for projects and research and to train researchers and establish an adequate infrastructure to think, promote, and generate new knowledge. Toward the end of the 1990s, a policy of science and technology was approved with its corresponding law, and the National System of Science and Technology was created (SNCyT). It is here that the Colombian government sets the mechanisms to consistently work toward the technological and scientific research in the country. With time COLCIENCIAS not only turned into the backup needed by some academics from different universities for the advancement in their own research but also allowed their interests to join into a national institutional network of research.

Despite the fact that research in psychology was being done in Colombia since the 1970s by researchers associated with specific universities, it is only since the

1990s where actual study groups were created. It was in 2004 when the thematic node in clinical psychology was created into the national network of researchers in psychology. This is considered an important event in the history of clinical psychology in Colombia with the support of the Colombian Association of Psychology Departments. There is improvement in the homogenization of research standards in psychology and the access to resources that allows researchers to have more time and dedication to their work. This development shows a research effort and the desire for knowledge exchange.

There are many types of clinical problems that are being studied from the cognitive behavioral perspective and are being published by specific journals s in Colombia and Latin America. In the most respected magazines, the bibliometric revision of articles that takes CBT into account shows an increasing interest in the psychologists for researching, diagnosing, and evaluating problems from this perspective, focusing on aspects such as development and the evaluation of treatment programs based on this theory. Additionally, it shows the interest in working with variables such as thinking styles, schemes, and automatic thoughts mostly in situations related to violence, depression, and personality. There are also publications that take into account research of clinical problems in childhood and adolescence (Polo & Díaz, 2011; Rey Anacona & Santos, 2005; Perdomo et al., 2003).

The 1990s is without a doubt the decade with the most quantity of articles with the objective of validating measuring scales for all types of psychological and developmental problems.

The descriptive analysis of the published articles of the "Revista Acta Colombiana de Psicología" (Colombian magazine of psychology) between 2010 and 2014 shows an increasing number of publications from the cognitive behavioral perspective and shows a particular research interest in addictions. This is related to the creation of a master's degree in psychology with emphasis on addictions and violence and the Catholic University's research group on this topic (Lega, n.d.; Méndez & Rodríguez, 2011; Castaño & Pérez, 2010; Anacona & Guerrero-Rodríguez, 2012; Ávila-Toscano et al., 2014).

The publication analysis from the magazine "Psychology Therapy Magazine," "Psychology Latin American Magazine," and "International Magazine of Clinical Psychology and Health" shows also that Colombia is the country with the greatest number of publications in cognitive and cognitive behavioral therapy in a large number of topics.

From a research perspective it is possible to say that CBT has large representation in research topics and that its research transcends into other countries of Latin America and Spain. It is also possible to say that there is an increasing number of collaborations between researchers of CBT and researchers from other study groups, both national and international (Ávila-Toscano et al., 2014; Allende, 2011; Ravelo et al., 2016; Duque, 2015).

## CBT with Special Populations in Colombia

Regrettably, the chronical armed conflict and the organized political violence in Colombia generated psychological consequences on the population as the mental survey states in 2012 (de la Espriella Guerrero et al., 2013). The number of people who were forced to leave their homes is unknown, and the number is likely to increase until pacification strategies reach every region in the country. It is because of this reason that most of the work with special populations is undoubtedly for those derived from the armed conflict; considered special populations are those who were forced to abandon their homes because of the conflict, family members of those who disappeared, communities of farmers, native populations, and the Afro-Colombian population. Also, other special populations are vulnerable groups due to religious beliefs, LGBTQ, social and syndical movements, and also psychologically affected populations due to the permanent fears of the country's conflicts.

Several studies done in other countries with a history of violence such as countries in Africa show the effectiveness of cognitive behavioral interventions focused on trauma (Guevara, 2020); however, the strategies used in Colombia are characterized by being too general in their theoretical construction and lacking at guiding the therapist about what strategies and methods to use on the execution of the project. The general guidelines of the programs are of a psychosocial focus that allows actions to be taken in regard to the well-being of the individual and his/her environment, with its focus on the creation of abilities and individual opportunities. However, the method used in the projects, even the ones that include individual attention, is made according to the criteria of the professional in charge of the project, which creates a difficult scenario for follow-up of these specific projects and on evaluating its results. As a reference for this situation we can use the reports of the consultation system of the development plan for the Caribbean region, in which evaluations found that programs, strategies, and topics used with vulnerable groups were formulated differently and under different names. The researchers also developed descriptive names for the programs, and then they grouped the activities found in the plans that were most related to it (http://www.ocaribe.org/pdcaribe/poblacion-vulnerable).

Other example can be found in the study that describes the work done by professional psychologists in the Health Ministry for Victims of Violence and Grave Violations of Human Rights (CAVIDH) (https://www.uv.es/edhc/edhc002_buelga.pdf) in Bogota. We can find here that the attention done by the psychologists focuses on the recovery of the victims and the restitution of their rights, as well as the professional work done by those who work in the center. Those centers operate in groups made up of a psychologist, a social worker, and a lawyer. The objective it to be able to give specialized attention to the problems that require different approaches as a consequence of the armed conflict. The population they work with must be victims of sexual and domestic violence, land restitution problems, and forced recruitment done against children and adolescents because of the armed conflict and grave violations of human rights. They also work with specific populations such as

women and children under special protection, native populations, Afro-descendant people and people who are found to be in a situation of extreme vulnerability. All those victims qualify to receive ten free sessions with the possibility of increasing this number. These services are differentiated for children, adolescents, elderly men, and women, and they have specific guidelines for each. This program is much more systematized and can be described on two axes: the general strategies of the psychological intervention and the specific tactics used in the psychological intervention, where it is possible to find dealing with loss, normalization of the associated feeling and the experimented responses, liberation from emotions, cognitive restructuring, relaxation techniques, as well as other activities.

So we have two regions with two very different approximations. It is likely that despite the broad evidence on the effectiveness of cognitive behavioral interventions on reducing the post-traumatic stress symptoms in different populations (soldiers, people who participated in armed assaults, kidnapping) (Alejo et al., 2007; Bisson & Andrew, 2007), and also that the results are superior to those of other kind of treatments, there is not systematic attention on special populations based on cognitive behavioral therapy. This situation, with a very diverse population, added to the political conditions, is an opportunity to develop projects and programs based on CBT and to do comparative studies.

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# Chapter 11
# Cognitive Behavioral Therapy in Costa Rica


**Adriana Gamboa Bou, Ana Catalina Vargas Fonseca, and Stephanie Pirie Gil**

## Overview of the Country

The Republic of Costa Rica is located in Central America, with Nicaragua neighboring to the northeast and Panama to the southeast. It is a sovereign nation, organized in seven provinces, with a population of 4,807,850 inhabitants. San José is the capital and the official language is Spanish. It is considered to be a solid democracy that earned recognition worldwide when it abolished its Army on December 1, 1949. Costa Rica has the fifth highest-ranking economy of Latin America and 47th in the world ranking of competitive economies. The Legatum Institute regarded it as the fourth most prosperous country in the Americas and 29th in the World. Costa Rica is considered to be one of the most competitive, progressive, developed, and stable countries of the region, predominantly in areas such as freedom of speech, global warming, stewardship of natural resources, security, equality, wealth distribution, healthcare, education, and social progress.

In 2007, the Costa Rican government announced its intention of becoming the first carbon neutral country by the year 2021. It is thought to be one of the most eco-friendly countries in the world. In the 2016 Happy Planet Index, published by the British "Think Tank" New Economics Foundation, Costa Rica was regarded as one of the happiest, greenest, most sustainable nations in the world. This small Central American country was honored with this title as well in 2009 and 2012. In the study "REBT and irrational beliefs in Costa Rica: A cross-cultural study (2015)" we mention how "happiness was measured using an average of subjective life satisfaction, life expectancy at birth and ecological footprint per capita." Costa Rica is known by

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the popular saying of "Pura Vida" or "Great Life," a place where everything is ok and life simply flows. For many years, it has been considered the Switzerland of Central America. Costa Ricans haven't had to struggle for basic standards of living like other countries in the region, thus enhancing the *pura vida* lifestyle. Costa Ricans did not have to fight for independence, have a mild climate, a history of minimal struggle to remove military influence, and enjoy universal free education and health care. These circumstances have marked the culture and social aspects of the Costa Rican way of life.

Like any Latin American country, the value of family is very important, making it an enabling cultural value. Women usually take on the important anchor roles of the household, and it is uncommon to see men and women leave home before they marry.

## History of Psychology in Costa Rica

The surge of interest of psychology in Costa Rica parallels the development of the field in Latin America, and its evolution in developed countries. The first training centers in Latin America were The Institute of Applied Psychology of Colombia and the Department of Psychology at the University of Chile, both founded in 1948.

The practice of psychology in Costa Rica began at The National Hospital of Psychiatry in the 1957 with the arrival of Dr. Gonzalo Adis Castro to the country. He had recently graduated from the University of California in Berkley, California, and thus became the first official "graduated" clinical psychologist in Costa Rica. Upon his arrival, Dr. Adis recalls in his book, *Psychotherapy in Costa Rica* (1975), how he soon realized he was the first psychologist with a doctorate degree in the country, despite the fact that there existed other professionals in the field that had been self-taught and who had been working with psychotherapy, particularly in the field of education (Adis C.G. 2016).

Prior to Dr. Adis' arrival after completing his studies in the United States, The National Psychiatric Hospital Manuel Antonio Chapui had been founded in the year 1890 and was initially called "The National Hospital of the Insane." By 1924, Lilia Ramos, trained in educational psychology, was teaching a program for parents in need called "School for Parents" (Adis C.G. 2016). In 1929, Juan José Trejos Quirós published his book, *Summary of Psychology*. In the year 1938 Dr. Fernando Quirós Madrigal created the Department of Mental Health in the National Ministry of Public Health. In 1940, Fernando Centeno Guell founded "The School for Children with Special Needs" that focused their attention on children with Down Syndrome, blindness, and hearing problems. In the mid-1940s Dr. Gonzalo Gonzalez Murillo founded the external practice in psychiatry and neurology in the hospital along with focus groups carried out by Lilia Ramos on the development and personality of children. By 1953, Professor Mariano Coronado had taken some

psychology and mental health courses in Europe, and as a result, he started the "Department of Well Being and Orientation" at the University of Costa Rica (Adis C.G. 2016). He became the first mental health professional who had worked with psychotherapy and support educational groups. During this time, other institutions were founded, such as the Neuro Psychiatric Clinic for Children and the Commission for Alcoholics, today renamed as the Institute of Alcoholism and Drug Abuse, or IAFA. There were many other disciplines that were being implemented by self-made academics, including pediatricians, psychiatrists, educators, educational psychologists, and social workers. In 1957 Dr. Adis founded The National Council for Rehabilitation known today as the Service of Clinical Psychology in the National Psychiatric Hospital of Costa Rica (Adis C.G. 2016). By 1962, specialized clinical psychologists were arriving in the country after completing their studies abroad, and others were being trained by Dr. Adis and his staff in the Psychiatric Hospital. In 1966 the School of Psychology at the University of Costa Rica was founded. Dr. Adis worked diligently with his fellow psychiatrists in the hospital, establishing working relationships, and laying the foundation for the harmonious relationship that exists today between the two disciplines. For many years he was the only formally trained clinical psychologist in the country. It was up to him to lay the foundation for standards and practices of psychology in Costa Rica. Dr. Adis was the head of the Clinical Department for thirty-three years. As more professionals in mental health joined the institution, and the biopsychosocial model continued to be implemented, the demand for clinical psychological attention grew. In the 1980s, the Hospital was known for its high-quality attention in the field of mental health, as well as for the training of mental health professionals. Over the years, many improvements have been made.

After the School of Psychology was founded at the University of Costa Rica, the University approved the Institute of Psychological Investigation and thus the career of psychology gained visibility through the Institute by means of admissions testing. Initially psychologists were considered as assistants to psychiatry and were not recognized as professionals. They were associated with the concept of mental health in the Psychiatric Hospital. Through the efforts of the initial pioneers in psychology, perceptions began to change. The Professional School Psychologists of Costa Rica (*Colegio Profesional de Psicólogos)* was approved by Congress on November 28, 1977, and the country began to have enough licensed professionals to meet client demand (Adis C.G. 2016). Some of the early members studied abroad and others graduated from the University of Costa Rica. Initially, the first psychologists focused only on clinical and hospital work, but as the number of graduates grew, areas of interest in educational, health, and labor psychology also increased. The main employer was the government, in particular the National Health Service (CCSS), Child Protective Services (PANI), and the Ministry of Justice. In the 1990s, social reforms in Costa Rican gave rise to private industry, creating a niche market for psychologists to assist in the restructuring of companies, commercial treaties, and interpersonal relationships within private companies.

## Regulations Regarding Psychotherapy

In Costa Rica, in order to work as a psychologist, you must be part of the Professional School Psychologists of Costa Rica. If a psychologist wishes to be integrated into the said institution, they have to apply for membership and supply a series of documents for review. A candidate must have the minimum grade of a post-graduate degree (licentiate) or a master's degree. Upon review, and if accepted into the Professional School of Psychologists, the new member has to partake in a Professional Ethics Workshop and take part of an Affirmation Ceremony before the President of the School.

The Professional School of Psychologists is the institution responsible for supplying the guidelines for treatment in Costa Rica. Among those guidelines, a psychologist is expected to have their clients sign an informed consent. This includes information pertaining the type of treatment, patient rights, limits of professional discretion, and possible risks of the intervention. In the case of children, a parent or guardian is required to sign the informed consent form. If the client is 15 years or older, they can sign the consent themselves. The psychologist is also expected to inform the client about the methods used, procedures, costs of the session, schedule, and any information regarding their session.

The recommended durations for a therapy session in Costa Rica are as follows:

Individual therapy: 50 min
Couple's therapy: 90 min
Family session: 120 min
Group therapy: 150 min

According to the Professional School of Psychologists, a psychologist should use techniques or instruments that are part of the psychological sciences. If another technique is used, the psychologist is required to be properly certified in the said technique in order for it to be integrated into the therapy and has to inform the patient of the scope of the technique and the fact that it is not a technique of the psychological sciences.

The Professional School of Psychologists of Costa Rica recognizes different professional associations in the field of psychology in Costa Rica, including the Association of Clinical Hypnotists, Forensic Psychologists, Sport Psychologists, Gestalt, Psychodrama, etc. There are no recognized associations for cognitive behavioral therapy (CBT) or rational emotive behavioral therapy (REBT).

## CBT Organizations

The history of CBT in Costa Rica is very recent. Outside from formal education in Universities, it was not until the late 1990s that the first CBT centers were formed and that some of the public and private universities started having international

guest lecturers on CBT. Previously, psychologists were trained in cognitive therapy (CT) and CBT in foreign universities or training programs. In Costa Rica, Albert Ellis Institute (AEI)–affiliated centers from Latin America gave a few primary and advanced trainings in REBT during this time. The University of Costa Rica also invited other important REBT contributors such as Leonor Lega and Janet Wolf. Leonor Lega has been a great supporter of REBT growth in Costa Rica.

The *Centro Costarricense de Terapia Racional Emotiva Conductual*, known as CETREC, is a psychotherapy and training center established in 2005. It is the only affiliated center from the Albert Ellis Institute in Central America and one of the few in Latin America. This center was founded by Ana Catalina Vargas after becoming an associate fellow of the AEI.

Since its foundation, CETREC's main goals have been the following:

- To allow professionals in psychology and psychiatry to receive quality CBT and REBT training
- To promote the efficiency of REBT and CBT as a psychotherapy treatment
- To provide evidence-based psychotherapy models in Costa Rica
- To translate REBT and CBT material for the Spanish-speaking clinical and professional community
- To offer public workshops on different topics for the Spanish-speaking clinical and professional community
- To support research with Costa Rican population, therefore aiding in AEI and REBT theory

## Training in CBT

Several universities offer a bachelor's degree or post-graduate degree (licentiate) in psychology. Only five of these institutions have the endorsement of the SINAES (National System for Superior Education Accreditation). Out of these universities, two offer courses in CBT. Two other universities offer courses in behavioral modification. The remaining institution does not have any course dedicated to CBT or cognitive or behavioral modification.

Besides the CBT courses offered in different Universities, the only other professional training available is offered by CETREC. Since the founding of CETREC, it has been training psychology and psychiatry professionals in REBT and CBT. Since 2005, approximately 250 professionals have received the primary and/or advanced certificate from the AEI. CETREC also offers a one-year training program that gives trainees deeper content and supervision in REBT and CBT. The center offers REBT and CBT workshops and lectures for the professional community including the treatment for anxiety, depression, anger, addictions, personality disorders, sexual dysfunctions, and eating disorders. The center offers training in REBT for the treatment of different populations including children, adolescents, parents, and couples.

To promote the goal of teaching Ellis' ABC model, CETREC has given lectures on the ABC model in many public hospitals, including the Calderon Guardia Hospital, Tony Facio Hospital, San Vicente de Paul Hospital, and The National Psychiatric Hospital. CETREC has also provided public lectures and workshops in topics such as stress management, lifestyle adjustment after bariatric surgery, nutritional treatment compliance, and coping with skin problems such as acne, psoriasis, and vitiligo, among others. CETREC has made it an objective to translate REBT material to the Spanish language, as a resource for clinicians in the field. Lega and Vargas also published the *Manual Práctico de Terapia Racional Emotiva Conductual* (Lega and Vargas, 2017). This manual compiles translations of REBT material, most of it taken from the handouts of The REBT Resource Book for Practitioners (Bernard & Wolfe, 2000). CETREC also offers REBT and CBT books and resources in Spanish and English for the professional community and has a small library for their clients.

In August 2008, Ana Catalina Vargas, Stephanie Pirie, and Adriana Gamboa founded the Clinica de Psicología CETREC. This private clinic is located at Cima Hospital in San José, Costa Rica, and it is the only outpatient clinic dedicated exclusively to REBT and CBT treatment in the country.

## Use and Adaptation of CBT

In 2018 Vargas, Pirie and Gamboa conducted an interview and focus group with 45 professionals who have trained in CETREC and concluded that 78% of those professionals have received their total training in CBT at this center and the remaining percentage have also received some sort of CBT training at a university level. Out of the therapists working with CBT in Costa Rica most of them report that they work with adult populations (72%), with only 28% applying CBT techniques with children and/or adolescents. Most of the therapists that participated in the survey report that they use REBT to treat anxiety, depression, anger, grief, couple, and/or family-related problems. The vast majority of therapists work in private practice (Vargas et al, 2018).

CBT's and REBT's framework and applied technique do not vary much from its origin in Costa Rica due to the fact that the CETREC affiliates and supervisors have been trained personally by the Albert Ellis Institute and have worked hard in not changing its structure and framework. Slight differences may vary because of cultural issues that triggered the initial work for this investigation. Shame attacks have required cultural adaptation. A study done by Dr. Lega (2003) comparing the effectiveness in Latin America compared to the United States concluded that Latin American clients are more skeptical of the use of this technique. The concept of "what is shameful" is different in Costa Rica and thus modified. In a non-assertive culture, where Costa Ricans avoid confrontation, REBT utilizes a less confrontational style. Techniques are applied in therapy by analyzing individual client preferences. Bibliotherapy is a limited resource due to lack of material in the Spanish language. It is important to mention the cultural resistance that exists in filling out

forms and doing homework. Costa Ricans are famous for not being punctual, affecting the possibility of them showing commitment and being willing to fill out forms and evaluations an hour before their appointment. The same happens with homework, many clients tell you they did it "mentally," but in the end, you realize they lack the commitment to do it. It is up to the therapist to be insistent and do the necessary follow-up. Therefore, the initial client form is usually given to clients to take home for homework, and time is dedicated to revise and reinforce in a positive way the importance of doing homework after each session.

## Research

In May 1961 the Psychological Research Center of the University of Costa Rica was founded. This center plays an important role in the field of psychology, contributing to the development of social and human science in Costa Rica and in Latin America. "Currently, the Institute of Psychological Research (IIP) is an academic unit of the Faculty of Social Sciences attached to the Vice-Rectory for Research. Its fundamental mission is to dedicate itself to do systematic research in the field of Psychology. It seeks thus the systematized construction of scientific knowledge about the national reality of Costa Rica, in an interdisciplinary relationship with the social sciences."

However, most of the research done in Costa Rica takes place at the universities as part of the thesis or graduation research project in order to obtain their "licentiate" or master's degree. There are non-doctoral programs in psychology in this country. According to seven of the oldest and largest university libraries' databases, eighty-two research papers have been done for graduate theses in CBT: seventeen of them in REBT and sixty-five in some form of CBT. Some of the research topics are related to identifying irrational beliefs or applying manuals or interventions in order to improve coping, social, communication, or emotional skills, improving self-esteem and adherence to medical treatments. There is a wide range of populations included in these research papers such as people with depression, anxiety, chronic pain, menopause, domestic violence, erectile dysfunction, addictions, effectivity of treatment of depression, chronic pain management, anxiety, homosexuality, learning disabilities, and physical disabilities, among others.

Some other research has been developed in the psychology schools as part of professors' development requirements or the SINAES accreditation requirements. The budget to fund psychological research is generally limited. To our knowledge, no research has been formally done specifically in CBT or REBT. Some integral research may use CBT or REBT as a theoretical reference, but not as their main focus.

CETREC supported the research thesis paper led by Fabian Agiurgioaei Boie and Alina Boie "REBT and Irrational Beliefs compared to Costa Rican Culture, a cross cultural study" (Agiurgioael et al. 2015) under the direction of Dr. Raymond DiGuiseppe on Irrational Beliefs and the application of REBT in different countries of the world, including Paraguay, Romania, Italy, England, the United States, India,

etc. It was presented at the American Psychological Association Congress in Hawaii 2015 by Stephanie Pirie and other fellow members of the Albert Ellis Institute. The purpose was to have a better understanding of the relationship between culture and irrational beliefs of clients in Costa Rica and the differences with other countries. Before initiating our study, we hypothesized that Costa Ricans would have a high demand of comfort accompanied with frustration intolerance due to the already mentioned cultural values and *pura vida* lifestyle. Results showed our hypothesis to be true, proving that Costa Ricans show a great demand of comfort and therefore high levels of frustration intolerance.

## REBT with Special Populations

In Costa Rica, other than the REBT treatments given at *Clínica de Psicología CETREC*, there are no targeted CBT programs designed for specific populations. Individual efforts have been made by CETREC former students or people that are self-taught or learn CBT as part of a university class and apply CBT to their daily work.

They apply it to a wide range of populations either in their private practice or in the public institutions where they work. Some examples are: CBT applied with different clinical pathology's like depression or panic attacks at Saint Vincent of Paul National Hospital and Mexico National Hospital, addictions or dual pathology at National Institute of Drug dependence (IAFA). Others are working combining REBT with a gender-sensitive approach, to life adverse conditions like domestic violence and sexual abuse. Some REBT therapy groups are running at the university's counseling or high school counseling. REBT is also applied for coping with health conditions like chronic pain, patients recovering from heart attacks, and patients with the human immunodeficiency HIV virus, among others. REBT is also used in different age groups in children that form a part of the autism spectrum, or the elderly populations at the National Geriatric Hospital. These interventions are done mostly using CBT or REBT but sometimes mixed with other psychological technics that do not follow the consistent REBT protocol.

These individual efforts need more training or supervision to improve the quality of the treatment that this population needs. Documenting the work done with special populations and doing more research in this area would also be important in order to be able to have more data.

## Conclusion

The study and practice of psychology in Costa Rica is recent. There is room for growth and development of this science for many years to come. It has been in the last fifteen years that CBT has had its development in Costa Rica, and more and

more professionals in the field seek to learn and put into practice the techniques it has to offer. Behavior therapy had been recognized and practiced by many, but not until recently the cognitive aspect of it was added in CBT protocols. Internet and social media have certainly played a big role in promoting the CBT trend as clients find this treatment online and seek it out. Many referrals come our way through Internet and social media. As the demand for CBT therapies increases in our clients, many professionals in the field in Costa Rica are motivated as well to learn and train themselves in CBT and REBT.

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# Chapter 12
# Cognitive Behavioral Therapy in Egypt


**Reham Aly and Hisham Ramy**

## An Overview of Egypt

Egypt is located in North Africa, bordered by the Mediterranean Sea to the North, the Gaza Strip and Israel to the Northeast, the Red Sea to the East, Sudan to the South, and Libya to the West. Egypt's approximate area is 1001 thousand square kilometers, divided into 27 governorates, with Cairo as the capital (Central Agency for Public Mobilization and Statistics (CAPMS), 2018).

The total population of Egypt according to the Egyptian Central Agency for Statistics is 96, 411,904. With these estimates, Egypt ranks the 13th among the world population and has 7.6 % of the total population in Africa and 1.3% of the total world population. Among the Arab world, Egypt ranks the 1st in the population. Arabic is the official language of Egypt, although English is widely understood (CAPMS, 2018).

Egypt lies within lower middle-income group, and the total annual health expenditure is $151/person. The World Health Organization estimates the burden of mental disorders in Egypt in 2014 to be 2567 disability-adjusted life years (DALYs) per 100,000 populations (Mental Health Atlas country profile, 2014), that is, how many days are "lost" due to sickness/not working. Within Egypt, major depression ranks 7th, anxiety disorders 18th, and drug abuse the 24th among the top 25 causes of DALYs (Institute for Health Metrics and Evaluation, 2010).

Egypt has gone a long way in regulating mental health services. There is a standalone law (law number 71 for the year 2009) for the care of patients with mental illness. The law regulates conditions of voluntary vs. involuntary hospital admission and medication (National Council for Mental health, 2019). Another law regulates psychotherapy provision (law number198 for the year 1956). This law specifies the

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process of training and accreditation for psychotherapists (AIMS Report on Mental Health System in Egypt, 2006).

Mental health services in Egypt include both governmental and nongovernmental facilities. Governmental mental health facilities include 18 mental hospitals and 7 psychiatric units in general hospitals. Current estimates indicate an approximate of 8 mental health services professionals per 100,000 citizens (Mental Health Atlas country profile, 2014).

An Egyptian national survey identifies prevalence of mental disorders to be 16.9%. Most common disorders were depression (6.43%) and anxiety disorders (4.75%), while the least common were alcohol dependence/abuse and adjustment disorder. Estimates indicate that women had significantly higher odds of having a mental disorder than males (Ghanem, et al., 2009).

## History of Psychotherapy in Egypt

History points out that Egyptians formed psychological–philosophical ideas about phenomena such as delusions, dreams, epilepsy, and hysteria and how to treat some mental–physical abnormalities (Girges, 1967). In modern days, the development of psychotherapy in Egypt paralleled the development of clinical psychology. In 1922, and in an attempt to develop the system of education and training, the Egyptian government invited Edouard Claparéde, a Swiss neurologist, child psychologist, and educator, to visit Egypt to modernize the graduate education and training of psychology. Accordingly, nominated Egyptian academics were sent abroad to gain further knowledge and training in the topic (Soueif, & Ahmed, 2001). Among those academics were Mostafa Soueif (assigned to study in the United Kingdom) and Moustafa Radwan Zewar (assigned to study in France). Both of them were to have a significant influence on the development of psychology and psychotherapy in Egypt afterward (Ahmed, 2004).

Moustafa Radwan Zewar (1907–1990) graduated from the Faculty of Arts in 1929 among the first batch from the Egyptian University. Upon his graduation, the young scholar was nominated by the highly celebrated dean of Arabic literature, University President, and novelist Taha Hussein to a scholarship in France for postgraduate literature studies. In 1930, Zewar travelled to France where he was immediately drawn to the study and practice of psychoanalysis. In order to pursue his passion in studying psychoanalysis, Zewar had to study medicine, which was a requirement for most psychoanalysis institutes then. Years later, he graduated the diploma of psychoanalysis in 1939 as well as Medical Degree (MD) in 1941 from the University of Lyon (Elshakry, 2017). The French-trained Egyptian psychoanalyst returned to Egypt in the 1942 to lay the foundations for diverse psychology disciplines and introduce Freudian Psychoanalytic techniques to the country (Ahmed, 2004).

Shortly after Zewar had returned from France, Moustafa Soueif, a younger colleague, was granted a scholarship to study psychology in the United Kingdom

(Soueif, 1988). Upon his return to Egypt in 1942, Soueif established the department of psychology in the University of Cairo and chaired the department from 1973 to 1984. He designed the undergraduate curriculum with a special emphasis on cognitive sciences and modern psychological theories (Ahmed, 2002).

The general view of psychotherapy in Egypt points clearly that Zewar and Soueif directly guided the psychology and thus the psychotherapy undergraduate education. Yet the case was different for doctors in psychiatry residency programs. Traditionally, psychiatrists were trained with a psychoanalytic perspective and therefore conceptualized mental health symptoms with Freudian explanations (Taha et al., 2003). However, the orthodox psychoanalysis is seldom practiced in Egypt nowadays. Many techniques and adaptations to psychoanalysis original theories and practices have occurred that integrate psychodynamic techniques with object relations, existential, Gestalt, and religio-cultural concepts into a new hybrid therapy program (Taha et al., 2010).

## Laws and Regulations of Practicing Psychotherapy in Egypt

Egyptian mental health law 71 of 2009 protects the patients' rights and lays the standards of hospitalization and treatment. This law addresses doctors providing mental health services (Court of Cassation, 2017). While this law outlines doctor provision of services, it is distinct from the legalization of psychotherapy provision. Law number 198 for the year 1956 regulates the practice of psychotherapy. The law mandates a valid license to engage in the professional practice of psychotherapy in Egypt. In addition to a postgraduate study in medicine or psychology (e.g., diploma, MA, MSc, and/or PhD), eligible candidates must also have a period of two-year duration of supervised training and a current membership in a recognized association in the field. Candidates then apply for the Ministry of Health and sit a licensing exam directed by an assigned Psychotherapy Licensing Committee (Ahmed, 2004).

By law, the Ministry of Health nominates a Psychotherapy Licensing Committee which consists of eight members of different sectors of the mental health services: a deputy of the Minister of Health, a representative of the Higher Council, two professors of neurology/psychiatry or internal medicine, and four professionals from the field. The law does specify that nonmedical professionals providing psychotherapy are prohibited to treat or medicate psychiatric patients and are clearly required to work supervised and guided by a psychiatrist.

Unfortunately, in the absence of a structured validated postgraduate psychotherapy training program in Egypt, very few professionals were eligible to apply for the practicing license. For example, in the late 1980s, only seven licensed psychotherapists were documented to operate (Abou-Hatab, 1997). To circumvent these challenges, some psychologists have instead opted to work under the license of a psychiatrist or open private practices as "educational training centers" under the regulation of other government ministries (Meleika, 1997).

## Professional and Cognitive Behavior Therapy Organizations

Institutes and associations of psychotherapy provide specific theoretical knowledge and clinical practice for practitioners who wish to pursue advanced training in psychotherapy. This type of education and training is different from academic graduate degrees. Below is a brief summary of some of the major organizations within Egypt that have guided and influenced the practice of psychotherapy and CBT.

## The Egyptian Association of Psychotherapists

The Egyptian Association of Psychotherapists, founded on 2012, provides training courses that focus on themes of psychological assessment (e.g., intelligence tests) and psychotherapy. These courses has a clear orientation to cognitive and behavior therapy techniques. All courses are delivered in Arabic. This focus in training is a direct reflection of the practical needs of the workload that most practitioners face in clinical practice. The association training activities target psychologists, social workers, and other professionals, with no psychiatrists' participation (Egyptian Association of Psychotherapists, 2017).

## The Egyptian Association of Cognitive Behavior Therapy (EACBT)

There is only one association in Egypt dedicated specifically for CBT: the Egyptian Association of Cognitive Behavior Therapy (EACBT). The association was established as a direct reflection to the general need for a standardized system for delivering CBT training and practice. The EACBT was founded by the author (RA) of this chapter in 2013. Efforts in the establishment of the organization were complemented by a prestigious assembly of Egyptian professors of psychiatry, young psychiatrists, psychologists, and mental health professionals. The early contributors to and leaders of this association included Prof. Ramy, H. (the former Secretary General of Mental Health in Egypt) and Prof. Ahmed Okasha (the founder of modern psychiatry in Egypt). The list of founding members extended to include some of the imminent professionals in the field, all with special dedication to CBT.

The leadership then took steps to pursue its goals in disseminating CBT across Egypt and providing a structured training route to teach and practice CBT for Egyptian practitioners. The EACBT has always been dedicated to science, ethics, and productivity. The association has successfully extended a wide network of collaborations and affiliations through participating at the international CBT community conferences. In 2018, the membership in the EACBT is around 1200 psychiatrists, psychologists, and social workers and is the only organization in

Egypt that offers its membership to all those professional disciplines. EACBT members are Egyptians, although some honorary fellows are awarded the fellowship of the association in recognition to their continuous support and contribution to the association in its early days (Egyptian Association of CBT, 2017).

The EACBT organizes an annual national congress of CBT (2014–2018). These congresses have attracted many of the worldwide known professionals in CBT to participate as well as provide an opportunity for Egyptian and Arab professionals to present their research. The EACBT annual conferences had a positive effect on the image of cognitive behavior therapy among the public and the government. Besides the annual conference of the EACBT, other major activities include lectures and symposia held occasionally on topics related to cognitive behavior therapy or allied disciplines. Recently, EACBT recognized and certified therapists join an online network to locate them all around the country (Egyptian Association of CBT, 2017).

## Training Opportunities in CBT

Egypt has 27 state, 4 nongovernmental, 20 private universities, and 12 academic institutes. Psychotherapy is taught in undergraduate psychology curriculum, faculty of arts (both bachelor's degree and graduate studies), and for medical postgraduate studies (MSc and PhD programs) (Supreme Council of Universities, 2017).

## Undergraduate Education

Only 12 Egyptian governmental universities offer bachelors, masters, and doctoral degrees in psychology. Curricular courses on psychotherapy tend to emphasize theory rather than research and practice. These courses are relatively general and basic (Soliman & Ibrahim, 1998). Undergraduate psychology programs cover areas such as cognitive, learning, personality, pathology, assessment, clinical, and counseling (Abdel-Fattah, 1999). Despite the previously mentioned psychoanalytic and cognitive–behavioral inclination of the two psychology departments in Faculty of Arts (University of Ain-Shams and Cairo), no specific course on cognitive behavior therapy is included in any of the undergraduate level studies in either.

## Graduate Education and Training

For all mental health professionals in Egypt, further training in psychotherapy can be pursued through the master's and the doctoral programs. For psychology graduates pursuing further training, a diploma in applied psychology is mandated initially. These diplomas are considered to be professional rather than academic

degrees. Nevertheless, the emphasis of this training program is mainly psychological assessment (Abou-Hatab, 1997).

Upon successful completion of the diploma, the psychology graduate gains admission to master's (MA) or doctoral (PhD) programs. Successful completion of MA or PhD includes a thesis (study design) to be submitted. The MA and PhD programs might take 2–4 and 3–6 years to complete, respectively (Ahmed, 2004).

Candidates who wish to pursue further specific training on cognitive behavior therapy can now agree (in cooperation with their supervisors) to work on a relevant subject as part of their thesis. In addition to theses conducted through postgraduate studies offered by state and private universities, there are other centers that provide an opportunity to conduct research and studies (Ahmed & Amer, 2013).

For psychiatrists, medical schools have offered a diploma of neuropsychiatry for more than 60 years, a master's degree in psychiatry (MSc) for the past 25 years, and a doctorate (PhD) for the past 20 years. Residency and postgraduate training years are typically spent at psychiatric hospitals, where junior psychiatrists develop competencies in medication management and, depending on the focus and expertise of their supervisors, learn counseling and psychotherapy skills (Okasha, 2004). As with postgraduate studies for psychology graduates, psychiatrists who seek further training in psychotherapy or CBT specifically, the thesis of the master's or the PhD is their only option. The choice of such topics is generally guided by the supervising department orientation and occasionally by individual preferences.

## Extracurricular Education and Training

While continuous education through conferences and workshops is important to Egyptian psychotherapists seeking further training in CBT, the limited budget and funding for such activities as well as language barriers influence the number of Egyptian psychotherapists who attend international and regional conferences and workshops (Ahmed, 2004). Accordingly, and in response to the absence of systematic counseling and psychotherapy skills training at educational institutions, many universities, private clinics, and professional associations arrange for workshops and training courses. These may be conducted by a visiting psychotherapy "masters" from other countries, particularly from the United States (US) and the United Kingdom or by a local professional (Amer, & Jalal, 2012).

## The Cognitive Behavior Therapist Certificate

The *Cognitive Behavioral Therapist Certificate* program was initiated in 2016 and was organized and supervised by the Egyptian Association of Cognitive Behavior Therapy. The program provides a postgraduate quality systematized training

approach that considers international standards of cognitive behavior therapy training for graduates of medicine, psychiatrists, psychologists, social workers, occupational therapists, educational staff, and counselors. The program provides practical skills training and emphasizes trainees' knowledge of CBT theory, techniques, and research. It is a two-year program that incorporates direct teaching, supervision of a minimum of eight cases and a case write-up, and an audiotape of a session successful completion of which makes candidates eligible for the certificate as a cognitive behavioral-accredited therapist (Egyptian Association of Cognitive Behavior Therapy, 2017).

## CBT with Specific Clinical Populations

The review of Egyptian CBT research described later in this chapter highlights a number of clinical areas often examined through the application of CBT. This section will briefly describe the status of clinical issues identified in Egypt and the role of CBT.

### *Anxiety Disorders*

Studies of psychiatric morbidity among university students in Egypt showed that anxiety is prevalent in 36% of the study sample with approximately 22.6% of diagnoses made in a psychiatric outpatient clinic in a selective Egyptian sample (Okasha, 2004). Studies examining effectiveness of CBT in treating anxiety disorders in Egypt are particularly significant in demonstrating transportability of CBT. Several studies provide data indicating that cognitively oriented therapy resulted in the reduction of anxiety symptoms among a sample of Egyptian population (Ahmed et al., 2008; Eldok et al. 2011; Elmoktry et al., 2005; Ismaeil et al., 2016; Mahmoud et al., 2015; Soliman et al., 2011).

Recently, modern technology was introduced as an alternative route for delivering CBT for 40 patients with a variety of anxiety disorders (Aly, et al., 2010). A randomized controlled study (RCT) compared participants receiving CBT therapy program as usual with a group who received CBT therapy assisted by the computer and Internet communication. Both approaches were found to be effective, and the introduction of technology in the application of CBT may be effective in disseminating CBT to more individuals.

### *Addiction*

Egypt's growing addiction problem is reflected in a study of 44,000 subjects that concluded that the lifetime prevalence of any substance dependence in Egypt varies between 7.25% and 14.5%. The authors posit that the true population prevalence is probably higher due to underreporting (Hamdi et al., 2013).

National research has shown the effectiveness of CBT in Egypt on coping with craving (Elgamil et al., 2010), in the management of relapsed addicts using both CBT augmented by environmental changes (Hany et al., 2006), with clients with comorbid ADHD and addictions (Helal & Dewedar, 2016), as well as in the management of substance use disorders and addiction in Egypt (Abdelsamie et al., 2017; Abdelrahman et al., 2017).

### *Depression*

The comorbidity of depression with other disorders whether psychiatric or medical disorders has often been the focus of research and attention in Egypt. Foud and colleagues examined the effectiveness of CBT in the treatment of depression symptoms among patients suffering from depression comorbid with hepatitis C and concluded a positive outcome in management of those patients using CBT program (Fouad et al., 2012). Another study provided CBT for patients suffering from depression and diagnosed with malignancy and further supported the application of CBT in management of depression in patients with cancer (Abdelhalim et al., 2016).

## Provision and Adaptation of CBT in Egypt

Currently, the number of licensed nonmedical psychotherapists in Egypt is 282 (Ministry of Health, 2018), and as a result, cognitive behavior therapies remain inaccessible for the majority of Egyptian patients. The availability is further hindered by the fact that to engage in the professional practice of psychotherapy in Egypt, a doctorate of psychology is required in addition to a license. Yet only one of psychology department (Cairo University) places a major emphasis on cognitive therapy in their curriculum while no psychiatry residency programs provide such training (Ahmed & Amer, 2013). The provision of CBT in Egypt may be further impacted by Egyptian patients' attitude and preferences for treatment with pharmacotherapy being the most preferred therapy. Further, with the burden of limited and under-resourced mental health services, the language barrier between the Western therapy and psychotherapy providers (especially nonmedical) and the cultural differences between the Western world and Egypt may impact the utility of CBT in Egypt (Falah et al., 2011).

While CBT has been endorsed as a culturally adaptable form of psychotherapy and its efficacy in adult populations has been explored in culturally diverse and non-Western settings (Rathod et al., 2010), there still remains the issue that very little has been written on how the approach should be adapted when working with clients who do not necessarily share the values and beliefs that dominate in North America and Europe.

Collectivist cultures, like Egypt, emphasize duty and relationships to others (Markus & Kitayama, 1991), and it would be important to consider these variables in efforts to deliver CBT in Egypt. As core beliefs are the products of temperament and environment (Padesky, 1994), it stands to reason that culture would influence their development as would warrant consideration. Further support to the multicultural applicability of CBT requires a strong body of evidence in local settings and clear recommendations if required to maintain the international rates of effectiveness.

## Research on CBT in Egypt

Of the 141 psychotherapy studies (case-based research, cohort studies, and randomized controlled trials) in Egypt identified between 1988 and 2017 through the Egyptian Universities Libraries Consortium, 118 studies (83.6%) focused on cognitive behavior therapy. Of the total 118 studies of CBT, 47 studies (39.8%) focused on CBT with children and adolescents while 67 studies (56.7%) examined CBT with adults. The remaining 4 publications were review of current status of theory and practice considering international and local settings. The majority of studies of CBT in adults in Egypt focused on anxiety disorders (31.3%), addiction (17.9%), depression (10.44%), psychosis (9%), and aggression (6%). Among the children and adolescents CBT studies, anxiety disorders (27.6%) were the most researched, followed by aggression and disruptive behavior (25.5%), depression (10.6%), ADHD (8.5%), autistic disorders (6.3%), addiction and smoking (6.3%), and eating disorders (4.2%) (Egyptian Universities Libraries Consortium, 2018).

An additional thirty relevant CBT studies were identified from the electronic literature search on the Egyptian Knowledge Bank *(www.ekb.eg/)* and were published in local journals in Arabic with eleven out of thirty published studies were CBT for children and adolescents and 19 were focused on CBT for adults (Egyptian Knowledge Bank, 2018).

A search through PubMed yielded only three studies. This might be due to the fact that international databases as PubMed does not take into account numerous articles published in languages other than English. Therefore, local research activity in Egypt (being mostly in Arabic) is not internationally visible. A detailed review of these studies detects the majority of researchers have applied a modified CBT program. As such, this may reflect the importance of cultural adaptation of cognitive behavioral therapy programs to the Egyptian culture.

## CBT with Special Populations

### *Cognitive Behavior Therapy with Children and Adolescents in Egypt*

The estimated prevalence of psychiatric disorders in a sample of Egyptian children concluded some varying levels of probable psychiatric diagnoses: any psychiatric diagnosis (8.5%), emotional disorder (2%), conduct disorder (6.6%), and ADHD (0.7%) (Abdelhamid et al., 2009). However, the general public does not favor the inclusion of disorders of children and adolescents within the province of psychiatrists (Okasha, 2004), hence the importance of cognitive behavioral psychotherapeutic interventions for children and adolescents. Advantages of using CBT for children and adolescents in Egypt highlighted the fact that CBT is goal oriented and symptom focused and provides the child or adolescent with skills and techniques to master their difficulties (Gendy et al., 2016).

The research on the efficacy of CBT for management of different psychiatric disorders in children and adolescents has shown that CBT is at least as effective as fluoxetine in treatment of childhood and adolescent depression (Haikal et al., 2008) and in reduction of aggressive, disruptive, and oppositional behavior (Elagha et al., 2016; Morsy et al., 2015), is effective in relapse prevention for adolescents with anxiety comorbid with addiction (Hegazy et al., 2016), and increases the attention span and improves executive skills, as well as decreasing disruptive behavior and aggression for students diagnosed with ADHD (Abdelfattah et al., 2010; Hendy et al., 2017). The work on children with CBT has also been expanded to parents (Salama, et al. 2017) and has been shown to enhance parenting skills for parents of children diagnosed with autism.

### *CBT for Patients with Medical Conditions (you can remove this section)*

CBT studies in Egypt has been shown to be as equally effective as the medication in treating irritable bowel syndrome (Heissam & Sobhy, 2003), reduced negative affect, and improved coping strategies for clients with tinnitus and hyperacusis (Salama, et al. 2011), in the treatment of depressive disorders in patients with chronic hepatitis (Fouad, et al., 2012), and in treatment of social anxiety among patients with hepatitis C using Rational Emotive Behavior Therapy (Mohamed, et al. 2017). The work of CBT with medical disorders has also been extended to children diagnosed with diabetes mellitus (Elareishy et al., 2017). A CBT program modified for children that targeted depression showed a positive outcome and a helpful extension of CBT to this population.

### *CBT with Elderly Adults*

An important clinical area that may be relatively under-examined is the application of CBT with elderly adults. While non-pharmacological treatments (cognitive behavioral therapy for insomnia; CBT-I) have been shown to be highly effective in the treatment of insomnia in all age groups, it hasn't been regularly adapted cross-culturally. Recently, ElGahsh and Mohsen (2016) examined the effect of cognitive behavioral therapy on quality of sleep pattern among Egyptian elderly people with insomnia and reported significant improvement after application of the therapy program which was maintained on the follow-up duration. Further research on the adaptation of CBT approaches with an elderly population in Egypt is warranted.

### *CBT with Criminal Offenders*

A modified program based on CBT for behavior modification of sexual offenders (sexual voyeurism) was studied in different locations and correctional facilities in Egypt and proved effective with further studies being recommended (Mekawy & Abou-zaid, 2012). Research has also supported the application of CBT for treatment for anger among incarcerated criminals in Egypt, and the authors recommended that anger management interventions based on CBT should be maintained as an important component of any rehabilitation program for the criminal offenders and in correctional settings (Elgenadi et al., 2014). Some additional support for CBT was shown for juvenile delinquents behavior in correctional institutions (Yossef et al., 2011).

## Conclusion

There has been an increase in the inclusion of psychotherapy theories in the academic curriculum of the undergraduate for psychoanalysis, cognitive sciences, and behavioral theories which has impacted the professional training and application of these approaches within Egypt. However, residency programs for psychiatrists still do not have any structured psychotherapy training embedded in residency training programs. Knowledge and training in CBT can only be pursued in graduate study programs, and as such, training on psychotherapy may be seen to be left to self-directed learning efforts.

Cognitive behavior therapy is an evolving, adaptive approach that is widely used in many different ways to deal with a range of psychological problems in a variety of settings. Unfortunately, no systematized platform for the display of research and studies could be found in Egypt. The local body of research demonstrates that cognitive behavior therapy can be effective in different Egyptian cultural contexts with

a variety of psychological problem. Nevertheless, there are only a small number of internationally published outcomes in Egypt contexts. As such, further research is warranted and greater consideration of what variables from the original CBT models need adaptation in consideration of language and culture.

The effective provision of CBT is only bolstered by adequate training and supervision. Ongoing clinical supervision for service providers should be offered and regulated with clearly defined responsibilities of the clinical supervisors. A good starting point would be to ensure that the training of cognitive therapy should be adequately covered in Egypt psychotherapy training programs, alongside a greater emphasis on evidence-based practice. There are obvious lessons here for how Egypt might increase access to psychological therapy and make better use of the Egyptian workforce.

It is imperative that psychotherapy is relevant to the needs of the country and accessible to all who might benefit. Strategies to address the disparity between need and provision of cognitive behavior therapy are many and are important to develop. An initial step is to review the available national governance. The regulating laws for the practice and provision of psychotherapy and hence cognitive behavior therapy require prompt revision to ensure adequate practice to best assist clients with well-trained individuals. For instance, the current regulations ignore many fundamental variables such as clear standards of practice, tactics to ensure compliance with statutes and regulations, confidentiality and information protection (especially with the emergence of electronic communication and involvement of the Internet and the social media into the practice of psychotherapy), reporting obligations, competence for provision of psychotherapy and maintaining competence, professional boundaries and conflict of interest, avoidance of exploitation, sexual relations with clients, sexual harassment, and other forms of harassment. Another important issue is the representation of services including accuracy of public statements, presentation of qualifications, promotion of professional practice, and eventually methods for provision of information to the public. Consideration of these variables from a governance perspective combined with the adaptation of CBT for use in practice and the ongoing development of research to guide practice will only further serve to enhance the profession of psychotherapy and benefit the people of Egypt.

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# Chapter 13
# Cognitive Behavioral Therapy in Germany


**Jürgen Tripp, Walter Ströhm, and Ulrich Schweiger**

## Overview of Germany

Germany is a middle-European country with nearly 83 million inhabitants (Zensus, 2011). It consists of 16 constituent states, and its political system is a federal parliamentary republic. It is a highly industrialized country, which, like many other developed Western countries, has seen over the last few decades a transition in the economy from traditional industry production to trades and services and more recently toward digitalization. After the reunification of the "both Germanys," the Federal Republic of Germany and the German Democratic Republic in 1990, the process of bringing together the country and adjusting standards of life all over Germany is still ongoing, with a higher degree of unemployment, lower wages, and a decreasing population in rural areas in the eastern part of Germany (Central Intelligence Agency, 2019).

In the last few years, immigration and its consequences have had a significant influence on German society and politics (OSED, 2020). As a consequence of the civil wars in Syria and Libya, the fight against the Islamic state and other terrorist organizations in several countries, and economic and political problems in African and near eastern countries, a considerable number of refugees tried to find asylum in European countries. In 2015, a peak number of about one million refugees reached Germany (OSED, 2020). This presented a challenging situation as the

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asylum and help system in Germany was at that moment not prepared for so many refugees. As a result, there was considerable solidarity and humanity toward refugees in the German population, but also, this led to a rise of a right-wing political movement and assaults on refugee housings. For the mental health system, this also led to a challenge, being faced with many people suffering from war trauma and other psychological problems related to immigration and relocation.

## History of Psychotherapy in Germany

Psychotherapy has several different roots in Germany that will be briefly outlined below. A complete review of the history of psychotherapy in Germany is beyond the scope of this chapter. For a more detailed description, the reader is referred to Fiedler (2010), Brückner (2010), and Margraf (2009).

Wilhelm Wundt (1832–1920) is regarded as the founder of modern psychology in Germany (Carlson & Heth, 2010). He founded the first psychological laboratory and the first academic institute for psychology in 1879 in Leipzig. Although he was not a psychotherapist or psychiatrist himself, his influence as a teacher is quite notable on many important early figures in psychiatry and psychotherapy like Lightner Witmer (the founder of the first psychological clinic in the United States) or Emil Kraepelin who brought methods of empirical psychology into psychiatry and formed the basis for modern classification of psychiatric disorders (Engstrom, 2007). In Munich, Kraepelin founded a research institute for psychiatry in 1917 which turned later into the Max Planck Institute for Psychiatry, one of the places where later behavior therapy has first been promoted in Germany (Fiedler, 2010).

Psychiatrists in Germany began to focus in the late nineteenth and early twentieth century mainly on severe disorders like psychosis or dementia and biological concepts and explanations for these disorders. In the context of growing nationalism and popular ideological social Darwinist theories at the beginning of the twentieth century, these concepts together with misunderstood theories about heredity began to influence psychiatry in Germany. These factors contributed to the practice of euthanasia in German psychiatry during the Third Reich with almost 300,000 psychiatry patients being murdered, as they were regarded as "degenerated" and not worthy of living (Brückner, 2010).

From outside of classical clinical psychiatry, psychoanalysis emerged first in Austria and Switzerland with Sigmund Freud, Carl Gustav Jung, and Alfred Adler as the first masterminds. As they were speaking and publishing in German, psychoanalysis quickly gained interest in Germany. When the national socialists gained power in 1933, psychoanalysis was seen as a "Jewish science" and as deformed literature, and the books of Freud were publicly burned.

In order to escape the Nazi prosecution because of their Jewish descent or political positions, a lot of Austrian and German influential psychoanalyst and psychotherapists like Freud, Adler, Erich Fromm, Wilhelm Reich, Otto Fenichel, Max Eitingon, and many others emigrated and later died in exile or didn't return to

Germany after the war. As such, this led to a substantial gap in the history of psychotherapy in Germany and Austria during this period.

After the Second World War, the psychoanalysts reconstituted their societies and had debates about the role of the psychoanalysts who stayed during the Third Reich and debates among the different theoretical branches of psychiatry. Psychoanalysis regained popularity among physicians after the Second World War. The field of psychosomatics (which was predominantly psychodynamically oriented) emerged and got popular as a contrast to the more biologically oriented psychiatry. In the 1960s and 1970s, mainly nonmedical professional groups like psychologists, social workers, and pedagogues began to engage themselves in the area of psychotherapy. Especially among child psychotherapists with a training in education, psychoanalysis remained popular, but new psychotherapy approaches like client-centered psychotherapy, gestalt therapy, systemic approaches, and behavior therapy began to gain interest among the nonmedical psychotherapists (Fiedler, 2010).

An early center of behavior therapy in Germany was the Max Planck Institute of Psychiatry in Munich, where Johannes Brengelmann worked since 1967. He worked with Hans Eysenck in England and the United States before he became head of the psychological department of the Max Planck Institute of Psychiatry. He was one of the founders of the Association for the Advancement of Behavior Therapy in 1968 (GVT; Gesellschaft zur Förderung der Verhaltenstherapie) and the first president of the European Association of Behavior Therapy (EABT). Many influential teachers in clinical psychology and behavior therapy started their career as co-workers or students of Brengelmann in Munich. Another early center of behavior therapy was the University of Münster where Lilly Kemmler taught many future proponents of behavior therapy and where Fred Kanfer, a pioneer in the behavior therapy movement, held a guest lecture in 1970. As more and more professor positions in clinical psychology were obtained by behaviorally oriented psychologists, the first universities began to establish psychological treatment centers where behavior therapy treatment and research was conducted (Fiedler, 2010; Margraf, 2009).

At more and more of the psychological institutes of the universities, the students in clinical psychology were trained in CBT or client-centered psychotherapy, and the psychotherapy associations began to conduct training for psychologists who were already working. As a result, the seeds of behavior therapy and cognitive behavior therapy were beginning to develop.

In 1967, psychoanalytic therapy and a particular version of a more focused psychodynamic therapy ("Tiefenpsychologie") became acknowledged by the German public health insurance, and treatments costs were allowed where paid if a medical psychotherapist conducted the treatment. Moreover, in 1980, behavior therapy got accepted as a treatment approach in the public health system. However, it became immediately obvious that there were not enough qualified physicians to conduct psychotherapy. As a result, psychologists became allowed to conduct psychotherapy as delegates of a physician, who was officially in charge of the treatment. That meant that psychologists could get paid by the public health insurance system for treating patients in their private practice, but they had to coordinate care with a physician on whom they were more or less dependent. A consequence of this was a split

in two "camps" of psychotherapy associations. While a lot of psychologists and their associations were against the option to treat patients only when commissioned by a physician, because they wanted to treat their patients independently, other associations accepted the rules of this system and oriented their training to fulfill the conditions. This split also led to a division among the behavior therapists in the different associations.

Therefore, since the 1970s, there has been a continued political debate about the psychotherapist's law, which regulates the professional work of nonmedical psychotherapists. After a first approach to get a law had failed in 1978, there was no progress for some time in the development of regulations. It was not until after numerous activities of the psychotherapy associations and protest demonstrations in 1998 that the German government developed a psychotherapist law.

Through this law, psychologists could get a license *("Approbation")* as a psychological psychotherapist, and social workers, pedagogues, and also psychologists could get a license as a child and adolescent psychotherapists. In addition to having the necessary degree, these professional titles require a minimum 3-year full-time psychotherapy training. With the *Approbation*, psychologists were allowed to treat patients independently and to apply for accreditation as a care provider to get treatment costs covered by the public health insurance system.

In addition to the psychotherapist law, federal psychotherapist chambers were erected, in which membership is obligatory for every licensed psychological psychotherapist and child and adolescent psychotherapist. As a result, since 1999, psychotherapy and psychotherapists as a professional group became better represented in the German health system, and patients could get easier access to psychotherapy.

Under the conditions of the new law, the training and practice of CBT have flourished in Germany. Many training institutes were build up, and the majority of the professor positions in clinical psychology were obtained by researchers who are CBT-oriented. In combination with the restriction for adult psychotherapy training to only be eligible for psychologists, this led to a predominance of CBT in training and the profession in general and more orientation on quantitative research methods, evaluation, and evidence-based therapies in the whole field. However, this trend toward a greater focus on CBT has also been criticized for impeding diversity in psychotherapy. Other orientations than CBT claim that they lose more and have less of an opportunity to get research conducted on their approach, and therefore, they have fewer chances to prove their evidence base.

## Current Regulations Regarding Psychotherapy Provision

In 2016, there were 41,657 psychological psychotherapists and child and adolescent psychotherapists registered in Germany. About 80% of them were working in outpatient care and 17% in centers for inpatient treatment (e.g., psychiatric, psychosomatic, or rehabilitation centers or wards) (Gesundheitsberichterstattung des Bundes,

2016a). In the medical specialties with a scope of psychotherapy, there where 12,052 psychiatrists, 5183 physicians with a specialization in psychosomatics and psychotherapy, and 2746 with a specialization in child and adolescent psychiatry and psychotherapy (Gesundheitsberichterstattung des Bundes, 2016b). Another 18,490 physicians qualify in psychotherapy besides another specialization (e.g., gynecology, internal medicine, orthopedics), which requires less training in psychotherapy than the main specializations in psychiatry or psychosomatics (Gesundheitsberichterstattung des Bundes, 2016c).

About 85% of the adult German population are insured within the public health insurance system. As such, they have the opportunity to consult a physician or a psychotherapist who is accredited as a care provider in the system. The other 15% are either insured by private health insurances or are covered mainly by the state as public officers. These persons may consult physicians or psychotherapists who are accredited care providers but also licensed doctors or therapists who are not accredited. In 2017, 25,297 psychological psychotherapist and child and adolescent psychotherapists and 6121 physicians specialized in psychotherapy were accredited as care providers in the public health system (KBV, 2017).

Patients who seek outpatient treatment in the public health system can contact an accredited therapist and then initially receive 1–3 sessions of counseling to assess the need for psychotherapy or other/additional needs for help. If psychotherapy is probably indicated, then another 2–4 sessions for therapy planning can be taken, and then the patient can apply for a therapy to be paid for by his/her health insurance. This therapy can start as a short-term therapy with 24 treatment sessions or as a long-term therapy for up to 60 sessions. If this amount of therapy provided is not sufficient to reach the treatment goals, an additional contingent of 20 sessions (for CBT) can be requested. In psychodynamic therapy, the therapy can be approved up to 100 sessions and in psychoanalysis up to 300 sessions. To apply for a contingent of therapy sessions (at least for more extended therapies), the therapist has to write a report with a case formulation and a description of therapy goals and a therapy plan. A reviewer (senior psychotherapist) gives a recommendation of the takeover of the costs on the basis of this application.

While in comparison with many other countries the access to psychotherapy in Germany is quite easy for the majority of the population and the length of the psychotherapy can be quite long if needed, there are some problems in the provision of outpatient treatment. Patients and therapists complain about long waiting times to get a therapy appointment at the practice of an accredited therapist. Depending on the region average, waiting times from 3 to 7 months or more were reported (BPtK, 2018). There are several potential explanations for this. First, a major epidemiological study tells us that about one-third of the German population suffer from a diagnosable mental disorder (Jacobi et al., 2014). Although this number seems to stay constant through the last 20 years, this number was and still is far more than could be treated with the given resources. What has changed is probably not the incidence of mental health issues but rather the demand for psychotherapy. With the de-stigmatization of mental health and the better conditions for psychotherapy, more and more people request and seek out psychotherapy.

Another trend in the last few years that may impact in the prolonged wait times for therapy service provision is the fact that psychological disorders have gained more and more prominent positions in the research about the causes for people taking sick leave and early retirement (BPtK, 2013; BPtK, 2015). This change was interpreted as a sign for more distress and insecurity in the working environment, resulting in increased numbers of stress-associated problems and disorders. So this might also contribute to the growing demand for psychotherapy but eventually could also reflect the effect of de-stigmatization of psychological causes for work-related health problems. However, many people with a need for psychotherapy still don't get a professional treatment that corresponds to best treatment guidelines and receive a "medication only" treatment or no treatment at all (Jacobi et al., 2014; Sachverständigenrat zur Begutachtung der Entwicklung im Gesundheitswesen, 2018). The health insurance companies claim that they already pay a lot for psychotherapy and that it is just unfairly distributed and that psychotherapists are not working enough, therapies are too long, and psychotherapists treat too many cases with minor problems instead of the severe patients. The German psychotherapy chambers and associations strictly reject this critique.

## Professional and Cognitive Behavioral Therapy Organizations

In 1976, the aforementioned first German behavior therapy association GVT combined with another association of behavior therapy professionals (DBV, Deutscher Berufsverband für Verhaltenstherapie) and formed the German Society for Behavior Therapy (DGVT; Deutsche Gesellschaft für Verhaltenstherapie). At present, this is the biggest German CBT association with more than 8000 members and a training academy with 19 training centers all over Germany.

Some years later, the professional association for clinical behavior therapy (FKV) was founded as an association of CBT therapists who were active in private training institutes and accepted cooperation with physicians to become established in the health system. This association later united with the German Academy for Behavior Therapy in 1992 and formed the German Professional Association for Behavior Therapy (DVT; Deutscher Fachverband für Verhaltenstherapie), which consists of about 900 members and over 30 training institutes for CBT throughout the country.

A third German CBT association, the German branch of the AVM (Arbeitsgemeinschaft für Verhaltensmodifikation (Working Group for Behavior Modification)) was founded in 1991 with a theoretical foundation in Kanfer's self-management approach. The AVM existed previously in Austria and Switzerland and is mainly active in southern Germany, where it has eight training centers in several cities.

Regarding theoretical orientation toward psychotherapy or CBT, the three German CBT associations have no major difference at present. All of them favor a modern version of CBT which incorporates aspects of the third wave of CBT like

mindfulness, acceptance, metacognition, and working with schemas. The differences between the associations are based more on their history, their organizational structures, and their perspectives on profession politics and health politics. For example, while DVT was mainly in favor of the recently proposed reform of psychotherapy education, the DGVT and AVM where (at least initially) more critical about this. The DGVT, DVT, and AVM are member associations of the EABCT, the umbrella organization for European CBT associations.

Although not a formal CBT organization in the strict sense, "unith" is a collaboration of university-based training institutes for psychotherapy offering CBT training. Unith is closely linked to the special interest group for Clinical Psychology of the German Psychological Association (*Deutsche Gesellschaft für Psychologie, DGPs*) and puts an emphasis on science-informed psychotherapy and a scientific practitioner model.

While in all of the associations mentioned above predominantly psychological psychotherapists and child and adolescent psychotherapists are organized, there is also a German medical association for behavior therapy (*Deutsche Ärztliche Gesellschaft für Verhaltenstherapie, DÄVT*) which organizes the practice for physicians who are engaged in CBT.

Additional training institutions in Germany that provide therapy and training in CBT from a more REBT-type approach may be seen at the Institut fuer Kognitives Management, Stuttgart (kmteam.de), and the Deutsches Institut für Rational-Emotive and Kognitive Verhaltenstherapie (DIREKT e.V.: ret-revt.de).

## Training Opportunities in CBT

Since the introduction of the psychotherapist law in 1999, the structure of psychotherapy training for psychological psychotherapy and child and adolescent psychotherapy is officially defined. The training takes at least three years in full-time practice or 5 years part-time. The first 1½ years (or 1800 h) consist of an internship in psychiatric hospitals or partly in other inpatient treatment facilities or practices. After that, trainees have to do 600 h of therapy under supervision in outpatient treatment centers. This is accompanied by 600 h of theory workshops, 150 h of supervision, and at least 120 h of self-experience/self-reflection in a group setting. For physicians, the way to become a psychotherapist is usually to absolve a specialist training, in the areas psychiatry and psychotherapy, psychosomatic medicine, and psychotherapy or child and adolescent psychiatry and psychotherapy with a duration of at least 5 years. The training in these areas is mainly done in hospitals and is accompanied by workshops, supervision, and self-reflection/self-therapy. For physicians, the amount of psychotherapy training depends on the specialization they chose. If they become psychiatrists, they will be required to complete 120 h of theory workshops, 240 h of therapy under continuing supervision, and at least 150 h of self-experience/self-reflection. If they specialize in psychosomatics and psychotherapy, the requirement is 240 h of theory and 1500 h of supervised therapy. The

rationale for this stems from the psychodynamic tradition in psychosomatics with quite long individual treatments.

The psychotherapist's law of 1998 led to a constant growth in the field of psychotherapy training. Since the late 1990s, almost every university developed a psychotherapy training institute, and a lot of private institutes for psychotherapy training got officially accredited by the state. In 2009, there were 180 institutes officially accredited for psychotherapy training, of which 82 (47%) offered training in CBT. When looking at the number of trainees, 63% of all psychotherapy trainees do training in CBT. This rate goes up to 70% when you consider trainees in psychological psychotherapy (focused mainly on adults) (Strauß et al., 2009). In absolute numbers, the number of graduates in psychotherapy training rose from 598 in 2005 to 2693 in 2017. As a result, we have more than four times more trainees finishing their training than 12 years ago (Siegel, 2013; IMPP, 2017). Moreover, this is only the number for psychological psychotherapists and child and adolescent psychotherapists. In 2017, 507 physicians got their admission in psychiatry in psychotherapy, 138 in psychosomatic medicine, and 155 in child and adolescent psychiatry and psychotherapy.

## Adaptations of CBT in Germany

Since the 1990s, German CBT has developed a focus on disorder-specific therapies. A major factor for this development was the widespread treatment of patients in psychosomatic hospitals that specialized in the treatment of substance abuse, major depression, agoraphobia, post-traumatic stress disorder, eating disorders, and somatoform disorders. The success and high acceptance of these specialized treatment programs was an influential factor for the status of CBT in the German psychotherapy community. These disorder-specific therapies were frequently manualized. There are several German-based publishers that specialize in the development of CBT treatment manuals like Hogrefe (blaue Reihe), Beltz (Therapie-Tools), Kohlhammer, or Pabst.

The German CBT community is also very attentive to the developments in CBT particularly in the United States, Canada, England, and the Netherlands. Many treatment manuals from these countries have been translated into German and have resulted in German special interest groups dedicated to training these specific CBT methods. Notable examples of specific CBT methods that have been well received in Germany include Beck's cognitive therapy, Kanfer's self-management therapy, a Linehan's dialectical behavior therapy, Salkovski's treatment of obsessive-compulsive disorder, McCullough's cognitive behavioral analysis system of psychotherapy, Fairburn's enhanced cognitive therapy for eating disorders, Turk's pain management, Arntz's schema therapy, Hayes acceptance and commitment therapy, Teasdale's mindfulness-based cognitive therapy, and David Barlow's unified protocol.

## Research on CBT in Germany

In Germany, 46 public universities offer courses leading to a master's degree in clinical psychology. In 45 of these institutes, CBT is the dominant paradigm for the treatment of major mental disorders. All these institutions are doing psychotherapy research frequently in cooperation with university psychiatry departments. The "Deutsche Forschungsgemeinschaft," the national research foundation, lists more than 50 major research projects funded since 1999 that can be linked to treatment with CBT. Results are typically published in English language publications, but also in German language journals, four of these are dedicated explicitly to CBT (Verhaltenstherapie, Verhaltenstherapie mit Kindern und Jugendlichen, Verhaltenstherapie und psychosoziale Praxis, Verhaltenstherapie und Verhaltensmedizin).

## CBT with Special Populations

While the research and practice in the application of CBT with all clinical disorders in Germany is fairly exhaustive, we want to highlight a few specific populations and disorders and discuss the role of CBT from a clinical perspective.

To begin, people with substance use disorders can be seen as a special population in the German mental health treatment system. They often can receive low-threshold counseling at special counseling centers for addiction. In the case of severe addiction, they can receive a detoxification treatment in psychiatric hospitals or general hospitals. A treatment model that is unique to Germany is that the addicted patients can get a long-term (2–4 month) inpatient rehabilitation treatment in special addiction rehabilitation hospitals (this is inpatient treatment) that are financed mainly by the German public pension fund (*Deutsche Rentenversicherung*). Although there has been a recent trend toward more day clinics and outpatient treatment in this area, the treatment of addiction is somehow independent of the treatment of other psychological disorders. Most of the psychotherapy for addicted patients is carried out not by an accredited psychotherapist but by social workers with specialized training in addiction therapy. This training could be CBT-based, but it is shorter than the regular psychotherapy training and only focused on addiction.

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# Chapter 14
# Cognitive Behavioral Therapy in Greece


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## Greece: Country Overview

Greeks, or Hellenes (from the ancient Greek toponym *Ellás*), are an ethnic group native to Greece. According to the World Health Organization (WHO), Greece has an estimated total population of approximately 11 million, as measured in 2016 (WHO, 2018). Its population is almost evenly composed by males and females, while there is also an even distribution of the population across all age groups (Hellenic Statistical Authority, 2018) with an estimated three million Greeks living outside of Greece. There has also been a rapid growth of incoming immigrants and refugees, technological advances, and communication exchange of information and economic crises-hardships-challenges that have caused many shifts within the Greek culture the last decade, affecting the society and its people.

## Mental Health Among Greeks

Few epidemiological studies have been conducted with the aim of investigating the prevalence of mental health issues in Greece. In recent years, a survey was conducted (Mavreas et al., 1986) aiming to determine the prevalence of psychiatric disorders in Athens. The prevalence was found to be 16% in the general population with women (22.6%) having a higher prevalence than men (8.6%). Factors that linked to increased prevalence were low levels of education, lack of active employment, and presence of physical illness. Since then, some smaller-scale studies have been conducted regarding specific mental health disorders. Several have been about

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the prevalence of depression in the general population (Madianos & Stefanis, 1992) as well as the elderly (Madianos et al., 1992).

The most encompassing study that investigated the prevalence (past 7 days) of common mental disorders in Greece was conducted recently (Skapinakis et al., 2013). This study surveyed a nationally representative sample and found that 14% of the population (males, 11%; females, 17%) was found to have clinically significant psychiatric morbidity according to the scores on the Clinical Interview Schedule-R. The prevalence (past 7 days) of specific common mental disorders was as follows: generalized anxiety disorder, 4.10% (95% CI: 3.54, 4.65); depression, 2.90% (2.43, 3.37); panic disorder, 1.88% (1.50, 2.26); obsessive-compulsive disorder, 1.69% (1.33, 2.05); all phobias, 2.79% (2.33, 3.26); and mixed anxiety-depression, 2.67% (2.22, 3.12). Harmful alcohol use was reported by 12.69% of the population (11.75, 13.62). Regular smoking was reported by 39.60% of the population (38.22, 40.97) while cannabis use (at least once during the past month) by 2.06% (1.66, 2.46).

When comparing the results to other countries, as reported by a World Mental Health Survey (Kessler et al., 2009), Greece is actually in the middle of the depression spectrum, while it is placed in the middle-high range for anxiety. Additionally, one thing to note is that Greece has one of the lowest rates of suicide due to depression in the world (Chishti et al., 2003). Skapinakis et al. (2013) credit this to sociocultural factors such as social and family support, as well as higher religiosity. On the contrary, social factors that are linked to increased prevalence of common mental disorders include low educational status and unemployment and are thus in accordance with previous literature (Mavreas et al., 1986).

One important piece of information that emerged from the Skapinakis et al. (2013) study is that only ⅓ of people in Greece that have a common mental disorder have sought professional psychological help in the past 12 months. Further studies have investigated the use of mental health services by patients in Greece. Grammatikopoulos et al., (2013) conducted an epidemiological study and found that 73.9% of the participants with a common mental health disorder do not receive any psychological treatment, while 73.3% had not spoken to a mental health professional in the past year. A higher percentage of those are men (54.6%), as compared to women (41.5%). Furthermore, the most common mental health disorder that people sought professional help for was depression (43.7%).

One of the proposed explanations as to why people in Greece do not seek professional treatment for mental health disorders is the prevalence of mental illness *stigma* in the Greek culture (Tzouvara et al., 2016). Given that stigma is connected to mental illness, it also has severe negative consequences not only for the mentally ill but for the next generations of all the blood relatives and the spouse as long as they live. In addition, a recent study (Stylianidis et al., 2017) suggests that because there is poor coordination among services and relatives, the latter become burdened by the care of their loved ones, and thus, the rate of involuntary hospitalization has increased.

Although Greeks are skeptical of psychiatrists, according to a recent New York Times publication in 2017, antipsychotic medication increased by 3500%,

antidepressant medication increased by 1100%, and tranquilizers increased by 1900% in the last 7 years among the Greek population. One explanation is that the hardships of the last decade have taken a heavy toll on the mental health of Greek people, coupled with the fact that there is insurance reimbursement for psychotropic medication but not for psychotherapy.

The current status of the Greek health-care system is going through a reform. Public health insurance companies cover a fraction of the psychotherapy services by a therapist with a license such as a psychologist or psychiatrist, although in many cases, an official referral from a psychiatrist is required. The number of sessions per week and the duration of therapy covered vary significantly. Private health insurance companies, especially foreign insurance companies, may cover a large percentage of the total costs of a course of therapy. Therefore, most clients have to pay for psychotherapy themselves, a situation that clearly limits the accessibility of therapy for financially disadvantaged groups.

Since many people pay out of pocket for mental health care services (i.e., psychotherapy) and since psychotherapy is not duly constituted in Greece (see below), there is no record or it is difficult to estimate how many people actually are in therapy.

## History of Psychotherapy in Greece

The first official movement of psychotherapy to enter Greece in the twentieth century was psychoanalysis. According to Avdi (2011), between the 1930s and 1950s, psychoanalysts had their own practice and became more common. Before this time, individuals with mental illness would consult trustworthy people in their community and/or monasteries. It is documented that in 1964, the first psychiatric hospital was in operation in the island of Corfu.

The Hellenic Psychoanalytical Association was founded in 1948 (http://www.psychoanalysis.gr/index.php/epse) and that initiated psychotherapy in Greece. During that time, the prominent psychoanalyst Andreas Embirikos, along with Princess Marie Bonaparte, created a study group of psychoanalysts that met to discuss new advances.

Later on, there was another psychoanalytic association that was established in 1977 – Greek Association for Psychoanalytic Psychotherapy.

During the 1950s and 1960s, a neurobiological model emerged with Anna Potamianou, psychologist-psychoanalyst, founder of the first Center for Mental Health in 1956, who started applying social psychiatry for the public. In 1958, the application of the psychodynamic-oriented therapy began at the university clinic of AHEPA University General Hospital in Thessaloniki, with many efforts to create group psychotherapy at the Greek public psychiatric hospitals (Dromokaiteio Psychiatric Hospital, Attikon University Hospital, Department of Psychiatry). Furthermore, in the 1950s, “AHEPA” University Hospital was founded in Thessaloniki, which provided psychoanalytic therapy for adults and children. In

1956, the Center of Mental Health and Research was created, while the 1960s saw the founding of the "Aiginiteio" University Hospital in Athens, which started the movement of providing psychotherapy for psychotic patients. In the beginning of the 60s, George and Vaso Vasiliou, a psychiatrist and psychologist team, respectively, founded the Athenian Institute of Anthropos which started the systemic orientation in group and family therapy with training in this approach. In 1963, the Association of Greek Psychologists was established which is the oldest association of psychologist in Europe, and until today, it is the largest psychology association in Greece.

In the 70s and 80s, after the fall of the Greek dictatorship, many changes and developments in the society were created, including in psychotherapy training and an intense criticism for the institutionalized practices and the central role of the psychiatrist (biological) model. During this time also, there were many psychoanalytic- and psychodynamic-oriented books and anti-psychiatry books that were published. There was also an increase in the formation of psychotherapy associations.

In 1974, psychiatrist Giannis Boulougouris, from Athens University, established the Greek Association for Behavioral Research, which later established in 1992 the Institute of Behavioral Research and Therapy. This is elaborated on further below in the section on CBT. In 1978, the initiation of the first psychiatric ward in a general hospital started providing psychotherapy in northern Greece, by psychiatrist Ierodiakonou.

In the public sector, the scandal of the island of Leros started the psychiatric reform. More specifically, this led to the establishment of the day clinic at Eginitio Hospital in Athens as well as the application of milieu therapy at the Psychiatric Hospital Thessaloniki, and other areas of Greece followed, such as in Ioanna, with the psychiatrist Liakos starting the first therapeutic community in the local psychiatric clinic.

In 1980, psychiatrist-psychoanalyst Chartokolis took over as department head at Patras Psychiatric University, whereas psychiatrist-psychoanalyst Sakelariou started the Association for Social Psychiatry and Mental Health and the first moving psychiatric unit in 1981.

In the beginning of the 1980s, there was distinct interest in the treatment of substance abuse disorders with therapeutic communities, with both mental health professionals and former substance abusers working alongside. Starting in 1983, with director psychiatrist Zafiridis, and with government funding, these communities reached a network of 70 units of community therapeutic units, open and closed counseling centers, and prevention units using the method of group therapy, psychotherapy and many experiential methods. Parallel to that was the beginning of the Alcohol Anonymous and Narcotic Anonymous self-help groups. In 1987, psychiatrist Katerina Matsa also initiated a substance abuse program called "18 Ano" which served substance abusers and with a network today of over 32 related structures in Athens.

In 1980, Ioannis Tsengos, psychiatrist, instituted the Open Psychotherapy Center (day clinic) which is a private center with the purpose of dealing with serious psychiatric disorders, using the main method of psychotherapy – community

psychotherapy and group analysis. This same organization initiated the Athens Group Psychoanalysis Institute, which operates a 5-year therapy training program in group analysis. The 80s also marked increased interest in body psychotherapies with psychologist Loubrano-Kotoula who founded the Center for Psychotherapy according to Wilhelm Reich which provides a cycle therapy training in physiological psychotherapy training.

Another landmark movement in psychotherapy which would influence many mental heath professionals was when psychologist Haris Katakis founded the Laboratory for the Study of Human Relations which provides training in systemic orientation, group and family therapy. The same year, psychiatrist Matthew Iosafat founded the Greek Association for Group Analysis and Family Therapy which provides training related to group therapy.

In 1989, psychologist Nizetta Anagnostopoulou founded the Center for Arts and Psychotherapy and in 1994 started a postgraduate program in Creative Psychotherapy. In 2004, the Association for Drama and Play Therapy started providing training. In 1989, Poli and Ioulious Iosifidis's team, psychologist and psychiatrist, respectively, founded the Institute for a Person-Centered (IPC) approach which provides not only person-center trainings but also has established an undergraduate degree program and a master's program in child psychology training and has since changed its name to today – Institution for Counseling and Psychological Studies (ICPS).

What follows in the 1990s is a tendency for psychotherapists trained in one of the above centers to provide their services in the private and public sector with the general public becoming more aware of psychotherapy. Medical University–Eginitio Hospital started a training program in cognitive therapy in 1963, but this would increase dramatically in the 80s through the directorship of psychiatrist Ioannis Papakostas. In the 1990s, psychiatrist Joannis Nestoros and psychologist Panos Asimakis started integrative programs in psychotherapy with the latter founding the Athens Synthesis Center which provides counseling and therapy training and services, currently the Greek Association for Humanistic Integrative Therapeutic Counseling and Psychotherapy (GAHITCP).

In 1994, Lily Anagnostopoulou, psychologist, founded the Athens Greek Center for Biosynthesis which is under the Auspices of the International Center for Biosynthesis. In 1998, psychologists Ioanna Giamarelou, Antonia Konstantinidou Katia Chatzilakou, and Despina Balliou founded the Gestalt Foundation which currently operates in Athens and Thessaloniki.

The Greek National Psychotherapy Association was established in 1998 and constitutes a regular member of the European Association for Psychotherapy, with the purpose of improving the working conditions of the psychotherapy mental health services in Greece through training, development, and improvement of the practice of psychotherapy. At the present moment, there are 12 member psychotherapy associations registered, with 1000 Greek psychotherapists and 349 holders of a European Certificate of Psychotherapy in Greece. There are no Cognitive Behavioral Therapy associations registered with this association.

## Cognitive Behavioral Therapy in Greece

Psychiatrist Giannis Boulougouris initiated the CBT psychotherapy movement with the Greek Association of Behavioral Research (GABR) which he founded in 1974 with its main objectives to promote behavior research, in compliance with learning theories as well as the application and development of behavior therapies.

In 1992, members of the GABR founded the Institute of Behavior Therapy and Research (IBTR), since the foundation of an organized research and education institute was proved imperative within the Greek framework. Among the activities of the IBRT is providing training in cognitive behavior psychotherapies, in compliance with the EABCT (European Association for Behavior and Cognitive Therapy) requirements. In 2001, GABR founded a branch in Thessaloniki, responding to the increasing demand in northern Greece.

In 2013, IBRT established more extensive CBT training and practice (including a new building to provide training and services) after receiving a government permit to operate as a government official training center, providing continuing postgraduate education and training to mental health professionals and mental health services for the public. Only licensed psychologists and psychiatrists are eligible for their 4-year training; however, allied mental health professionals also participate in specialized CBT training (i.e., including the first 2 years of the IBTR, without receiving the full 4-year training) and apply what they learn within context of their organizations (e.g., hospitals, schools, businesses).

Psychiatrist Ioannis Papakostas founded the CBT training at the University Hospital–Eginitio, in the late 1980s, primarily to provide training for psychiatrists in CBT, although today it has grown into an intensive 3-year program and includes both psychiatrists and psychologists in their training. Within this context, the last 5 years, there is a growth in more specific CBT training (e.g., Dialectical Behavior Therapy, psychiatrist Fragiskos Gonidakis, and Schema Therapy, psychiatrist Ioannis Malogiannis).

Psychiatrist Gregory Simos founded the Greek Association for Cognitive and Behavioral Psychotherapies (GACBP) in Thessaloniki in 1994 as an organization for the promotion of Cognitive and Behavioral Therapies (CBT). GACBP members are professionals from mental health disciplines (e.g., psychiatrists, child psychiatrists, psychologists, clinical social workers, and psychiatric nurses). GACBP became a member association of the European Association for Behavioral and Cognitive Therapies (EABCT) in 1995.

In 2003, psychologist Chrysoula Kostogiannis founded the Hellenic Institute for RE&CBT (HI RECBT), which is an Albert Ellis Institute (AEI)-affiliated training center. HI RE&CBT offers adult and child/adolescent 4-year psychotherapy training programs that also adhere to and are benchmarked along the standards of 2 European Associations – European Association for Behavioral and Cognitive Therapy (EABCT) and British Association for Behavioral and Cognitive Psychotherapies (BABCP) – complete with accreditation application procedures and processes (www.recbt.gr/en/the-institute/professional-accreditation).

The Hellenic Association of Cognitive Analytic Therapy (HellasCAT) was founded in 2012 by psychologist Stavros Charalambidis and colleagues and who also established the Institute for Relationship and Group Therapy with same method. Training in cognitive analytic training includes theoretical seminars, supervised clinical practice, and supervision over a period of 3 years, with the first level of training as an associate member of HellasCAT which is equivalent to "CAT skills training" and the second as a full member of HellasCAT which is equivalent to "CAT Therapist."

There is a new trend in the last few years in private colleges offering postgraduate courses leading to an MSc in CBT (e.g., New York College and Mediterranean College) with the latter offering eligibility to apply on an individual basis for registration to the British Association of Cognitive and Behavioral Psychotherapy (BABCP, Level 2) and includes 320 h of clinical practice and in-house supervision. The training includes the most contemporary CBP methods (Mindfulness-Based CBP, Schema Therapy, Compassion-Focused Therapy) and meets the academic standards for registration with the Hellenic Counselling Society and the European Association for Counselling (EAC).

Overall, the increasing number of CBT training institutes currently in Greece reflects that this is a vibrant and developing field.

## Current Regulations and Legislations Regarding Psychotherapy Provision

Currently, there is no legislative framework regarding the practice of psychotherapy, no statutory registration of individual psychotherapists, and no official accreditation of training courses in Greece. The title "psychotherapist" is not protected, which means that it can be used by anyone, and there is no state or professional charter that regulates or monitors psychotherapy practice. Still, many psychotherapy centers/institutes have their own accreditation criteria benchmarked along the guidelines of European and/or American Psychotherapy Organizations/Associations.

Major landmarks included the legislation concerning psychology as a profession (1979) while the separation of psychiatry from neurology occurred in 1981. 1986 marked the beginning of the first independent psychologists department at the University of Crete, and 1989 marks the first time psychologist graduate from an independent psychology department at the University of Athens. License for independent practice in psychology became mandatory starting in 1993 and was enforced within the next 5 years, while, until today, there are no formal recognized specialties; nevertheless, there are specialized associations which reflect areas of interest/specialties (Greek Association for Clinical Psychologists, Association for School Psychologists, Association for Industrial Psychologists as well as the Association for Doctoral-Level Psychologists–Hellenic Psychological Society and the ELPSE Association in Greek Universities which differentiate between different

branches of study in psychology, like Clinical Psychology, School Psychology, Organizational Psychology, Developmental Psychology, Social Psychology, etc.).

A subcommittee was created in 2000 by the Central Council for Health (Department of Health) that submitted a report in 2003 {Institute of Medicine (US) Committee on Assuring the Health of the Public in the twenty-first Century (2002)}. It aimed to establish centralized training criteria and standards for a psychotherapy accreditation. The council would also provide ethical guidelines and keep a register of accredited psychotherapists.

Ethical Guidelines:

http://www.seps.gr/index.php?option=com_content&view=category&id=46&Itemid=129; http://www.recbt.gr/en/the-institute/code-of-ethics.

The report proposed that in order to become eligible for psychotherapy training, a psychologist should have a license for independent psychology practice, as well as relevant experience. The training should last at least 3 years and be composed of both theory and clinical practice, along with a component of personal development.

## Professional and Cognitive Behavior Therapy Organizations

A Greek National Organization for Psychotherapy was established in 1998 and represents Greece in the European Association for Psychotherapy. According to its website (https://www.europsyche.org), it includes 26 different professional therapy organizations that follow 14 different Greek psychotherapy approaches. The Greek National Organization supports the importance of training and has adopted the training criteria of the European Association of Psychotherapy (EAP). In Greece, only 12 training institutes are part of the EAP while none of the institutes accredited offer training in Cognitive Behavior Therapy (CBT).

The Greek Association for Cognitive and Behavioral Psychotherapies was founded in Thessaloniki in 1994 and aims to promote the application of CBT. It is a member of the European Association for Behavior and Cognitive Therapy (EABCT). It provides its own 3-year training program for CBT, while it also accredits psychotherapists who have completed the EABCT accreditation criteria. According to its website (www.eabct.eu: EABCT, 2018), there are 115 EABCT therapists accredited in Greece.

The Greek Association for Behavior Modification and Research was founded in 1974 and aims to promote and apply behavioral research and therapies. The association organizes lectures, workshops, and seminars and participates in conventions in order to fulfill its aims. It also includes a list of accredited psychotherapists with training in CBT, according to the standards of the EABCT. Furthermore, it also founded the Institute of Behavior Research and Therapy, which provides training that is accredited from the European Association for Behavior and Cognitive Therapy (EABCT), since 2010. According to its website, there are 97 accredited

members-psychotherapists (therapists with adequate education in Cognitive Behavioral Therapy, http://www.eees.gr/pistopoihmenoi.htm).

The Hellenic Institute for Rational-Emotive and Cognitive Behavioral Therapy (HIRE&CBT) is an Albert Ellis training-affiliated center founded in 2003 and with an accreditation scheme aligned with the EABCT and has 12 accredited member-psychotherapists (http://www.recbt.gr/en).

## Training Opportunities in CBT

There has been a substantial increase in the CBT training programs in Greece. Currently, there are **10** programs in Greece that offer training in different forms of CBT while not all have accreditation schemes. The organizations affiliated with these programs are the European Association for Behavioral and Cognitive Therapy (EABCT), the British Association for Counselling and Psychotherapy (BACP), the Albert Ellis Institute (AEI), the Academy of Cognitive Therapy, and the Hellenic Association for Cognitive Analytic Therapy. Most programs are targeted to mental health and allied health professionals. Some of them prefer professionals that have certain clinical experience, but most will accept any individuals with degrees in the aforementioned professions. Most programs include theory, supervised clinical practice, group/individual supervision, and personal therapy, and some require a clinical paper and/or research. The following is a list of all the programs that currently operate in Greece:

The Institute for Behavioral Research and Therapy (IBRT), which was founded in 1992 by psychiatrist Ioannis Boulougouris, has created the branch of the Association for Cognitive Behavioral Training which conducts all training. The program is affiliated with the Hellenic Society for Behavior Research and is accredited by the European Association for Behavioral and Cognitive Therapy (EABCT). The program lasts for 4 years (2667 h) and includes theory, a Journal Club, supervised practice (8 cases, 600 h), group supervision, and personal development groups. Two additional stages are also available for training in CBT for children and adolescents (775 h). Furthermore, the program is catered to licensed professionals such as psychologists, psychiatrists, and child psychiatrists.

Founded in 1989, by psychiatrist Ioannis Papakostas, the Medical University Research Institute for Mental Health – EPIPSI – offers a program in cognitive psychotherapy. The program's accreditation is not specified, and it lasts 2 years. It includes theory (60 h), supervised practice (8 cases), group and individual supervision, as well as a clinical paper. The program concerns mental health professionals with previous clinical experience. Associated with this center is the "Aiginiteio" University Hospital, which encompasses the Athens Medical School. The psychiatric wing was created in 1963, and psychiatrists in training undergo 1-year training in cognitive psychotherapies, which includes theory, supervision groups (50 h), and supervised clinical practice.

Founded in 2006, the Center for Applied Psychotherapy and Counselling is accredited by the British Association for Counselling and Psychotherapy (BACP) and lasts 2 years (220 h). It includes theory, supervised practice (4 cases, 100 h), personal therapy (10 h), as well as written exams and a paper. Eligible for the program are psychologists, social workers, counselors, and related health professionals.

The Hellenic Institute for Rational-Emotive and Cognitive Behavioral Psychotherapy (HI for RE&CBT) was founded in 2003 by psychologist Chrysoula Kostogiannis, and its program is accredited by the Albert Ellis Institute (AEI). The program lasts 4 years (total of 1846 h) and includes theory (200 h), research (240 h), supervised clinical practice (600 h), personal therapy (30 h), individual study (100 h), and supervision (192 h). Since 2015, the HI for RECBT also operates a 4-year child/adolescent psychotherapy track with equivalent hours as the adult program. Psychologists, psychiatrists, child psychiatrists, and psychiatric social workers are eligible to apply, whereas the child/adolescent program also allows for educators and other mental health specialists, who serve children, adolescents, and parents, to apply.

The Frederick University, a branch of University of Nicosia, which was founded in 2007 is accredited by the European Association for Behavioral and Cognitive Therapies (EABCT) and lasts 4 years (2004 h). It encompasses theory (504 h), supervised practice (600 h), group supervision (150 h), personal development (250 h), as well as case analysis, bibliography, and assignments (500 h). Psychologists, psychiatrists, child psychiatrists, psychiatric social workers, social scientists, and educators are eligible to apply.

The Center for Mental Health in Patra, Greece, Unit for Cognitive Psychotherapies, founded by psychiatrist Stephanos Koulis, also provides training in CBT which was founded in 1956. The program is accredited by the Hellenic Association for Cognitive Psychotherapies and lasts 3 years. It encompasses theory, supervised practice (8 cases), as well as group and individual supervision. Psychologists, psychiatrists, child psychiatrists, and psychiatric social workers are eligible to apply.

Some other training programs are not provided by organizations but by clinical psychologists with a clinical practice. One example is the Schema Center of psychiatrist Vasilis Boulougouris, who provides training of 1 year (80 h), with theory, group supervision, and supervised practice.

There are two training programs that specialize in Cognitive Analytic Therapy. The first one is provided by the Institute of Cognitive Analytic Therapy, which was founded in 2016 in Athens. The program lasts 2.5 years and includes theory (3370 h), supervision (250 h), participation in group therapy (190 h), and personal therapy (35 h), along with written exams and a paper. The program is addressed to psychologists, psychiatrists, and related professionals with work experience. The second program is offered by the Medical Psychotherapy Center in northern Greece – Thessaloniki – and is accredited by the Hellenic Association for Cognitive Analytic Therapy. It lasts approximately 3 years and includes theory and supervised practice (8 cases). Psychologists, psychiatrists, child psychiatrists, psychiatric social workers, and doctors are eligible to apply.

Additionally, there are two e-programs offered for CBT. The first is offered by the Athens National and Kapodistrian University, which was founded in 2001. The program lasts 5 months (145 h). The second program is provided by the International Psychotherapy and Education Center "Alipia" and is accredited by the European Association for Cognitive and Behavioral Therapies (EABCT). The program lasts 2 years and is addressed to psychologists, psychiatrists, social workers, nurses, university students, and educators.

## CBT with Specific Clinical Populations

Feelings, attitudes, and behaviors are prime targets for intervention in CBT psychotherapy. Therefore, when the therapist is unaware of the client's particular emotional language, values, norms, and belief systems, the treatment is bound to suffer. Knowledge about the client's cultural background is necessary for accurate diagnosis and treatment. Similarly, cultural beliefs and values are immersed and intertwined into the symptoms and conceptualizations of issues (Kostogiannis, 1994).

Based on our extensive combined CBT professional practices for the past 30 years in Athens, Greece, we present the following cultural adaptations to be noted to allow for the best and most effective applications of the CBT approach(es) within the context of the Greek culture and when working with individuals of Greek heritage. Consequently, there will be a better understanding of the cultural influences contributing to personal and interpersonal issues as well as the meaning of demands placed upon these individuals and families.

*Generally, there is a shift within the Greek culture from a collectivistic to an individualistic society.* However, there are still many cultural enduring effects that persist and prevent individuals from fully exploring their growth potential. For example, shame is an emotional experience closely connected with collectivistic to individualistic movement and needs to be processed within the context of change. Another example is that some members of the family may knowingly or unknowingly sabotage the therapeutic progress. Thus the central theme in the CBT approach regarding emotional and behavioral responsibility is oftentimes an eye-opener for some and may create resistance in others.

Traditionally, Katakis (1998) in her book *The Three Identities of the Greek Family* mentions that generally, Greek families are often organized in a hierarchical manner, with the father as the dominant figure and cohesive enmeshed within family dynamics, although this family pattern is rapidly changing. The family is the central social unit, and every member is expected to defer to the greater needs of the family. The roles of a husband and wife in Greek marriages are very traditional and have philosophical and religious roots dating back to ancient times. Traditionally, mothers are the primary caretakers of children and the maintenance of the Greek language, customs, and values in the family, whereas the father is expected to take care of the family's economic stability. In the Greek nuclear family, the child has a

central role which stabilizes the family and is expected to succeed academically and professionally (Tsemberis & Orphahnos, 1996).

CBT psychotherapy practice with Greek individuals requires sensitivity and flexibility in order to deeply understand the cultural and social contributions to the personal and interpersonal dysfunctional patterns and further assist in the development of healthy cognitive, emotional, and behavioral functioning and development.

While each individual seeking psychotherapy brings with them specific background complexities, including cultural-social uniqueness, for Greeks, it is important to note the degree of affiliation and meaningfulness that the individual reports with the Greek cultural values, traditions, beliefs, attitudes, and behaviors.

## Adaptation of CBT with Greeks: Initial Clinical Steps for Consideration

### *Immediate Phase or Arrival*

The therapist may potentially receive phone calls from different family members in between sessions and/or someone else may call for an appointment other than the client. In addition, during the first session, a family member may accompany the (adult) client in the waiting room or in the session (Samouilidis, 1978).

It is important to note that, Greek individuals may attribute emotional and psychological problems to "nerves" or mask them as physical problems such as headaches, dizziness, stomachaches, and so on (Samouilidis, 1978). This explains the interest and growth of the body psychotherapy movement in Greece. To reduce any stigma related to the presenting problem, the CBT therapist can conceptualize psychological or psychiatric symptoms as being health-related or stress-related problems.

For the best implementation of the cognitive behavioral theory and interventions, it is important that the CBT therapist be attentive to the verbal and nonverbal cues presented by the Greek client in the therapy session and provide explicit respectful attitude toward the client's values and traditions while being aware of their own reactions toward the Greek client's ideas, meanings and experiences. Thus, an ethnographic interview with a genogram may be helpful, where clients are treated as experts and the therapist seeks to be enlightened by them, followed by CBT psychotherapy, which would also increase the effectiveness of the approach. Several common values should be explored, for example, belongingness, independence, achievement, and spirituality/religion.

The role of the CBT therapist as an active directive collaborator is perceived favorably by Greek individuals seeking psychotherapy. However, it is very important that CBT therapy be conducted in a comprehensive and a timely manner – efficiently, but not hastily. The therapist can start the process of psychotherapy by explaining the philosophical roots of the CBT approach.

## *Middle and End Phase of Cognitive Behavioral Socialization and Intervention*

Once in treatment, Greek clients may appear compliant and obedient; however, this may also be a form of pseudo-obedience as Greeks have a tendency to mistrust the therapist as an authority figure (Tsemberis & Orphahnos, 1996). Delivery of the CBT therapeutic protocol and services for Greek clients may be different in terms of process, not in terms of content. Still, the roles and responsibilities of both therapist and client need to be made explicit from the beginning while maintaining a strong therapeutic alliance. Given that Greeks place a significant value on education, the CBT approach gravitates well with them as it has deep philosophical underpinnings and is composed of a series of psychoeducational steps and procedures and tools to learn and apply.

The goal in the middle phase is to maintain the cultural adjustment, preserve rapport, trust, and confidentiality, understand the value system and develop cultural competence, and preserve ethnic patterns and values while at the same time aim for learning healthy living and functioning (e.g., rational/helpful thoughts, healthy emotions, and functional productive behaviors). Sensitivity, understanding, competence, and cultural context benefit all clients, including culturally diverse clients. But virtually, all clients can be seen as culturally diverse in nature.

The following observations are not intended to explain the ABC model, rather to point out some unique, culturally sensitive areas associated with the delivery of the protocols and its full implementation when working with Greek people.

The following REBT/CBT framework sequence applies:

Initially when gathering information about the trigger/antecedent event (A), be mindful to provide cultural validation of the (whole) experience/event, including taking the time to learn from their narrative (which may take longer than anticipated), while training clients to focus on the critical components of the trigger.

It is important to spend ample time explaining the distinction between beliefs/thoughts/attitudes (B) in terms of irrational/rational, dysfunctional/functional, and unhelpful/helpful with a cultural specific example, while providing cognitive empathy for the rational belief/thought/attitude.

Ample amount of process time should be alloted to distinguishing between emotions (e.g., emotional education, including healthy/unhealthy emotions), cognitions, and behaviors, with particular careful notice to the meaning somatic complains/reactions and nonverbal behavior.

Make explicit the B-C connections and explain how irrational beliefs are central in creating emotional disturbance, dysfunctional behavioral behaviors, intense somatic reactions and negative thoughts.

The disputation process refers to challenging the person's irrational beliefs and providing them with a mechanism of change to construct rational beliefs and thus more adaptive functional and healthier reactions.

New healthy emotions, functional behaviors, cognitions, and somatic reactions are the products of the new mindset. The benefits of a new, creative, productive mindset are usually welcomed with hope and inspiration by the Greek people. When the new rational, logical, helpful mindset has been established, many individuals ask guidance for how to deepen their conviction, challenge themselves more, and develop their personality and life. Greeks are goal oriented and gravitate well to accomplishing their therapy and life goals.

## Research on CBT in Greece

CBT research in Greece is still limited but highly promising, as the following review will detail. The National Archive of Ph.D. Theses in Greece includes a number of theses published on the topic of CBT use for the treatment of several disorders. These disorders include, but are not limited to, panic disorder (Legaki, 2013), anxiety (Papavasileiou, 2005; Zikopoulou, 2017), learning disabilities (Karmpa, 2003), depression (Bregou, 2015; Malogiannis, 2015), smoking (Ypofanti, 2015), ADHD (Dalaka, 2017), and eating disorders (Pavlaki, 2009; Troulaki, 2016; Varouma & Stavrinidou, 2010). CBT has also been used as a psychoeducational tool for students and parents (Konstadinidis, 2011; Psilou, 2014), as well as a tool for improving communication in marriage (Haints, 1995).

Furthermore, several training centers conduct their own research. For instance, the Institute for Behavioral Research and Therapy (IBRT) has published 3 volumes of the Hellenic Journal of Cognitive Behavioral Research and Therapy since 2014; this is the first journal of cognitive behavioral research and therapy in Greece. It publishes two issues every year, which encompass theoretical and experimental approaches as well as case examples and analyses.

The journal has published several articles regarding the principles of CBT (mostly Beckian CBT) as well as its effectiveness. For instance, Greek researchers have investigated the foundations of Cognitive Behavioral Therapy in relation to philosophy (Maimari & Charila, 2016). Furthermore, they have investigated the role of the therapeutic relationship (Kamboli & Rakitzi, 2017), as well as the role of empathy in Cognitive Behavioral Therapy (Roussinou & Kouvaraki, 2017) and the role of role playing in psychotherapy (Syntila & Aggeli, 2017).

Additionally, the journal has also published several papers that investigated the effectiveness of CBT for specific disorders, akin to papers published in the National Archive of PhD theses. The disorders encompass schizophrenia (Bandouna et al., 2015; Palli et al., 2014), depression (Foundoulakis & Efthimiou, 2015), autism spectrum disorder (Gena et al., 2014), and eating disorders (Dimitropoulou & Giannopoulou, 2016; Xirou & Gonidakis, 2015). Other disorders include Internet addiction (Filioglou & Aggeli, 2016), post-traumatic stress (Vlassopoulou & Rakitzi, 2016), social anxiety disorder (Kontaxi & Pehlivanidis, 2016), attention deficit hyperactivity disorder (Prokopi & Pehlivanidis, 2017), and trichotillomania

(Pavlopoulou et al., 2014). Furthermore, the journal has published research regarding CBT and parenting (Eptaemetos & Aggeli, 2015; Vlachogianni & Aggeli, 2014).

Independently of the Hellenic Journal of Cognitive Behavioral Research and Therapy, the Institute for Behavioral Research and Therapy (IBRT) has made several journal publications regarding CBT for the treatment of several disorders of adults and children. Those can once again be grouped as follows: schizophrenia (Efthimiou & Vlavianou, 2007; Efthimiou et al., 2009; Rakitzi et al., 2016a, b, c), depression (Efthimiou & Psoma, 2012; Papadopoulou & Charila, 2011; Panagiotopoulou & Pashali, 2012), and anxiety (Kalantzi & Karadimas, 2005; Konstantinou & Charila, 2011; Panagiotopoulou & Pashali, 2012).

Researchers affiliated with the Institute for Behavioral Research and Therapy (IBRT) have also published several books regarding the use of CBT for certain disorders on smoking (Efthimiou & Sofianopoulou, 2007; Sofianopoulou et al., 2013), eating disorders (Gonidakis & Charila, 2011), anxiety (Kalpakoglou, 1997), depression (Efthimiou et al., 2016), and schizophrenia (Rakitzi et al., 2016). Furthermore, there are several other books published that concern CBT as a general tool (e.g., depression, anxiety, social skills, parenting, and others).

A second organization that has performed its own research is the Hellenic Society of Cognitive Psychotherapies. The journal and book publications of researchers affiliated with the institute include the use of CBT for obesity (Bathrellou et al., 2010a, b), depression (Micholopoulos & Zervas, 2009), anxiety (Papakostas, 1997a, b, 1999; Papakostas et al., 1997), schizophrenia (Papakostas, 2001), and depression (Papakostas, 1996). Additionally, there have also been publications about CBT principles in theory and action (Papakostas, 1994, 1995, 2000) and its use in training programs (Pehlivanidis, 2007; Pehlivanidis et al., 2006; Pehlivanidis et al., 2009).

Another organization and training center that also conducts its own research is the Hellenic Institute for Rational-Emotive and Cognitive Behavioral Psychotherapy (RECBT). Some of the publications are of general nature; for instance, regarding evidence-based practice (Katsikis, 2014) and the distinguishing characteristics of REBT (Katsikis, 2017). Other publications are more specific; for instance, some concern coaching and CBT (Katsikis et al., 2016; Katsikis et al., 2017).

Several researchers conduct their own studies, independently of any organization or center, regarding the use of CBT for certain disorders. These are as follows: autism (Moutsinas, n.d.); Papageorgiou (n.d.), phobias (Zartaloudi, 2011), addictions (Georgopoulou et al., 2015; Pomini et al., 2014), depression (Efthimiou, 2003), and pain (Soulia & Giannakopoulou, 2011). Furthermore, research has been conducted regarding CBT use in education (Tamami 2015), while there have also been several publications regarding general resources for CBT, such as its theoretical principles and practice (Efthimiou & Lardoutsou, 2007; Kalpakoglou & Charila, (2007); Zafeiropoulou et al., 2012).

The European Association for Psychotherapy formed a task force in 2016 with the aim of addressing mental health concerns regarding the refugee crisis (https://www.europsyche.org/). They published guidelines concerning the treatment of

refugees. For instance, the guidelines state that security, support, and treatment are needed in order to avoid long-term mental health issues. They also state that special consideration needs to be given to victims of torture, asylum seekers, refugees with special needs, and unaccompanied minors. The guidelines also outline any possible issues that psychotherapists might have, such as a cultural and language barrier, stigmatization of therapy, and documentation.

Even though there is no proof regarding whether the guidelines have been enforced in Greece, there has been some research regarding the psychological health of refugees. For instance, Kalantzi and Anastasiou (2017) conducted a pilot study regarding an online program for children refugees. The researchers used a manual, in the form of a self-help trauma picture book, as a tool for prevention and preparation of the refugees for psychotherapy. The refugees were of Afghan origin and were present in a refugee camp (Agios Andreas in the area of Nea Makri, Attica, Greece), in the summer of 2016. The response from both the children and the parents was positive, while the CBT psychologists administering the program could identify psychological difficulties in the children from early on.

## Conclusions

Overall, there has been substantial growth in the CBT approaches in Greece in terms of research, practice, and training. There is a need for implementing common accreditation standards and adherence to continued professional education/training in CBT. It is also important to ensure CBT cultural-sensitive training and consultation, when needed.

We propose that just as in the translation of questionnaires/instruments attention is placed on the equivalent translation of the meaning of the question/item, the same holds true and be applied to the translation and application of CBT, making sure that protocols are adapted appropriately for the particular culture to ensure the evidence-based implementation of the interventions of CBT.

The main point is that when applying CBT with Greek people, there needs to be a balance between process of REBT/CBT and the delivery of the protocol content. More attention needs to be directed in the way that the cognitive behavioral approach is first introduced to college students, workshops, and trainings and later on as a part of CBT psychotherapy training with a required component of personal therapy/personal development during the CBT training. As far as practice, CBT therapists need to be culturally competent as well as CBT competent, while adhering to ethical guidelines and professional best practices.

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# Chapter 15
# Cognitive Behavioral Therapy in India


**G. Row Kavi, Swati Khanolkar, and Trupti Talekar**

This chapter aims to bring out the history of psychotherapy in India, the current status of the practice of CBT in India, and the adaptation of CBT to the Indian cultural context. In India, the practice of psychotherapy in general and the practice of CBT in particular are still in its growing stage. Several cultural factors that are strongly embedded in the Indian societal fabric impact the influence and growth of psychotherapy here. The last decade has seen a significant improvement in people's awareness of and willingness to seek therapy. Research data so far is minimal, but we hope that with further research on adaptation of CBT within the cultural parameters most effectively, we will make good progress. This chapter discusses ideas on how to adapt CBT to the general clinical population and also specifically to children.

## Overview of Country

India can be best described as a vast country with an ancient civilization, the birthplace of four religions (Hinduism, Buddhism, Jainism, Sikhism), and a potpourri of myriad cultures, traditions, customs, languages, and mindsets. Geographically, India is prominent in the South Asian subcontinent, sharing its borders with China, Nepal, Myanmar, Bangladesh, Bhutan, Afghanistan, and Pakistan. The Indian peninsula is surrounded by the Arabian Sea, Indian Ocean, and the Bay of Bengal. India speaks 22 languages recognized by the Constitution of India, with Hindi as its

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official language. India became a secular democratic republic, after getting its independence from the British Colonial rule, in 1947, with New Delhi as its capital.

One of the most largely populated countries (2019 World Population Prospects population India stood at 1,352,642,280), it is a unique mixture of modern and traditional sensibilities and belief systems, those which have been passed on through generations and part of the Indian DNA and some which are fast changing, what with globalization and technology knocking at every door.

Hence, it's no surprise that the psychological health of the country could also only be served with several approaches, in which religion and spirituality too hold a prominent place. The Bhagwad Gita, the holy book, could be the first example of actual "live, one on one counselling," with Lord Krishna explaining the philosophy of life to Arjuna, during the epic war, Mahabharata (Bhatia et al., 2013). As a result, some forms of psychotherapy have existed in the country for centuries, albeit without any clinical research.

The Vedas, wisdom of ancient Indian scriptures, and Yoga, which could be viewed as the Indian philosophy of life, focus on a spiritual growth, which begins with a healthy balance of psychological health. Unfortunately, this rich heritage was soon neglected with the advent of modernization and replaced with Western concepts.

While, on one hand, India was racing to be one of the fastest growing economies in the world (7th largest as declared in India Economic Summit 2017 at New Delhi), back home, its fabric was crumbling under pressures of a modern world. The joint family system, which was an epitome of unity against all adversities began breaking; industrialization increased rural to urban migration, and a collectivistic society was slowly turning individualistic in nature. The psychosocial composition was drastically changing.

Although psychosocial and mental health services began getting researched and made available to the masses, India as a country is still way behind its Western counterparts, in terms of offering organized and professionally monitored services in psychotherapy. When weighted against bigger physical health-care needs, mental health looks smaller in dimension even though, not necessarily, less critical.

The Indian mindset, emotional in nature, and with its deep belief in karma, superstitions, religious beliefs, etc., makes it difficult to rationalize issues cognitively. Then there is also the growing field of alternative healing modalities and medicines, such as Ayurveda, Homeopathy, Yoga, etc., which psychotherapy currently contends with.

## A Brief History of Psychotherapy in India

Since its inception in India, psychology has been viewed by academicians and practitioners alike as a bundle of knowledge foreign to the culture and thus only "Western." There have been countless debates on its application to eastern cultures

like India. There has been an ongoing effort to develop Indian psychology, which is based on Indian philosophies and cultural schemas.

When was the birth of psychotherapy in India? There are no clear-cut instances or developments in history that can pinpoint its inception. However, as per Indian mythology and ancient scriptures, there has always been a form of psychotherapy and mentoring present in the culture. There have been references in various religious and philosophical scriptures like the Vedas that present a possibility of counselling in ancient times. Many practitioners and academicians still draw from these scriptures as references to teach and promote healthy emotions, behavior, and ways of thinking.

A "guru-chela" (teacher-student) relationship has been existent in the Indian culture since time immemorial. The teacher as a mentor and counsellor guides the student through important decisions while helping create insights. This could be considered as the earliest form of psychotherapy, later progressing to include family therapy or some sessions with family members. Supportive therapy was also used with other forms of psychotherapy.

As India is the birthplace of four religions, it is not surprising that religious concepts, and teachings from Yoga, taken from ancient Vedic scriptures, have been imbibed into the "psychotherapeutic" process.

There is a high emphasis on interdependency which facilitates more dependency of the client on the counsellor. There was also a tendency to seek an external intrapsychic explanation for their psychological issues which leads to a higher level of expectation from the counsellor to figure out an external explanation and explain it to the client. This also leads to an ignorance of personal responsibility toward the disturbance.

Keeping in line with this belief of external locus of control, the client believes that there is an external cure to their difficulty which does not require efforts of introspection or change on their part. It will also require teaching or advice from the counsellor. Thus, therapies that provide explanation and insight into the cause of the disturbance handed over by the therapist is preferred as short-term relief.

The "Indian Journal of Psychology" was published in 1926 (Verma, 1998). Verma pointed out distinct features of India, which would be challenging for psychotherapy in India, as compared to countries in the West:

- Lack of psychological sophistication.
- Religious belief.
- Confidentiality.
- Personal responsibility.
- It was not meant only for the sick.
- Since the therapist and patient could not be considered as equals, a dyadic relationship wasn't possible.
- The patient must accept what the therapist considered as truth.
- Everyone is not considered fit for psychotherapeutic relationship.

In the 1950s, the focus of psychology included psychoanalysis, phenomenological studies, and few therapeutic traits, while in the 1960s, epidemiological and

phenomenological studies continued on topics such as mental morbidity, suicide, correlation between social class and mental illness, industrialization and migration, drug abuse, etc. The 1980s added the standard experimental controls with significant sample sizes and sound statistical methods.

Indians prefer a "holistic" approach, an integration of cognitive psychotherapy within a spiritual framework. And often, apart from family, various spiritual leaders and institutions provide the much-needed support to cope with stressful lives by offering individuals a sense of belonging and purpose toward a more meaningful goal. Mindfulness techniques, which are used with conventional CBT, have their roots in meditation, an ancient practice of bringing a sense of balance in mind and body. Researchers are also finding evidence to prove that techniques like meditation and Yoga relieve ailments of mind and body (Catherine Woodward, 2011).

Challenges in the delivery of evidence-based psychological therapy in India (Kumar & Gupta, 2012):

- Concept of psychological therapy is still an emerging concept although it is becoming trend catching, especially in Metro cities.
- Lack of an organization to regulate practice, ethics, provide guidelines, etc.
- No uniformity in the profession and inability to follow a single systematized form of therapy.
- Most practitioners follow eclectic approaches including various kinds of therapeutic techniques as well as alternative therapies.
- Complicated family structures and presence of other protective sociocultural institutions.
- Simultaneous use of multiple therapies/treatments making evidence-based study difficult.
- Social stigma attached with seeing a "mind doctor".
- Client noncompliance and desire for "magical cures."
- Inability to separate cognitions and emotions or to think in purely cognitive terms.
- Variety in literacy and language.
- Lack of opportunities for specialized training and supervision in any one particular form of psychological therapy.
- No statutory body in India to provide professional registration to clinical psychologists.
- No mechanism for the monitoring, evaluation, and official accreditation of training programs.
- No existing provision for legislation or insurance of practitioners.
- Existing training courses deepen trainees' knowledge base but do very little to enhance skill literacy.
- Relatively little stress on documentation or research.
- Audio/video recording of sessions is rare.

## Current Regulations Regarding Therapy

As a profession that deals with the mental health of individuals, there is a higher responsibility on psychotherapists to practice professional integrity and accountability. In India, the rules and regulations regarding pharmacotherapy and psychiatry are concrete and structured. The Indian Psychiatry Association in 1989 established ethics for practicing and conducting research in psychiatry that every licensed psychiatrist in the country must follow (Agarwal, 2010; Gupta & Menon, 2016). However, currently, for clinical psychologists, counsellors, and other mental health professionals in the country, it is a chaotic system wherein there is no licensing system, no central professional agency, and no legal or governmental branch that can enforce regulations of concerned therapists. There is a lack of regulations for the practice, training of psychotherapy, and competence of mental health professionals in general (Kumar & Gupta, 2012).

Psychotherapists all over the world are expected to follow the ethics prescribed by the professional regulatory body and relevant legal laws in their respective countries. However, India does not have such standards in place. There have been attempts at the organizational and regional levels to establish professional regulation. One such independent organization working toward regulations of the field is the Indian Association of Clinical Psychologist or IACP. IACP has established professional ethics based on the ethics of American Psychological Association (APA) for the members (Sathyanarayanan, 2018; Misra & Rizvi, 2012).

The IACP ethics code related to psychotherapy (IACP, 1993) prescribes:

1. Clinical psychologists need to be competent and should update their knowledge of the field, and the interest of the client is paramount.
2. Whenever required, appropriate referrals to other professionals should be made.
3. Appropriate expert opinion should be provided, and full responsibility should be assumed for the expert opinions and inferences.
4. Information should be provided regarding the nature of illness, method of treatment, and its efficacy and risk factors to the patient and take informed consent from the patient.
5. Should have high regard for patient's integrity and welfare. Professionals need to employ treatment procedures based on scientific knowledge and which have reasonably proven efficacy and should not treat individuals outside their competency.
6. During court testimony, professionals should follow etiquette, maintain image of a reliable expert, and refrain from prejudices.
7. Professionals should not disclose information provided by the client to anyone other than co-professionals or appropriate authorities (Misra & Rizvi, 2012).

These ethics are not as comprehensive or as detailed as the APA guidelines (Bhola et al., 2015; Misra & Rizvi, 2012). Furthermore, membership is not mandatory for all the practicing clinical psychologists in the country but only for the members (Bhola et al., 2015).

One of the revolutionary changes in the Indian mental health area has been the revision of the Mental Health-Care Bill. India was one of the earliest counties among its Asian neighbors to establish regulations for mental health services in 1987 (Galhotra & Mishra, 2018). The Mental Health-Care Bill passed by the government of India in 2017 is a revision of the previous mental health-care bill (Galhotra & Mishra, 2018). The MHA 2017 has given prominence to the rights of the mentally ill and is based on the WHO's Rights of Persons with Disabilities (UNCRPD) (Galhotra & Mishra, 2018; Duffy & Kelly, 2020). Most of the guidelines in the MHA pertain predominantly to pharmacotherapy and hospitalization. The act does not have any clauses for psychotherapy and also lacks regulations for mental health professionals other than psychiatrist. The sole clause that mentions psychological services prescribes the qualification or definition of a clinical psychologist, a postgraduation in clinical psychology and membership with Rehabilitation Council of India (RCI), is mandatory (Mental Health Act, September 2017, Chp 1, section 2 (g) p. 2).

The Rehabilitation Council of India (RCI) would be regulating practices of all the professionals treating patients with physical and psychological disabilities, including mental illnesses, once the MHA comes into practice in respective states. RCI as originally a regulatory body for professionals working with differently abled individuals provides a code of ethics that would now also apply to clinical psychologists in the country. The Rehabilitation Council of India Act of 1993 prohibits:

- Advertising services in media.
- Charging exorbitant fees.
- Indulge in exaggeration of forecasting of illness.
- Involvement in indecent act(s).
- Maintain an improper relationship with a person with a disability.
- Take undue advantage of the client.
- Neglect a person with a disability knowingly or unknowingly.
- Undertake practice in any field other than her/his specialization.

These are basic ethics that apply to all the rehabilitation professionals, even those that do not deal with mental disabilities, and therefore are more general in nature and not related to specifically therapeutic settings (Bhola et al., 2015). Although considering the progress of the mental health field globally, the Mental Health-Care Bill 2017 is the first time there has been an attempt to regulate the profession by any authority in the country. Although a small step, one can only hope that this act is the first of many future efforts to regulate the profession.

Clinical psychologists and counsellors are taught about the APA code of ethics as a part of the masters programs at universities. One of the commendable factors has been that most of the mental health professionals seem to follow essential ethics prescribed by the APA without any supervisory agency. A study conducted by Bhola et al. (2015) identified that most of the trainee counsellors resolved their ethical dilemmas by consulting their supervisors and found the current established ethical code to be limited and not helpful in resolving the dilemmas (Bhola et al., 2015). There are some informal reports of violation of ethics, yet the extent and credibility

of such reports cannot be commented upon without a formal investigation (Kumar & Gupta, 2012). There have been reports of legal cases filed against psychologists in the court of law; however, due to lack of awareness, these cases are limited mostly to psychometric assessments, and they are only filed in relation to other legal issues, such as violation of basic human rights, marital or divorce hearings, and property rights.

The primary reasons for lack of regulations for psychotherapy could be due to many reasons including, but not limited to:

1. The priority given to pharmacotherapy as primary and at times the only treatment required for psychological disturbances.
2. The lack of consensus between professionals about the definition of psychotherapy and psychotherapist. For example, who should be called a psychotherapist? Who is qualified to practice as a counsellor? What is the difference between counselling and psychotherapy? There has not been a clear-cut and legal definition of psychotherapy and psychologist in India. There is a constant debate and questioning about the applicability of the "Western" therapies in the Indian culture, which adds to the confusion about who can be called a psychotherapist.
3. There could also be resistance from some professionals to establish a certain norm due to the intolerance of discomfort created by additional procedures, restrictions on the practices, anxiety toward creating ethical issues, and an inability to trust other professionals to establish a fair set of norms.
4. Psychotherapists have given more importance to creating awareness about psychotherapy in the general population rather than to establish a professional agency that is approved by all and has the legal power to enforce the necessary rules, thus perhaps have unintentionally neglected the issue.

Rathna Isaac (2009) notes that professionals in the country need to take up the task of establishing a mechanism that will hold psychologists all over the country accountable and have a formal code with behavioral specifics (Isaac, 2009). Although the experienced professionals all over the country have been analyzing and promoting a uniform code of conduct and a central enforcing regulatory agency, the efforts have been lacking. There is a requirement of a professional body that brings about standardization of the rules, enforces them, and guides professionals to resolve various ethical issues.

## Professional and Cognitive Behavior Therapy Organizations

CBT is widely practiced, often as the first line of treatment for a majority of mental disorders, either within an eclectic approach or even as a stand-alone intervention. CBT has a high success rate, justifying its popularity in the country. CBT practitioners practice as private practitioners and counsellors working in government and private hospitals, counselling and therapy centers, and clinics, nonprofit organizations, schools, and colleges. Corporate organizations are now slowly but steadily

employing industrial/organizational psychologists to cater to their employees' work-life imbalance, and many of these psychologists are trained in the CBT approach.

There are therefore numerous small- and medium-sized CBT-driven counselling centers spread across the country, with a sizable chunk nestling in the urban areas. The rural population relies primarily on services deployed at government hospitals or counselling provided by social workers associated with nonprofit organizations.

Few of the better-known organizations working for advocating, researching, and promoting CBT are:

- Indian Association of Cognitive Behavior Therapy – an interest organization for students, professionals, and consumers of mental health services striving to work toward evidence-based practice, research, and supervised training in India. It is a member of the Asian CBT Association (ACBTA, n.d.)
- National Institute of Mental Health and Neurosciences (NIMHANS) in Bangalore, India, which is primarily a training institute, has been working in training, research, and practice of CBT (NIMHANS, Behavioral Medicine Unit, n.d.).
- Affiliated Training Centers of Albert Ellis Institutes in India, two of which are based in Mumbai and one in Nagpur.

## Training Opportunities in CBT

According to WHO report in 2011, the rate of psychologist in India per 100,000 is 0.047, and the rate of training is 0.010 per 100,000. Yet the mental health illness rate per 100,000 is much higher than most other countries in the world (WHO Mental Health Atlas, 2011). Psychologist, psychiatrists, as well as paraprofessionals from allied mental health fields have shown inclination in training themselves in CBT approach to facilitate better mental health care to their clients (Kumar & Gupta, 2012).

The current scenario of training opportunities in the country indicates few levels at which a psychologist can receive training in CB, one of the levels being the master's level training in India. Various universities in India offer master's degrees in clinical psychology and counselling psychology which includes a module on various psychotherapies, one of which is CBT. The second opportunity being postgraduate diplomas and certificate courses offering specialized skill-based learning in counselling and psychotherapy, which offer CBT as one of the numerous psychotherapies taught as a part of the program. These course modules however are quite inadequate and theoretical in nature with nil or minimal supervision (Kumar & Gupta, 2012). Some organizations conduct informal certificate or diploma courses that train individuals in Aaron Beck's CBT and Albert Ellis' REBT. However, they are neither affiliated nor recognized by the parent institutes– Beck Institute for Cognitive Behavior Therapy or Albert Ellis Institute (AEI) in USA.

Indians are eager to learn and are "certification hungry," providing a fertile ground for learning opportunities. However, there are very few standardized trainings with a uniform course curriculum and quality standards. Institutions have their own teaching methodologies and pricing is competitive.

Some mental health centers however offer training courses in CBT conducted by trainers certified abroad and those subsequently mentored by them from the parent institutes. Recently, the training in REBT has become much more structured and therefore popular among psychotherapists in India due to efforts of the affiliated training centers (ATCs) of AEI in India. There are three ATCs of AEI in India, and they provide both local certificate courses as well as the International Primary and Advanced Practica conducted by the AEI. Those who wish to acquire certification in Aaron Beck's CBT need to do the CBT courses offered by Beck Institute for CBT directly from the Beck Institute, USA.

The paucity of available skill-based training and supervision seems to be affecting credibility of professionals (Kumar & Gupta, 2012) as well as the reception of CBT among the general populations (Gupta et al., 2019). Gupta et al. (2019) conducted a study to assess the effects of a series of formal CBT training workshops in a teaching hospital in Northern India. The study indicated that the quality of the training, supervision, as well as the increased number of trained professionals in CBT affected the number of consultations (Gupta et al., 2019). Psychologists in India tend to prefer practicing the eclectic approach combining various therapies to cater to different problems rather than training and practicing in one particular approach (Kumar & Gupta, 2012). There is a need to propagate in depth and specialized skill training, ideally "a two-stage CBT training model, a smaller group of supervisors and a larger group of practitioners, ensuring the continuation of CBT provision and monitoring beyond the training period" (Gupta et al., 2019, p. 344) as proposed by Beck et al. (Beck et al., 2016).

## CBT with Specific Clinical Populations

Cognitive Behavior Therapy in India has been successfully used for a host of pathological disorders including mood disorders, anxiety disorders, substance abuse disorders, eating disorders, personality disorders, bipolar disorder, sleep disorders, schizophrenia, PTSD, and obsessive-compulsive disorder, albeit with some culturally relevant altercations.

### *Cognitive Behavior Therapy for Schizophrenia and Psychosis*

CBT has been effectively used in India since the 1960s as a therapeutic support provided for patients with schizophrenia. Substantial studies carried out over decades show that the commonly used techniques were behavioral control,

cognitive methods, and socialization. Chances of improvement were significantly higher in patients where the duration of illness was shorter (less than 1 year), with family history of no mental illness, acute onset, and younger age. The content of delusions was also affected by sociocultural factors. Current evidence suggests that CBT is a powerful aide to pharmacotherapy in psychotic conditions and effectively deals with symptoms of schizophrenia while improving medication adherence. CBT has also shown its effectiveness in treatment of psychosis (Avasthi et al., 2020).

## *Anxiety Disorders*

Anxiety disorders are characterized by biases and avoidance behaviors. Studies in the Indian subcontinent have shown CBT's effectiveness in reducing such behaviors with stronger effects as compared to other disorders. Research studies prove the efficacy and effectiveness of CBT across a range of anxiety disorders, including panic disorder, specific phobia, social phobia, and generalized anxiety disorder, making it the most consistent and empirically supported psychotherapeutic intervention in the treatment of anxiety disorders (Reddy et al., 2020).

## *Depression*

According to a survey done by WHO in February 2017, 7.5% of Indians suffer from major or minor mental disorders requiring therapeutic intervention. National Mental Health Survey of India in 2015–2016 reports that 1 in 20 Indians suffer from depression. Studies in India indicate successful treatment with CBT for mild to severe symptoms of depression (Gautam et al., 2020; Tripathi et al., 2020).

## *Bipolar Disorder*

Although considerable research has been carried out on bipolar mood disorders, not many have been reported on biological, neuroimaging, and genetic studies and long-term course of bipolar disorders. Also, several studies have had small number samples.

Cognitive Behavior Therapy has been shown to be efficacious in the management of bipolar depression and during the maintenance phase of treatment. The basic goals of CBT are to educate the patient about the illness, teaching them cognitive and behavioral skills for coping with their illness and psychosocial stressors and problems arising out of the same, enhance medication and treatment compliance, and monitor the symptoms to prevent relapse (Rao, 2010).

### *Obsessive-Compulsive Disorder*

Recent studies have shown that almost 50% of patients suffering with OCD experience remission. Therefore, managing treatment-resistant cases of OCD continues to be challenging and dependent on the individual's disease phenomenology. Sociocultural factors responsible for developing the psychopathology need to be considered while planning the line of treatment, especially in a country with so many diverse cultures collectively woven in its fabric.

Treatment in India is either on an outpatient or an inpatient basis, with the former sufficiently serving its purpose for most patients with mild to moderate OCD. Periodic follow-ups of psychotherapy and pharmacotherapy show good results. Aggressive treatment of CBT over long term has the potential to improve outcomes even for initially treatment nonresponsive OCD (Sharma & Math, 2019). However, those who may not respond well to standard interventions may require admission in rehabilitation centers.

In conclusion, in a survey on the current use of CBT, Kuruvilla evaluates the evidence base to support the use of CBT in a number of psychiatric disorders, its role in the management of certain physical disorders, innovations in the delivery of CBT, and the current findings which show that CBT modulates the functioning of specific sites in the limbic and cortical regions of the brain. These findings support the conclusion which Prochaska and Norcross arrived at after evaluating various psychotherapies: "Cognitive Behavioral approach is the fastest growing and heavily researched psychotherapy in the contemporary scene." It will be immensely beneficial for patients in India if psychiatrists in India make greater use of this model of therapy (Kuruvilla, 2010).

Also referred to as a "third wave" of behavior and CBT, this new trend of CBT differs from conventional CBT, wherein the goal is to alter the role of psychological events experienced and foster strategies for modifying emotions rather than change the perception of the event (Hoffman et al., 2010). Remedial effect is also achieved through various methodologies like Acceptance and Commitment Therapy (ACT) (Hayes et al., 2006) and Mindfulness-Based Cognitive Therapy (MBCT) (Segal, 2008). However, even though these "third wave" therapies are currently proving to be effective with sufficient evidence to support them, further research is needed to compare their effectiveness over conventional therapies (Ost, 2008).

Case examples of how REBT is used within the cultural context for specific clinical populations may serve useful. Many clients come with dilemmas that they face which broadly belong to the "Individualism versus Collectivism" conflict. For example, in the case of a 28-year-old Muslim girl who was engaged to be married, she presented severe anxiety about her situation along with anger. Her situation as she described it was that her religion required her to follow certain customs quite rigidly, premarriage and post-marriage. These customs included many things that were incongruent with her individual beliefs and in a way would require her to compromise her self-respect and self-identity. She strongly wished not to adhere to these expectations, but she was anxious that if she rebelled, then she would bring many

negative consequences on herself and her family. Her family would probably be disowned from the religious community, and it would bring a lot of shame to her parents. She wasn't sure if she was strong enough to face the consequences herself. In fact, there was a sense of unfairness that she felt, and she thought that she should not have to make such a difficult choice between maintaining her self-respect and her identity and protecting her family from the wrath of the religious community, and she felt quite angry about it. This is a common situation for many people in India where they feel torn between what they have come to believe in as an individual and what their religion, community, caste, or family expects them to believe, and then they see themselves as a victim of the situation and see themselves as quite helpless, and they feel self-pity and depressed marked by resignation to the situation. They view themselves as not really having a choice, and their choice is completely determined by religion, community, caste, or family that they were born in. They see it as binding on them to dogmatically follow what has been preached to them over the years, but they carry a lot of anger and bitterness about not being allowed to live their own individual life and to keep up a facade of a happy family.

The motivational interviewing process in RE and CBT can help such people to really focus on making a choice and then learning to bear the costs of their choice. By starting with the question "Which cost would I rather bear?" one can learn to commit to a choice and to tolerate the consequences of their choice. Using RE and CBT, people can be shown that there can be a midway between total compliance and total rebellion and that they can choose the things they are willing to compromise on and things they are not willing to compromise on.

Another case is of a 30-year-old male who presented with a complaint of obsessive thoughts with the main theme of those thoughts religious in nature. For a few years, he was following a particular school of spirituality that had apparently inculcated many rigid rules for what good or moral behavior is. Over the years, he had become much habituated to following those rules and now found himself obsessively adhering to those rules. He had several thoughts about whether thinking in an immoral way was going to result in being punished by God. If he as much as even thought about sex or if he thought a bad thought about God or if he had any thoughts about lying to someone, he would quickly reprimand himself, obsessively keep thinking about having had that bad or immoral thought, feel guilty about it, and feel excessively anxious that he was going to pay for it in a bad way. This client was a voluntary, willing client and could quickly see that these obsessive thoughts were not logical and had no base in reality, and he was willing to work on modifying them. He could see that his anxiety was directly triggered by the rigid standards that he set for himself. Through disputation, he realized that it would help him the most if we worked on modifying the rigidity of his standards while still allowing himself to adhere to the religious standards that he wanted to or still continue to believe in them. For example, he referred to this scripture that most Indians know of, may have studied, and definitely believe in, called the "Gita" which has become the guiding book for good or bad behavior in Indian culture. The "karma theory" has its basis in this book. It is supposed to have emanated from God in the form of Krishna. This client believed in this scripture, so in the disputation process, we used this scripture

and references from it to help him see that most of his interpretations were extreme interpretations of what the book said. We focused on the fact that the book spoke about the importance of acting and doing things. Lord Krishna is trying to teach his pupil Arjuna on the battlefield that he shouldn't let his emotional disturbance get the better of him and that he should act toward his goals no matter how hard they seem. We used these references to help the client see that holding onto the rigid rule of being good at all times was in fact blocking him from acting in constructive ways. So his action tendencies were being negatively affected in fact because of this obsessive thinking and not taking him toward his goals.

This approach is more likely to help people in Indian culture because they then view therapy, in this case REBT, as an extension of what their cultural scriptures have taught. If they see the two as being disparate or contradicting each other, it is very likely that they will not want to follow the therapy, or the therapy will not resonate with them because there is a very stringent dogmatic belief in the scriptures.

## Adaptation of CBT in India

It may help to understand how Indians look at psychotherapy as a treatment method for mental disturbances. The most common reason that people give to explain why they wait to approach a therapist while they are suffering with their mental disturbance is that they "did not think the problem was big enough to need professional help." In India, counselling is still largely one of the later options that people will consider while coping with their problems. They are likely to seek help from God, religion, astrologer, healer, family guru, etc., before they come to a counsellor. People may also prefer going to a psychiatrist and taking a pill rather than make the effort to go through the "process" of therapy. There could be various reasons underlying this behavior, including:

- There is still a stigma associated with having a "mental disturbance." There is more awareness and acceptance so more people are likely to seek therapy now than before, but they would still want to do it secretly. People across economic and educational levels believe that they will be negatively judged by society for having a mental disturbance big enough to seek therapy.
- Many people still have a deterministic, passive attitude toward mental disturbances and their treatment. They view disturbance as something that is inflicted externally on them and determined by factors beyond their control. Therefore, they might seek externally focused "treatments" such as religious rituals, superstitious actions, and alternative therapies "to make it go away." For example, people who believe in the karma theory may attribute their disturbance to previous "bad karma" and seek to alleviate it through some religious rituals or just resign to their "fate."
- Seeking help for mental disturbances is seen as a sign of weakness. A piece of advice very commonly given to people with anxiety, depression, and anger issues

is to just "stop being angry, depressed, or anxious" as if it were a switch that could just be turned off. People find it hard to believe and acknowledge that these disturbances require help to cope with. Thus, it has become a common impression among people that one is expected to be strong enough to deal with one's own emotional problems. If you seek therapy for it, that proves you are weak.

- A lack of awareness about the process of psychotherapy – Many people may still believe that psychotherapy only offers a way to vent about one's feelings and in that sense is no different than talking to a close friend. People may also convince themselves that they have all the tools required to cope with their problems and that a therapist may not bring any additional value because the therapist mainly will just "sit and listen."

Various factors need to be considered about the Indian societal fabric and culture while adapting CBT to the Indian setting. Religion, community, and family are central and highly desired structures in the Indian society. They influence and direct the Indian culture and its values. There is a hierarchy within each of these structures, and a strict adherence to it is expected, encouraged, and rewarded. For example, full faith and devotion to God (based on the religion one follows) and complete obedience to one's community rituals and compliance to elders in the family are inculcated early on as virtues to be lived by. As a unit, "family" is valued more than "an individual," and therefore, interdependence is more highly valued than independence. A high preference for individualistic living and thinking may also be viewed as selfish and hence counterproductive to the survival of the family unit. Thus, a strict adherence to the norms and the rules is seen as more fruitful to keeping the interdependent family structure strong. A majority of the population in India still live in a joint family – with parents and possibly grandparents living together with the children. Thus, a collectivistic mindset is viewed to be more helpful for coexistence.

Self-sacrifice for the larger good of the family, community, religion, and nation is almost seamlessly embedded in the societal fabric. Most children grow up viewing self-sacrifice for a larger good as a moral standard to live up to. Thus, working toward individual interest can be easily viewed as selfishness and therefore can be morally looked down upon.

Similarly, self-control is regarded quite highly in the eastern philosophies. Experience and expression of emotional disturbance can be viewed as a failure to control one's own mind and therefore looked down upon. This may lead many people to live in denial of having a mental disturbance that requires help.

Environmental influences are strongly determined by the religion, community, caste, and family status one is born in. People could live their entire lives within the boundaries set by these factors from the time they were born. Change driven by individual needs and critical thinking could be viewed as rebellion and therefore discouraged. It could thus become harder for individuals to express themselves in ways that are incongruent with the norm. Any philosophy or set of ideas that are different than the set norm of the religion, community, or family can be distrusted. For example, it has been a common belief for years that Western philosophies or

models of therapy are not appropriate for the Indian cultural setting since the Western world is more individualistic in its approach and its way of life. Though this belief is now changing gradually, thanks to increased attempts toward better awareness, more work needs to be done toward adaptation of these models to the Indian way of life.

These factors influence mental health of the Indian people in numerous ways:

- Many people report feelings of anxiety, depression, and shame triggered by irrational beliefs with the content revolving around need for approval, need to avoid being negatively judged, and negative self-rating for not living up to people's expectations.
- There is a strong tendency toward a stringent moral evaluation of self based on certain rigid societal, cultural standards triggering feelings of guilt.
- Judging oneself for experiencing and expressing emotions is a common theme leading to feeling meta-disturbances of guilt and depression for being emotionally and behaviorally disturbed.
- People are highly likely to believe that fate is responsible for their mental state and could sink into depression triggered by self-pity. They could perceive themselves as victims of the circumstances their fate or karma put them into and resign.
- Culturally, the ability to tolerate is considered a proof of self-control. But the choice of what I want to tolerate may not be viewed as an open choice. Thus, people believe that they "have to" tolerate whatever suffering comes their way to prove that they have high self-control. As a result, tolerating people tends to lead to either self-pity for having to tolerate or anger and bitterness for being made to tolerate by other people or by fate.

There are several ways CBT can be adapted to the Indian culture:

- Emphasizing that the therapy, though Western, has principles that are overlapping with the Indian culture.
- Dogmatic versus critical thinking – Teaching critical thinking is essential but without challenging the cultural ethos. Indians need to see that thinking for yourself is not equivalent to rejecting the collective norm.
- Only pragmatic disputation may not work. It might be misinterpreted as selfishness. Therefore, a good combination of philosophical, realistic, and pragmatic disputation may work better.
- Accepting oneself for having a disturbance needs to be emphasized and taught in order to deal with secondary disturbance of guilt, which is quite common in the Indian culture.
- Indians need to be shown that self-interest is not an extreme construct encouraging harmful antisocial behavior. It has a negative connotation attached to it in the Indian societal fabric.
- It's important to demystify the concept of "tolerance," emphasizing that it is a proactive choice and that an individual who chooses to tolerate certain costs of her/his choices does not necessarily make them a victim.

Indians shy away from seeing psychotherapists and instead seek alternative modalities of healing due to stigma associated with mental health. Having said that, they also respect expert authority and prefer structure and short-term treatments, significant reasons for CBT's popularity in India, among other Western psychotherapies. However, to be an effective line of treatment, CBT needs to adapt and consider the Indian culture, family dynamics, and belief systems. Professional training, supervision, and professional regulatory services are needed, and psychotherapy in general, CBT included, needs to be more organized, as a preferred treatment for patients/clients to seek in times of psychological distress. CBT may be the first line of treatment for many mental disorders from a psychologist's purview. But is it for the person in need, which is the million-dollar question?

## Research on CBT

CBT is one of the highly researched therapies internationally. Its concrete structure lends itself to both quantitative as well as qualitative analysis. Jaiganesh Selvapandiyan (2019) generated a list of 26 articles on CBT published from India from various online journals, out of which he reviewed only 11 that were outcome studies as others were from non-indexed journals or were review articles. Out of the 11 outcome studies, 4 used a single case for the study, 7 had sample size lower than 10, and all were conducted on clinical population (Selvapandiyan, 2019).

He assessed these studies on the basis of their relevance (e.g., the exact nature of techniques used), clarity (e.g., content of the therapy session), appropriateness (e.g., description of the technique), and transparency (e.g., session allocation). The review indicated that these studies had many defects such as use of nonspecific terminology, improper conceptualization, use of outdated techniques, and use of techniques that are not CBT techniques and more focus on behaviorism (Selvapandiyan, 2019).

Over the years, much focus has been given to discuss how Indian cultural population is based on eastern values, and therefore, the Western-based therapies may not be applicable in Indian culture in its original form and the need for cultural adaptation (Neki, 1975; Kuruvilla, 2000). However, Jaiganesh S. points out in his review that the defects in the CBT studies in India were however not related to the cultural adaptation. There seems to be a general lack of research on cultural adaptation (Selvapandiyan, 2019).

According to Jaiganesh Selvapandiyan (2019), it is possible to adapt the CBT interventions to a cultural population while adhering to the standardized specific CBT protocol, with minor alterations. It is stressed that one does need to be thoroughly aware of what is being changed and why (Selvapandiyan, 2019).

In India, the focus of research in CBT has been mainly on the efficacy of the therapy in various populations. Mahigir et al. (2012), and Ayatollah Karimi conducted a quasi-experimental study on the efficacy of REBT as a psychological treatment to influence pain intensity in cancer patients in Iran and India. The results indicated that REBT was highly effective in lessening the pain in cancer patients.

Kannan et al. (2017) compared the effects of different modes of treatment – pharmacotherapy, pharmacotherapy with REBT, and pharmacotherapy with psychoeducation on the management of pain in patients with musculoskeletal pain and headaches. The effects were seen to be more significant in the group that received pharmacotherapy and REBT than the other two groups.

Two studies were conducted on REBT's effects on depression. Mousavinik and Basavarajappa (2012) studied the effects of REBT on depression in infertile women and Mangayarkarasi and Sellakumar (2017) studied the effects of REBT in HIV-infected women. Both the studies indicated significant reduction in symptoms of depression in respective populations. Two studies aimed to find the effectiveness of REBT in adolescents. G. Ventakatesh Kumar (2009) investigated and reported significant impact of REBT on symptoms of conduct disorder in adolescents. Ghasemian et al. (2012) in their study of effectiveness of REBT on shyness in male and female adolescents found that the shyness reduced significantly in the posttest, and the gender comparison indicated higher reduction of shyness in male adolescents than in females. Two studies explored the effects or presence of rational and irrational beliefs. One of them, by Modi and Thingujam (2007), explored the role of anger and irrationality on minor physical problems in married couples. The study showed significant correlation between need for comfort, other downing, overall irrationality, and the anger and physical issues experienced by the couples.

Mullai et al. (2018) explored the prevalence of irrational belief among elite shooters, which indicated that there were irrational beliefs related to their performance. Need for achievement and demand for fairness of the performance were noted to be higher than other irrational beliefs. Another study conducted by Kulkarni and Patwardhan (2015) on "Gender and Behavior – Stressful life events and irrational beliefs as predictors of psychological well-being" showed that irrationals beliefs were moderately significantly correlated with psychological well-being in adolescent girls in Pune, India, as against the uncontrollable events and life events having low significant correlation with their psychological well-being.

An overall analysis of the current research indicates few striking features. The research is conducted many times with clinical populations or in samples that suffer from a physical ailment. Very little research is done with the general population. This could either be because of the ease of access to the clinical population or the priority given to a crisis intervention-orientated objective rather than a prevention-orientated objective.

The research also seems to be focused on the efficacy of the therapy and seems to be using overall therapy intervention at the methodology level. There are very few studies that attempt to study an aspect of the therapy, such as irrational beliefs, emotional disturbance model of REBT, etc. The research also focuses on the evaluation of the result or outcome of the therapy as against the evaluation of the process of the therapy.

The research can be used not only to establish the efficacy of the therapy in India but to study the cross-cultural application as well. REBT is considered an evidence-based therapy worldwide; however, the acceptance of this evidence in the context of Indian culture has been low as the evidence providing research is conducted mostly

in Western countries. The various aspects of the CBT and REBT model need to be investigated, and its applicability in the local population needs to be showcased more prominently, which would possibly lead to much more acceptance of it among the clinicians and the public. The paucity of psychotherapeutic literature could be credited to many factors, namely, a lack of training/teaching centers, instruments needed to conduct research studies, time restraint, lack of facilities, inadequate supervised training, and clients' perspectives about secrecy, as well as privacy and stigma.

Kuruvilla (2010) in his rigorous analysis of CBT research emphasizes the need for research on the *process* of the therapy and how it helps the client form newer helpful schemas as well as the factors that may interfere with its efficacy. His recommendations for the research of CBT practice in India aim at the modification of the therapeutic processes in keeping with the cultural and religious factors present in the Indian population. The review of studies over the years indicates the need for research at the conceptual, process, and outcome level (Kuruvilla, 2010) and quality control of the studies (Selvapandiyan, 2019). This would then require a structured and standardized practice of the therapy among certified and competent therapists. This kind of practice can be increased by creating more acceptance and favorability among the practitioners and also improve the training opportunities in the field.

## CBT with Special Populations in India

The current situation in India as far as psychotherapy with children is a concern (Venkatesan & Shyam, 2015). A major setting in which children are more likely to receive psychotherapeutic help is the school setting. It is mandatory in India for schools to have at least one counsellor as part of their staff (National Council of Educational Research and Training's Guidance and Counselling Guidelines for States, January 2015). However, practically speaking, the quality or the value added from a counsellor for the children in the school setting is limited by several factors, including:

- There is a lack of understanding about the scope of a counsellor's work in the school setting. The counsellor is mostly dependent upon the reading or the interpretation of the teachers or parents for referrals. Usually, the counsellor has one room assigned to her where she does individual work with children. There are very few opportunities for awareness-based group interaction with children.
- It is very likely that there is only one counsellor available for children right from the first grade to tenth grade which is a large number considering there are 40 students per class and three divisions per grade in most schools (Venkatesan & Shyam, 2015).
- Parents still look at therapy as a stigma, and they may be resistant to believing that their child may need help. They believe that their child is being singled out

and that the problem is not as big as the school thinks it is, and it is nothing that the parents cannot solve at home.

- Children could also feel ashamed for being sent to therapy and therefore not engage in the therapy process.
- The aspect of therapeutic goal setting is largely undermined when it comes to children. Most therapists set up goals according to what the parents and the teachers have recommended. This may lead to the child not really being invested in the therapy process since she/he cannot relate to the goals of therapy.
- Supervision for counsellors in a school setting is absent. Many graduates are likely to take up a school counselling job because it is relatively easily available without having the support required to hone their skills on the job. Outside the school setting, children are increasingly referred to therapists and the scenario is far better. The most common problems that children are referred for are:
- Academic difficulties – Academic achievement is highly valued in the Indian population and may even be considered as a parameter for the child's and the parents' overall competence and worth. Achievement and education are status symbols in Asian society. Hence, achievement and excellence in school tend to be a source of pride for parents who see their children as an extension of themselves and also a measure of their successful parenting (Kumar & Gupta, 2012).
- Problems related to noncompliance – Compliance is considered a mark of respect in the Indian culture. A child who expresses her opinions too much and doesn't obey or doesn't fit the norms as far as ethics or rules of behaviors are concerned raises an alarm for parents. Compliance and conformity are often rewarded with approval, acceptance, and emotional nurturance.
- Somatic complaints – Indian parents find psychological distress couched in somatic complaints more acceptable and rarely equate academic underachievement as arising from emotional disturbances. A study in socialization of emotions in Indian children (Kumar & Gupta, 2012) revealed the range of problems reported among these children included mostly depressive and somatic complaints. Raguram et al. (1996) in their study of stigma, depression, and somatization in South India found that the tendency to perceive and report distress in somatic terms was influenced by various social and cultural factors, including the degree of stigma associated with the particular symptom (Kumar & Gupta, 2012).
- Behavioral tantrums – Within the joint family system, children often grow up with a feeling of entitlement. The whole family (including grandparents) loads the child with love conveying to the child that he or she is extraordinary or special. Thus, the child is likely to believe that she/he is entitled to this love and attention and might not be able to cope with the real world outside their home environment. Children could also become quite dependent on parents to solve their problems. Mothers commonly quit working once they have children and are dedicated to "taking care" of their children. They work very hard to prevent their child from having any problems and rescuing their children quickly if they do end up having problems.

Cognitive behavioral work with children has just started to take roots in India. In our professional experience and our interaction with other counsellors, increasingly, counsellors want to learn CBT and apply it as it is a concrete model and easier for the therapist to learn and apply to children and measure progress.

To be effective, CBT must be adapted to children in India with an understanding of the values and beliefs that are a part of the Indian culture. A therapeutic model like REBT is quite likely to be effective with Indian children. Within its structured framework, this model also allows creative flexibility. With its focus on goal setting and engaging in concrete cognitive-emotive-behavioral tasks and a vast repertoire of children-specific techniques, REBT is gradually growing more popular as a therapeutic tool for working with children.

We have looked at the historical underpinnings of present-day psychotherapy in India and the factors that influence the practice of CBT in India currently. In creating and influencing the future of CBT in India, effective training and intensive research that can allow us to adapt the CBT philosophy to the Indian cultural context will prove to be important contributors. We have taken the first small steps toward raising the quality of training available here. Affiliations with international institutes have made high-quality trainers and training programs more accessible to Indian psychologists, professionals, and students. There is a big scope for improvement in the area of research. We need more studies that can rigorously test the efficacy and effectiveness of various forms of CBT within the cultural context. There is increased awareness among the masses about the need for psychotherapy in general and the role of CBT in particular. Public awareness programs, conferences, and group interactions are already on the rise. Going forward, it will be helpful if we can identify and implement ways to make therapy more time-efficient and cost-effective. We can be optimistic that CBT is going to gradually become a sturdier and more sustainable part of mental health work in India.

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# Chapter 16
# Cognitive Behavioral Therapy in Indonesia


**Neila Ramdhani**

## An Overview of Indonesia

Indonesia is an archipelagic and equatorial country consisting of 17,504 islands, which is geographically located in Southeast Asia, between the mainland of Asia and Australia continent, and between the Pacific Ocean and Indian Ocean (Kusmana, 2011). With population as many as 260,700,000 people in 2018, Indonesia is the world's fourth most populous country with the most Muslim population (Central Intelligence Agency, n.d.). Indonesia shares land borders with Malaysia on the island of Kalimantan, with Papua New Guinea on the island of Papua, and with Timor Leste on the island of Timor. The other neighboring countries are Singapore, the Philippines, Australia, and Indian Islands of Andaman and Nicobar.

The history of Indonesia has been influenced by many other nations. The Indonesian Archipelago has become an important trading region since the seventh century, concurrently with the golden era of Srivijaya Kingdom, a Hindu-Buddhist empire located in today what is known as Palembang. The kingdom had religious and trading contact with China and India as well as the Arab world. Hindu and/or Buddhist kingdoms began to emerge since the fourth century up through the thirteenth century. From the eighth to sixteenth century, traders and scholars came to the archipelago, bringing also with them the religion of Islam. The Europeans came in the late fifteenth century; they fought with one another in the archipelago to try to monopolize the spice trade. After being colonized by the Dutch for almost three centuries, Indonesia, which at that time was called the Dutch East Indies, had an opportunity to declare its independence in the end of World War II, to be exact on 17 August 1945. Since then, it has been not easy for Indonesia to develop; it has to face various challenges and complexities, ranging from frequent events of natural

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disaster, massive corruption, social conflicts, separatism, process of democratization, and social-economic-political changes to rapid modernization.

From Sabang in the Aceh to Merauke in the Papua, the population of Indonesia consists of various ethnic groups, speaking many different languages and embracing different religions (Webster, 2007). Based on the race, Indonesian natives are Southern Mongoloid/Austronesia and Melanesia. The Austronesians are the largest in number, and they inhabit the western part of Indonesia. Javanese is the biggest ethnic group with a population of 41.7% of the entire population (Yuliwulandari et al., 2009). Indonesia's national motto "Bhinneka Tunggal Ika" means diversity in unity, describing the sociocultural diversity that forms the nation. Besides having the big population and large area, Indonesia has natural areas, home to one of the largest amounts of biodiversity in the world (Von Rintelen et al., 2017).

## History of Psychotherapy in Indonesia

The history of psychotherapy in Indonesia cannot be separated from the birth of psychology education in this country. It started with the idea from Prof. Dr. Slamet Iman Santoso, a psychiatrist who stated the importance of a way to put a person at the right position (Fuad Hasan, 2007, in "*Dialog Psikologi Indonesia: Doeloe, Kini dan Esok*" published by Himpsi Jaya). The first psychology department in Indonesia was established in Jakarta's University of Indonesia in 1952. As the person who promoted the importance of psychology education, Prof. Dr. Slamet Imam Santoso was chosen as the head of the department. Then, as the department was upgraded to a faculty in 1960, he was then promoted as the dean. In 1961, Padjadjaran University of Bandung inaugurated its Faculty of Psychology, which was established on the initiative of an Indonesian military officer who had studied psychology in the Netherland and Germany. The third faculty of psychology was opened in Yogyakarta's Gadjah Mada University in 1964.

The development of psychology as discipline in Indonesia received a positive reception from public. The stereotype of psychological services that formerly was assumed to be identical with treatments given to people with mental disorders gradually faded as the number of psychology education institutions at the level of university grew. At present, there have been more than 100 universities carrying out the discipline of psychology for undergraduate level, 19 of which also have professional psychology program (http://himpsi.or.id). The increasing number of students of psychology can be an indicator of the increase of people's awareness of the importance of psychological services.

People's enthusiasm toward psychology, especially the profession of psychologist, increases the number of psychological service providers outside health services provided by the government. There are more than 50 psychological service institutions operating now. The services vary from recruitment service, talent and interest scouting, and counseling to psychotherapy. This condition certainly needs

to be supported with government's regulations that can guarantee the welfare of the recipient communities and to maintain the professionalism of the psychologists.

Although it has taken a long time, the efforts of strengthening the institutions providing services related to psychological problems have already been noticeable. In 2014, the government of Indonesia passed the Law No.18/2018 on Mental Health. In order to confirm the explanation of psychological problem and mental disorder, Article 1 of the law defines them differently by two terms, namely, *Person with Psychological Problem* and *Person with Mental Disorder.* The former is any person who experiences physical, mental, social, growth, and developmental problems and/or quality-of-life problems so that he/she is at risk to suffer from mental disorder. The latter is any person who experiences disruptions in thought, behavior, and emotion manifested in the form of a group of symptoms and/or significant behavior change, which can cause suffering and obstacles in conducting his/her function as human being.

On the other hand, persistent socialization and education have been carried out to make the public have knowledge about the psychological services and profession of psychologists. People without enough knowledge, perhaps, go to see physicians when feeling sick so that they have to take medicine or injection that they actually do not need because what they feel and experience is not caused by physical problems. Regulations from the government in order that people can be protected and psychologists can participate more comfortably is warranted.

The criteria stated in the Law No. 18/2014 are sufficient to describe the differences between psychologist and psychiatrist. The measures taken to treat persons with psychological problems are relevant to the profession of psychologist. In the explanation section for the Article 55 letter a, it is stated that a psychologist provides services of diagnosis, prognosis, counseling, and psychotherapy.

Counseling and psychotherapy are techniques of delivering aid to client experiencing psychological problem. Counseling is the process of helping people make adjustments in normal developmental processes across the life span, including educational, vocational, and marital adjustment and planning, family dynamic, aging, and rehabilitation after disability. Psychotherapy is the process of relieving mental disorder by psychological means. There are numerous therapeutic approaches, used throughout Indonesia which use a wide variety of theoretical approaches and techniques (Matsumoto, 2009). The differences between these two processes of aid delivery are also stated in the Indonesian Psychological Association's Code of Ethics, to be exact, in Article 68, which is approved by Article 71 that the focus of counseling is more on the prevention and development while psychotherapy is on the process of healing from psychological problems or personality problem. Thus, to be able to deliver counseling and psychotherapy services, it needs the qualifications of a psychologist.

The association's code of ethics explains that professional psychology education in Indonesia is conducted by universities that meet the requirements by involving the Indonesian Psychological Association in developing curriculum and equalizing psychologists' competence. In the professional education program, the prospective psychologists are required to study psychotherapy that puts interpersonal

interaction between a psychotherapist and a client as a very important aspect of training. Psychotherapy helps individuals with psychological problems to regain their well-being and to get better mental health by assisting them to face and recognize conditions potentially causing problems in them so that they are able to increase their ability to build social relation.

In order to describe psychotherapy in Indonesia, the writer first distinguishes it from counseling. Since counseling is a service given to help a client who wants to develop him/herself, psychotherapy is a service of delivering aid to a client who experiences psychological problems. With this definition, psychological counseling has more and wider settings; it can be conducted in schools and working environments. In school, the responsibility is taken by school counselors who have education backgrounds in school counselor program and in psychology.

In contrast, psychotherapy is provided by certified psychologists only. With this requirement, psychotherapy is more recognized after a professional psychology education program is carried out, usually at private clinics, universities' counseling agencies, and hospitals' policlinics. Once, psychotherapy could only be given by senior psychologists who had studied it in universities abroad. In Padjadjaran University, there was Prof. Sawitri Supardi Sadarjoen who very often applied psychodynamic psychotherapy. The writer has learned how to use the approach from her. Her seriousness in teaching techniques of psychotherapy was proven with her initiative to conduct Brevet Psychotherapy Training, a training organized in collaboration with RINO Groep from the Netherlands. The participants were required to be psychologists. The training was conducted in stages consisting of class session, role play, and supervision from the basic to advance levels and final test of conducting psychotherapy before the examiners who were senior psychologists.

In Gadjah Mada University, where the writer studied and at present works, psychotherapy at the beginning was taught by a senior clinical psychologists who graduated from Oregon University, Prof. Johana Endang Prawitasari. In this university, theory of psychotherapy is taught at the level of undergraduate, while the principles of psychotherapy with diverse approaches and methods of psychotherapy are comprehensively given at the level of master program. Although psychotherapy was not taught as specific as how Prof. Sawitri trained in Bandung, Prof. Johana often gave feedbacks to psychologists who were interested in clinical field related to the development of psychotherapy competence. The model of small-group learning was regularly done with clinical psychologists.

## Current Regulations Regarding Psychotherapy Provision

In Indonesia, services of giving aid to people with psychological problems are provided by several professions. According to the Law No. 18/2014 on Mental Health, it is stated that a person with a psychological problem can be helped by counselors. Counseling service can be done by school counselor at school, physician, and

psychiatrist. The significant differences between processes of therapy with counseling and psychotherapy lie on the role of the therapist and the client. The book of Indonesian Psychological Association's Code of Ethics states that counseling service is especially delivered to help an individual in developing their competencies.

Psychotherapy emphasizes much on collaboration of both sides because client's participation is very important. Putting both sides in empowering positions is the advantage of psychotherapy as compared to other psychological help services.

In the psychologists' Code of Ethics, psychotherapy service is regulated with Article 71, and the qualification of service providers is regulated with Article 72.

## Professional and Cognitive Behavior Therapy Organizations

Formerly, the organization for psychological professions in Indonesia was called *Ikatan Sarjana Psikologi* (ISPSI; *Association of Psychology Graduates*), which was founded in 1959. Along with the development of psychology education and the change in education system in Indonesia, in 1998, ISPS was also changed to *Himpunan Psikologi Indonesia* (HIMPSI; Indonesia Psychological Association). The members of this organization are entire graduates from psychology programs of all levels: bachelor degree, master degree, or doctoral degree.

HIMPSI itself also accommodates their members to associate themselves based on their professional interests and similar interests. As follows are 15 organizations of their specific interests:

1. Clinical Psychology Association
2. Social Psychology Association
3. Indonesian Development Psychology Association
4. Indonesian Psychotherapist Association
5. Sport Psychology Association
6. Industry and Organization Psychology Association
7. Indonesian Educational Psychology Association
8. Indonesian School Psychology Association
9. Islamic Psychology Association
10. Christian Psychology Association
11. Health Psychology Association
12. Aviation Psychology Association
13. Forensic Psychology Association
14. Indonesian Military Psychology Association
15. Positive Psychology Association

Of the fifteen associations, the Clinical Psychology Association (CPA) and Indonesian Psychotherapist Association apparently are the closest to the practices of psychotherapy, especially Cognitive Behavioral Therapy (CBT). Activities of increasing psychologists' competence of CBT are regularly done by the association;

generally, they are in the form of workshop involving role play session. So far, there has been not special association accommodating the enthusiasts and specialists in CBT.

## Training Opportunities in CBT

As the complexity of human life's problems increases, psychotherapy competencies need to be constantly developed and adjusted. CBT is one of the psychotherapy approaches that are studied and applied more often today. Several occasions of developing the skills of CBT had been held in Indonesia, both through formal education and workshops.

Formally, CBT competencies are trained in magister profession program. The website http://himpsi.or.id lists 19 magister profession study programs in Indonesia. Their curriculums are designed and developed jointly by the universities and HIMPSI. In this master program for psychological profession, all students are required to learn various approaches of psychotherapy, one of which is CBT. Psychotherapy is trained in class, ranging from assessment to intervention. Then, the students are assigned to practice their skills in health service centers to directly work with clients. They have to complete 700–720 hours of clinical work.

Considering the limitation of opportunity for prospective psychologists to learn CBT during their study in the master program, various organizations have designed programs of developing competencies related to psychotherapy approaches, especially the CBT. Clinical Psychology Association has worked together with universities to hold workshops and trainings of CBT. These activities do not only address theories but also give examples and opportunity to exercise and receive feedback. The duration of workshop varies from 24 to 30 hours.

Workshops and trainings usually involve very diverse experts and trainers, ranging from practitioners to academics. Working together with the association, Faculty of Psychology of Gadjah Mada University had for several times held general lectures on CBT, workshops for psychologists who wanted to master CBT, and approaches similar with CBT, inviting Prof. Theo K. Bouman from University of Groningen as trainer. *Cipta Aliansi Profesi* in Jakarta invited Piyali Chakrabarti, M. Phil., a certified psychologist from Singapore and a practitioner in the field of professional development.

More serious program of CBT competence development was held by Padjadjaran University in collaboration with RINO Groep, Utrecht, the Netherlands. This program was an activity organized by the university's Psychology Profession Training and Study Center. It was initiated by Prof. Sawitri Sadarjoen from the Faculty of Psychology and Dr. Arend Veeninga from RINO Groep. CBT Certification is one of two types of certificate offered through 2-year study. It is delivered in the form of workshop, and then the students then apply the competencies at their respective

workplaces. Regular meetings are done for sharing lessons, and the program is concluded with a final test. At present, the program of psychotherapy certification has passed 20 psychotherapists from different regions across Indonesia (http://psikologi.unpad.ac.id/pkp3/).

## Adaptation of CBT in Indonesia

Practically, CBT has already been widely used in Indonesia. Research has been conducted by students of professional psychology masters to clients with diverse problems. The CBT technique included in this paper has generally been adapted by combining it with the methods of reducing psychological tension commonly practiced by Indonesian people when facing problems of life, such as combining CBT with gratitude (Dita, 2018; Fitriani, 2018; Mayasari, 2018; Mutia et al., 2011; Pratiwi, 2018). Another adaptation involved combining CBT with mindfulness therapy that is very suitable with Indonesian culture (Priyuda & Ramdhani, 2016; Stefani & Ramdhani, 2017; Syamanta & Ramdhani, 2017). In addition to the adaptations based on local cultures, CBT is also developed by responding to technological developments to be presented online (Daulay & Ramdhani, 2018; Makarim & Ramdhani, 2018; Ramdhani et al., 2015).

Gratitude is a feeling of happiness bursting from within when an individual receives something that he/she really wants to have (Emmons & McCullough, 2003). Religiously, gratitude is a reminder of the Creator who gives human pleasure (Mutia et al., 2011). Other researchers have combined CBT with religious therapy to help individuals with psychotic symptoms reduce their depression (Fitriani, 2018), individuals with cervical cancer to improve the quality of their lives (Mayasari, 2018), individuals with breast cancer to increase their resilience (Dita, 2018), and individuals with kidney failure increase their self-acceptance (Pratiwi, 2018).

Adaptations following such problem-solving patterns are done not only with local Indonesian cultures, and several studies more broadly have combined CBT with mindfulness techniques, which indeed are rooted in the Eastern approach. This adaptation has been specifically developed to help teenagers who experience addiction to online gaming on basis of the frame of mind that the addiction is caused by difficulties with their self-control and self-regulation. Stefani and Ramdhani (2017) and Priyuda and Ramdhani (2016) have developed guidelines of conducting CBT-based mindfulness training, which is called "Young Mindful Warrior." This naming aims to motivate teenagers who become targets of program implementation in order that they can get mindful despite still playing online games. The therapy guidelines that had been tested on subjects aged 14–15 years old were then tested with feasible result to be used on university students aged 17–21 years old (Syamanta & Ramdhani, 2017).

## Research on CBT in Indonesia

There have been many studies done to test the effectiveness of CBT in Indonesia. Most of them mentioned here were done by students of professional psychology program. CBT research has aimed at reducing depression (Retnowati & Martinah, 1990) and anxiety in facing death (Irawati et al., 2011). Besides reducing the symptoms of depression and anxiety, CBT also was tested for reducing the symptoms of insomnia (Wulandari, 2015) and increasing subjective well-being of individuals with chronic kidney failure (Putri et al., 2016).

The application of CBT in Indonesia is generally combined with the local characteristics of Indonesian societies that are culturally religious; CBT is matched with expression of gratitude as done by Mutia et al. (2011) to help clients suffering depression. A religious approach is used along with CBT as done by Dita (2018) to help clients suffering from breast cancer. Religious culture that encompasses the social life of Indonesian people has driven researchers to combine CBT with religiosity. Trimulaningsih and Subandi (2010) conducted a religious CBT therapy for reducing depression. Their findings were endorsed by Hayatussofiyyah et al. (2017), who studied this religious CBT for reducing the symptoms of depression in teenagers, and Radiani (2017) conducted a similar study on individuals who lost sight.

The modifications of CBT in Indonesia are done not only based on the contexts of culture and religion but also on technological development. Ramdhani et al. (2015) started to develop CBT therapy with support of Internet technology to help high school students who experienced social anxiety. This study has been developed further by Makarim and Ramdhani (2018) to help people who suffer from depression and by Daulay and Ramdhani (2018) to help clients who suffer from social anxiety.

## CBT with Special Populations in Indonesia

In Indonesia, CBT has been applied for a number of specific population. For example, it is used to help reduce depression in individuals with physical disabilities (Sulistyorini & Prawitasari, 2005) and individuals suffering from stroke (Rahmasari & Rosy, 2009). In addition to reducing depression level, CBT in Indonesia is also used to reduce anxiety of facing medical procedures in children who suffer from leukemia (Mawandha & Ekowarni, 2009) and anxiety experienced by asthma sufferers (Rufaidah & Hadjam, 2009), and even it was successfully applied to help individuals with HIV/AIDS cope with their anxiety of death (Irawati et al., 2011).

CBT studies having been done aimed to test the effectiveness of psychotherapy mostly conducted in Indonesia. In general, the reliability of CBT in helping individuals who experience psychological problems has been well tested. So far, the effort to compare CBT with other approaches still needs to be done so that opportunity to develop more proper adaptation for the implementation in Indonesia can be revealed.

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# Chapter 17
# Cognitive Behavioral Therapy in Iran


**Tahereh Pirhekayaty**

## Country Overview: Iran

Iran is a country that has often been viewed – whether positively or negatively – in stereotypical terms. The fact remains, as evidenced in written and oral history, that Iran, based on its geo-socio-political uniqueness and complex dynamic, holds a central position in relation to the world in many domains. Among other countries reviewed in this book, with their various methods and processes of adopting cognitive behavior therapy (CBT), Iran presents a structurally unique case due to a number of factors, including its cultural heritage, historical events, and advancements in the profession of psychology, prior to its transition to Western modality.

Iran has been considered one of the richest countries not only in natural resources but also as a center of science and technology, at various times in history. Iran has had at its core an ancient and enduring heritage of philosophers, poets, mystics, and intellectuals whose works form the very foundation of logic and logical thinking processes. Iranians' cultural heritage includes contributions at the most foundational level, such as the introduction of logic, epistemology, and the development of and understanding of cognition and the relationship between cognition and behavior. These comprise the very underpinnings of CBT.

Often, religions have played the role of being the center of resources in many domains of human life, including education, information, safety, economic resources, and sometimes even governing society. However, the title of any religion should not be used to stereotypically minimize the contributions of individuals in the context of their society and country. In that manner, not every country contributed as much as Iran did with its valuable cultural heritage, such as during the Islamic Golden Age. The Islamic Golden Age, a period that predated Europe's

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Renaissance and Enlightenment by centuries, was a time of profound advances in the sciences, economics, mathematics, philosophy, and the arts.

The essential reason that CBT was readily adopted into psychotherapy practice in Iran is that the very notion of cognition and its relationship with behavior was already a deeply and historically held hallmark of Iran's culture. Considering modernization as one evolutionary process, it is important to avoid the cultural bias of equating the concept of modernization with westernization. Iran's position is one that was rooted with a highly developed modern way of thinking and doing with Iranian scholars being highly advanced in technology, using scientific tools and contributing to the foundation of science and math.

Consider, for example, how modern sounding are these words of wisdom written in the middle of the twelfth century by Nizami Arudi:

> The physician should be of tender disposition, of a wise and gentle nature, and more especially, be an acute observer, capable of benefitting patients with accurate diagnoses, that is by being able to offer rapid deduction of the unknown from the known. And no physician can be of a tender disposition if s/he fails to recognize the nobility of man. (From Chahar Maqala The Four Discourses of Nidhami-i- Arudi-i- Samarqandi)

Another outstanding example is the mind-body connection, whereas Avicenna (c. 980–1037) wrote extensively and insightfully about the interrelationship between the mind/soul and body (Keyhani & Torkaman, 2017).

The study of human knowledge, cognition, and the concept of epistemology – the question of "how do we know that we know" – which is central to CBT, was of great concern to Iranian philosophers. This interest is reflected in poetry, words of wisdom, and literature. The success of the adaptation of CBT in Iran is rooted in the indigenous cultural value of epistemology.

In the West, there is a growing recognition that mainstream psychological science reflects and promotes the interests of a privileged minority of people in affluent centers in the West. "Compared to other social science disciplines, there are few critical voices who reflect on the Euro-American colonial character of psychological science, particularly its relationship to ongoing processes of domination that facilitate growth for a privileged minority but undermine sustainability for the global majority" (Adams et al., 2015). The acronym WEIRD, referring to Western, Educated, Rich, Industrialized, and Democratic societies, is shorthand for the dominant population that occupies the privileged position of being the subjects of research in the field of psychology. Researchers from the University of British Columbia found that people from these societies represent as much as 80% of study participants but only 12% of the world's population (Azar, 2010). In a process that has been variously described as decolonization or reindiginization, the field of psychology in Iran has drawn on native and historical influences rather than merely following the West's lead uncritically.

It is Iran's cultural foundation that informed its intellectual challenge to the wholesale importation of Western sciences, including psychology. Following an initial period of adoption of Western psychological principles and practices leading up to the revolution in Iran, there was a profound rejection of anything that was

considered "*gharbzadegi*" or westernized. The rejection of western values and influences extended to the field of psychology with its renewed embracing, acknowledging, and incorporating of philosophy, religion, mystical, and cultural influences that had too often been disregarded in the past. These are not merely contributions; rather, they are integral to CBT in Iran.

The unique richness and geographic centrality of Iran made it very attractive to the outside world. Throughout history, Iranians faced the repeated challenge of invasions aimed at accessing its resources. As a result, the social psyche of Iran was impacted by many forms of totalitarian government and the authority of religion throughout its history. The function of totalitarianism is to manage/control its diverse population. A totalitarian regime's view of the world is influenced by power and control through a motivation lens. As a negative stereotype, it has a kind of paranoia, as if seeing foreign hands behind everything. This phenomenon existed in the social psyche of Iran, similar to other totalitarian societies in the world. However, unlike other countries, Iranians resisted oppression and remained vigilant since their perception of reality was not always based on "paranoia" but on its enduring resiliency and cultural foundation.

Iran, also known as Persia and, currently, the "Islamic Republic of Iran," is located in Western Asia. It is the second-largest country in the Middle East and the 17th largest in the world. Iran's centralized location, as well as its proximity to the Strait of Hormuz, gives it considerable geostrategic importance, while its reserves of fossil fuels – which include the world's fourth-largest oil reserves and largest natural gas supply – provide it with significant influence in the world economy (World Atlas, 2018).

The variety of ethnicities living within Iran contributes to its vast diversity. These include Persians, Kurds, Lurs, and Balochs, Azerbaijanis, Turkmens, Armenians, Assyrians, and Georgians (World Population Review: Iran, 2018).

Nearly all of Iran converted to Islam in the seventh century (Gillis, 2013). The country is predominately Shi'a Muslim; the remaining are Sunni Muslim, Christian, Zoroastrian, Baha'i, and Jewish (World Population Review: Iran, 2018). The revolution led to significant changes in the demographics of Iran, including the diaspora of many who were left vulnerable by the forceful dominance of the established Islamic religion to leave their homeland in search of safety as a fundamental human right.

The lingua franca/common language of Iran is Persian (Farsi). Indicative of the unique social and ethnic diversity Iran, other languages include Azeri (Azerbaijani), Kurd, Gilaki, Mazandarani, Lur, Arabic, Baloch, Tati, Talysh, and Turkmen. There is a very high literacy rate within the country, and many are fluent in a language other than Farsi (Languages of Iran, Iran Atlas, 2018).

At the heart of Iran's culture are its literature, poetry, and words of wisdom. Eagerness to learn is not limited to those pursuing formal education. Proverbial sayings or words of wisdom function as a method of conveying important life lessons and may be referred to as an authority. Many Persian poets, such as Sa'di, Hafez, and Mulawi (known as Rumi in the West) expressed their wisdom in writing moral and allegorical sayings many of which are infused with Sufi-inspired mysticism.

As part of their collectivistic culture value, Iranians feel obligated to support family members and even strangers without any expectation of repayment. The word of wisdom symbolizing this refers to the time in life when people can benefit from support for survival and home: "you do great deeds and throw it in the river as God/the Observer will return it to you when you are stranded in the wilderness." Another word of wisdom about lived experience states that "he who never learned from the passage of life would never learn from any teacher."

Persian literature inspired Goethe, Ralph Waldo Emerson, and many others in the West, and Farsi has been often considered a most worthy language to serve as a conduit for poetry. Persian poets such as Ferdowsi, Sa'di, Hafiz, Attar, Nezami, Rumi, and Omar Khayyam are also known in the West and have influenced the literature of many countries. Persian literature is one of the world's oldest literatures, spanning two and a half millennia (Spooner, 1994).

Another important element in Iranian culture is mysticism. Much of Iran's heritage of mysticism is drawn from Sufi teachings. "In a broad sense, Sufism can be described as the interiorization, and intensification of Islamic faith and practice" (Chittick, 2007). Culturally, Iranian fascination with mysticism moves beyond its connection with religion.

## Cultural Identity

Culture is defined as a way of life, attitude, and a way of thinking and behaving based on values and beliefs that develop among specific groups in the context of society. Accordingly, we are multicultural within, as we are multicultural between different groups in our community. In terms of Intersectionality Theory, the overlap of social identities contributes to an individual's experience of social privilege and oppression in the context of their society. This explanation is directly related to Iranian cultural identity as many intersectionalities of culture played a significant role in the experience of oppression and privilege throughout history. Accordingly, oppression and privilege are not independent of societal context and in fact are embedded in the interrelatedness which creates a unique dynamic for each individual Iranian.

Iranians' sense of themselves is grounded in ancient wisdom and cultural heritage with resiliency in the face of unforeseeable upheavals. The intersectionality of Iranian cultural identity creates a dynamically unique characteristic that requires deeper analysis of contributing factors.

For centuries prior to the revolution in 1979, the form of government in Iran was a monarchy. The latest monarch was Mohammad Reza Pahlavi, the Shah of Iran. In April 1979, by referendum, Iran became the Islamic Republic of Iran. Iran's political structure includes the office of Supreme Leader; the Executive, Legislative, and Judicial systems; as well as the Assembly of Experts, the Expediency Discernment Council, and the Village Councils (World Atlas, 2018).

## History of Psychotherapy in Iran

The origins of psychotherapy in Iran predate the introduction from the West of modern psychology. Although the history of psychotherapy in Iran is mainly drawn from the Islamic era, there are further influences drawn from ancient Greek and Islamic thought (Javanbakht, 2010).

Recognition of mental illness dates back to 2100 BC when the Babylonians believed that the cause of mental illness was devils conquering the soul. The treatment for this was a combination of magic and pious prayer. Zoroastrian literature refers to three types of physicians: herbal therapists, surgeons, and divine word healers who may be thought of as the first psychotherapists in Iran. In ancient Iranian kingdoms, there were always two major figures in the royal court: one, a healer/health-care provider called a *hakim* and the other an astronomer, one who could foretell the future. In the Middle Ages, in Iran, people with mental illness were treated with medicinal herbs, perfumes, music, and similar methods of treatment (Nejand, n.d.).

The history of psychotherapy in Iran is rooted in the indigenous approach from the Islamic era. In the writings of Muslim scholars, the term *Nafs* (self or soul) was used to denote individual aspects of personality and the term *fitrah* for human nature. These concepts, drawn from the Qura'n, correspond remarkably to Freudian and Jungian terminology developed over a thousand years later. *Nafs* encompassed a broad range of faculties including the *qalb* (heart), the *ruh* (spirit), the *aql* (intellect), and *irada* (will). Early Muslims wrote about human nature, referring to it as *llm-al Nafsiat* or self-knowledge. "In many cases, their works seem be the original ideas for many modern day psychological theories and practices" including Freud's Id, Ego, and Superego (Haque, 2004; Abu-Raiya, 2014).

The first psychology laboratory in Iran was established in 1933 under the supervision of A. A. Siassi. Following the Second World War, Iranian sociopolitical life was divided between religious and secular/Marxist ideology. By 1950, a psychology program was founded at Tehran University. It was in this context that psychoanalysis was first formally introduced in Iran. *Freudianism*, the first book on Freud's ideas in the Persian language, was written in 1951 by Amirhossein Arianpour, a Marxist sociologist at Tehran University.

In more recent history, two major events affected the field of psychology in Iran in profound ways. One was the so-called in 1979; the other was the 2003 Bam earthquake and its aftermath.

## The Revolution (1979)

Numerous factors led to strong opposition to the Shah by various factions within Iran, including clashes with Islamists, increased communist activity, severe inflation, as well as opposition to reports of the monarchy's oppression, brutality,

corruption, and extravagance (Harney, 1998; Abrahamian, 1982). The 1979 Islamic Revolution began with major demonstrations against the Shah in 1978. A year of demonstrations and strikes paralyzed the country and its economy. The Shah fled the country, and Ruhollah Khomeini returned from exile to Tehran in February 1979 to form a new theocratic government.

Leading up to and continuing after the revolution, there was a shift in intellectual attitude which turned eastward, with a renewed appreciation of Persian culture, religion, and heritage. This coincided with a general rejection of Western influence. The westernization of Iranian culture that preceded the revolution was now referred to as "*gharbzadegi,*" the pejorative Persian term translated variously as "westernized," "West-struck-ness," "Euromania," or "Occidentosis." The term gained popularity following its use by Jalal al-e Ahmad, a prominent Iranian author, philosopher and sociopolitical critic (Brumberg, 2001). The term *gharbzadegi* is used to describe the fascination with and dependence upon the West, an indiscriminate borrowing from and imitation of the West. It implies a sense of intoxication or infatuation that impairs rational judgment needed to see the dangers presented by the West, such as moral laxity, social injustice, and obsession with materialism (Brumberg, 2001).

In my view, the essence of the revolution was opposition to what was regarded as extreme westernization at the expense of Iranian cultural and intellectual heritage. I prefer to frame this movement as evolutionary rather than revolutionary as I believe Iran has been pioneering advancement with resiliency and commitment to the foundation of its heritage. In fact, Iran is the first country in the Muslim Middle East where a viable grassroots democratic movement challenged the existing government/monarchy. In the end, this movement was in effect hijacked by an opportunistic radical group promoting Islamic authoritarianism and claiming divine legitimacy (Milani, 2004).

A renewed emphasis on the native Iranian identity arose and a quest for its past religious, intellectual, and traditional perspectives. "This development has drawn on the contributions of early Muslim scholars, such as Abu Hamid Al-Ghazali and Ibn Sina (Avicenna) to the development of psychology and thus, toward the recognition of spirituality as a fundamental factor in psychology" (Kaplick & Skinner, 2017). This reindigenization has continued in the form of considerable research in recent decades "exploring the unique cultural and religious nuances of the application of clinical psychology to Muslim clients as a response to the traditional Eurocentric narratives of psychology" (Haque et al., 2016).

The revolution affected virtually every aspect of the profession of psychology in Iran. For example, one the largest centers of education, research, and treatment founded in 1977 as the Residential Training Center was renamed the Tehran Psychiatric Institute becoming one of the centers under the cover of Iran University of Medical Sciences, when medical education was merged with the Ministry of Health. In addition, the Quarterly Journal of Psychiatry and Clinical Psychology of Iran, which can be found in the International Index of PsycINFO, is published by the institute.

## Bam Earthquake

The death toll from the earthquake in Bam in 2003 rose to at least 26,271 people, with up to 30,000 injured. According to the Earthquake Engineering Research Institute (2004), the impact of the earthquake on community institutions, as well as individuals, was devastating, destroying or severely damaging schools, hospitals, and health-care facilities in the area (EERI, 2004). Since so many local health-care professionals lost their lives in the earthquake, many health services were provided by health-care providers from Kerman, Tehran, and other parts of the country (EERI, 2004).

With funding from UNICEF and the mental health department of the Ministry of Health, a large-scale project was established to provide psychosocial support to residents of the impacted area, similar to response efforts following other major earthquakes (Livanuo et al., 2002). The intervention included extensive outreach and needs assessment throughout the region, beginning with "tent visits" conducted by trained mental health professionals (EERI, 2004). These were followed by a series of group counseling sessions focusing on problems such as anxiety and avoidance behavior. Longer-term individual counseling was also provided (EERI, 2004). In addition to physical symptoms, survivors exhibited depressive and traumatic stress symptoms, following the earthquake.

The devastating effect of the Bam earthquake impelled a response that included the imperative of developing community mental health centers and the recognition of mental health as a part of health-care system. This comprehensive integrative advanced model of health-care delivery was subsequently replicated throughout Iran and recognized internationally. In 2016, Bloomberg News ranked Iran as the 30th most efficient health-care system (bloomberg.com, *2016*).

The Psychological Association of Iran was established in 1968 under the Shah's regime but ceased its activities after the Islamic revolution. In the 1970s, a series of epidemiological research projects were initiated, new psychiatric hospitals built, and the Tehran Psychiatric Institute formed (Yasamy et al., 2001).

The Roozbeh Hospital was the first university psychiatric hospital attached to the medical school of Tehran University (Ghassemzadeh, 2007). This hospital remained the main training center until the early 1970s when a group of US-trained psychiatrists and psychoanalysts returned to Iran with a different orientation from the mainly organic and descriptive approach of that time. In 1997, the CBT clinic in the Roozbeh Hospital was established with Dr. Ghasemzahedeh's efforts and support of his colleagues (Ghassemzadeh, 2007).

During the 1980s, a comprehensive national program of mental health was established which was then integrated into the primary health-care system in pursuit of "efficiency."

## Current Regulations Regarding Psychotherapy Provision in Iran

Health-care and public health and mental health services in Iran are provided through a nationwide network. The health system in Iran is uniquely structured to be integrated with health education. In 1986, the government integrated medical education into the Ministry of Health (MOH), which is now called the Ministry of Health and Medical Education. The integration was designed to develop a more coordinated approach to health-care provision and medical education, including psychological education (from Islamic Republic of Iran Nationwide integration of mental health into primary care).

Iran is divided into 30 provinces, each of which has at least one medical university. The president of a medical university, who is in charge of public health, health-care provision in public facilities, and medical education, is the highest health authority in the province and reports directly to the Minister of Health and Medical Education. "The National Health Network system proved effective because it provided a unique framework for primary health care in deprived areas, and health indicators increased accordingly" (Heshmati & Joulaei, 2016, p. 23).

Iran has been able to extend public health preventive services through the establishment of an extensive Primary Health-Care Network, and the health status of Iranians has improved over the last two decades (Iran Daily, July 2, 2009). Iran's integrated public health-care system is a model of including mental health as an integral and prominent feature of health-care provision.

The regulations regarding psychotherapy provision in Iran have evolved over the past few years. As recently as 2001, Ghobari and Bolhari concluded that most psychologists in Iran were operating with a bachelor's or master's degree (Ghobari & Bolhari, 2001). Iran had no centralized system for credentialing of psychologists, and in order to engage in clinical practice, a person needed only to have completed specific coursework in clinical or counseling psychology, including psychological assessment, as well as practice and internship at psychiatric hospitals. Indeed, according to Ghobari and Bolhari (2001), there were only 25 clinical psychologists in Iran who held a PhD degree at that time, while there were over 5000 individuals with bachelor's degrees in psychology. According to the Psychology and Counseling Organization in Iran, there are currently approximately 140 licensed psychologists in Iran divided among regions (e.g., there are 92 licensed psychologists in the capital Tehran based on information from 2019) (http://www.pcoiran.ir).

Although there was no requirement for licensure or certification for clinical psychologists, they had to work under the supervision of physicians or psychiatrists. Although psychologists worked under the aegis of physicians and there was no formal system for ensuring competence to practice, employers preferred advanced academic degrees in psychology and, as Birashk noted, the Iranian Psychiatric Institute and Tehran University had both developed rigorous training programs for mental health providers (Birashk, 2004).

Currently, there is a two-strata system for practice that includes a professional work permit and licensure. Conditions for obtaining a work permit include having, at minimum, a bachelor's degree in psychology and counseling, membership in the Islamic Republic of Iran Psychological and Counseling Organization (www.pcoiran.ir), and at least 1 year from the graduation date.

In order to become a licensed psychologist in Iran, one must complete an application process that includes an interview to demonstrate academic qualifications (completion of a postgraduate degree in psychology), a membership in the Islamic Republic of Iran Psychological and Counseling Organization, and signing a commitment to adhere to the profession's Code of Ethics. Having a military end-of-service card is an additional requirement for male applicants (Iranian Psychological Association, 2018). Iranians, with their progressive tendencies, moved the structure of authorization to practice psychology to a high-standard and organized level, such as in any advanced level of credentialing process in other professions and disciplines. Needless to say, the authoritarian governmental control is apparent throughout all aspects of development, implementation, and outcome of the sciences and technology, including the profession of psychology.

## Professional and Cognitive Behavior Therapy Organizations in Iran

The Iranian Psychological Society was founded in 1968, but its work was ended by the Iranian revolution in 1979. Currently, there are several psychological organizations that operate in Iran, most notably the Iranian Psychological Association (http://www.iranpa.org/) and the Islamic Republic of Iran Psychological and Counseling Organization (http://www.pcoiran.ir/).

Specific to the area of CBT, the leading organization in Iran is the Institute for Cognitive Science Studies (ICSS) in Tehran. In fact, ICSS is one of few academic institutions in Iran devoted to teaching and conducting research in the field. ICSS is a nongovernmental institution and is committed to providing a research and educational environment that brings together the various disciplines that contribute to cognitive sciences. Initially founded in 1997 as a study group, ICSS later expanded its scope to include educational programs for master's and doctoral degrees in different subfields of cognitive science.

The prime interest of ICSS is to conduct research studies that enhance the profession's knowledge and understanding of cognitive science. The institute also adheres to the principle that research findings should be shared with other scientific communities through their publication in respectable peer-reviewed journals and books. To these ends, ICSS engages in a number of other activities, including:

- Graduate studies programs
- Short-term training programs and workshops
- Scientific conferences and discussion meetings

- International collaborations
- Publishing (or supporting the publication of) specialized books and journals
- Providing an effective research environment by means of modernizing and equipping its laboratories and maintaining a resourceful library

## Iranian Clinical Psychology Association/Iranian Association of Clinical Psychology

In 1979, a group of clinical psychologists formed the Iranian Association of Clinical Psychology. Its establishment received final approval at the fifty-third session of commissions of Community Medicine Department and Ministry of Health and Medical Education. The association's objectives include promoting and protecting the legal, scientific, and professional interests of clinical psychologists; promoting public awareness; providing courses, seminars, and regional and international congresses; coordinating and supporting research in the field of clinical psychology, including mental health, treatment, and medical diagnostic tools; and promoting community mental health services.

## Iranian Mental Health Research Network (MHRN)

MHRN, founded in 2006 and supervised by the Iranian Deputy of Research and Technology of the Ministry of Health, is a network of 10 related research centers in Iran. The aim of the Iranian MHRN is to promote high-quality research in the field of mental health, especially in the area of applied research and health system research.

## Tehran Psychiatric Institute, School of Behavioral Sciences and Mental Health (TPI)

TPI, Iran's largest and best-known educational center in the field of psychiatry and clinical psychology, was founded in 1977 in Tehran. TPI is a professional center of education, research, and practice. A division of Iran University of Medical Sciences, TPI is active in the fields of professional psychiatric training, masters and doctoral level education in clinical psychology, treatment of patients with mental illness, and research.

## Training Opportunities for CBT in Iran

Training opportunities for CBT in Iran are found in universities through institutes, such as the Institute for Cognitive Science Studies and Tehran Psychiatric Institute, Iran's largest and best-known educational center in the field of psychiatry and clinical psychology, School of Behavioral Sciences and Mental Health (TPI), and widely available at professional conferences.

## CBT with Specific Clinical Populations in Iran

The basic principles of Cognitive Behavior Therapy (CBT) developed by Dr. Aaron T. Beck in the 1960s while he was at the University of Pennsylvania have proven to be effective for an extensive range of disorders (Naeem & Kingdon, 2012a, b) such as anxiety disorders, schizophrenia, psychosis, mood disorders, and addictions. All of these applications of CBT are practiced in Iran and will be briefly described below.

## Depression

Depression is a global health problem, and CBT has long been viewed as an effective treatment for depression. However, interventions need to be adapted across settings and cultures, and for work in Iran, this is no exception.

One pilot study conducted in outpatient clinics in Iran investigated the impact of 1 week of daily imagery in individuals who suffered major depression. Participants were randomly allocated to a group receiving treatment and a group not receiving treatment. Outcomes in the group receiving treatment included improvements in depressive symptoms, interpretive bias, and imagery vividness. This pilot study provides first preliminary evidence that imagery CBM-I could provide positive clinical outcomes in an Iranian psychiatric setting and further that the imagery component of the training may play a crucial role (Torkan et al., 2014).

## Anxiety

Another clinical population that has received CBT in Iran is comprised of individuals diagnosed with anxiety disorder. Social anxiety disorder is recognized as the fourth most common psychological disorder in Iran (Zare & Ghorbani, 2016). Children and adolescents who are diagnosed with social anxiety have a tendency toward academic difficulties, substance abuse, prolonged disability, and significant difficulties in their daily lives. One study conducted at Payame Noor University in

Tehran compared the effects of positive- and negative-induced memory on people with anxiety-depression. Results of the study showed that positive and negative mood along with depression-anxiety state increases false memory (Zare & Ghorbani, 2016).

## Schizophrenia

CBT is also widely used in Iran in treating individuals with schizophrenia. It has been regarded as favorable to other forms of therapy. For example, in research focusing on improvements in neurocognition and psychiatric symptoms in schizophrenic patients, Dr. Manouchehr Gharaeipour et al. found that while cognitive remediation therapy (CRT) produced an overall improvement in neurocognition, the impact on symptomatology, especially depression and anxiety, was only significant in the group receiving CBT (Gharaeipour & Scott, 2012).

## Adaptation of CBT in Iran

The adaptation of any intervention – especially those related to human cognition and behavior – must be analyzed and adjusted in the context of culture and social psychology. The functional definition of adaptation involves taking a concept, analyzing it, and making it suitable to one's own use – in this case, CBT in Iran. The adaptation in Iran of CBT and other psychological principles and practices that were essentially exports from the West can only be fully understood in the context of Iran's rejection of all things "*gharbzadegi*" or westernized and the idea of "otherness."

The concept of "other" is rooted in our history as human beings, and many philosophers have addressed it through various analytical lenses. It all may be summarized, regardless of the analytic approach, in the question "What is the truth and who is closer to it?" Developmentally speaking, we begin in a symbiotic phase of being one big entity before experiencing separation; then at around the age of two, we begin including others in our connecting with those outside of self. That "other" brings us to being a member of so many layers of community: home, immediate family, neighborhood, country, continent, and global world/planet.

Historically, there have been different approaches and concepts of self and other, including in phenomenology. Georg Wilhelm Friedrich Hegel (1770–1831) introduced the concept of the other as a constituent part of self-consciousness. Jean-Paul Sartre (1903–1980) described how, to the self, the world is altered by the appearance of the other. In this view, the world appears to be oriented to the other and not to the self. The philosopher Emmanuel Levinas (1906–1995) expressed the ethical proposition that the other is superior and prior to the self. Otherness can be regarded as a condition of exclusion, even disenfranchisement, as by the state or social

institutions such as professions (e.g., psychology) that are invested in their own position of dominance. This is the very basis of colonization of psychology, which is a particularly relevant conceptual context within which to examine the adaptation of CBT in Iran. Accordingly, we recognize a deliberate resistance to Western domination in general and specifically in the helping professions such as in the field of psychology. However, the ground for inclusion and adaptation of CBT was paved by the concepts of epistemology and cognition that were the subjects of much ancient philosophy and literature in Iran.

It is essential to view CBT in the context of culture, as reflected by a response from a survey among professionals, students, professors, and others in Iran who in response to a question about the adoption of CBT, "it would be adopted if the clinician learned about the cultural framework" (Pir, 2018). It is also critical to regard culture as integral to the therapeutic approach. The author of this chapter recently developed a Cultural Diversity Training component for an APA-accredited doctoral clinical training program, which emphasizes that cultural considerations are not an adjunct or complement to treatment; rather, that they are fundamental and essential.

Attempts to develop population-specific approaches for ethnic groups have been misguided and have resulted in the unintended consequence of sanctioning stereotypes and giving primary consideration to cultural attributes over an appreciation of the uniqueness and life circumstances of the individual patient within that culture. This has spawned concern over the danger of developing a "cookbook approach" in which characteristics of a particular group or culture are memorized with pat counseling techniques applied without the mindfulness of the specific nuances of the culture and the individual. It is imperative that individuals are treated "as a unique case, exploring directly his or her cultural identity" (Castillo, 1997).

In her article, *Culturally Responsive Cognitive-Behavioral Therapy in Practice*, Pamela A. Hays recounts an incident when she was approached by a trainee who suggested that her presentation of a particular case example might be more effective if she had given the example of "a person, generally, without the part on culture, so that we could have spent more time on actually learning the multimodal approach." The question, posed by a member of the dominant culture of North America, illustrates a tendency to marginalize cultural considerations that Hays points out is pervasive in the field of psychology. She posits that the most influential psychotherapies, including cognitive behavior therapy, "were developed with little and/or highly biased consideration of people seen as being different from the majority of psychologists" (Hays, 1995). The factor of presumption is influenced by unconscious biases and stereotypical thinking.

Despite what Hays describes as an apparent disinterest in culture and minority groups among cognitive behavioral researchers, "there is nothing inherent in cognitive behavior therapy that would preclude its use with diverse people" (Hays, 1995). Indeed, as in the case of Iran, some non-Western cultures may be particularly receptive to the practice, by virtue of culturally compatible values and beliefs. Nonetheless, it is important to recognize that therapies, such as CBT, which were initially developed for mainstream America, need to be modified for individual clients in other cultures. Indeed, "treatment should match, or fit, the cultural lifestyle or experiences

of the client" (Sue & Zane, 2009). As Dr. Habibollah Ghassemzadeh of Tehran University Department of Psychology stated it, "one of the most important issues regarding the cultural aspects of CBT is the dual role of a cultural system or cultural model as it relates to any assessment, treatment, and change process" (Ghassemzadeh, 2007). At the same time that culture provides a valuable means and context for change, "it creates serious obstacles in learning experiences and restructurings, which are also necessary for a change process" (Ghassemzadeh, 2007).

The first training program in Iran for behavior therapy, generally, began in 1975–1976 under the direction of Dr. Habibollah Ghassemzadeh, who became influential in the adaptation of CBT in Iran. In the 1980s, CBT was introduced in Iran by Ghassemzadeh and others. In the late 1980s and 1990s, two texts, the *Cognitive Behavior Therapy for Psychiatric Problems-A Practical Guide*, edited by Hawton, Salkovskis, Kirk, and Clark (1989), and *Science and Practice of Cognitive Behavior Therapy*, edited by Clark and Fairburn (1997) were translated into Farsi and adopted as a textbook in most Iranian universities (Ghassemzadeh, 2007).

Led by Dr. Ghassemzadeh, who became the face of cognitive behavior therapy in Iran, a CBT clinic was opened at the Roozbeh Complex of General Outpatient Clinics in Tehran in 1990, treating a broad range of psychological and psychiatric problems, including depression, anxiety, personality disorders, marital dysfunction, and nonassertiveness (Ghassemzadeh, 2007). Although Dr. Ghassemzadeh was trained in the West, he saw the need for CBT to be adapted in consideration of the cultural experiences of Iranian clients. He recognized that change is twofold: in addition to influencing the client's progress, it also effected change within the provider. Dr. Ghassemzadeh was expert at utilizing Iranian literature in the process of adapting CBT. Drawing on his depth of knowledge in Iranian culture, literature, philosophy, and poetry, he integrated these indigenous components in the adaptation of CBT in Iran.

## Research on CBT in Iran

Research on CBT in Iran is robust and broad ranging, including studies on depression, anxiety, marriage, addiction, obsessive-compulsive disorder, post-traumatic stress disorder, etc., despite economic, political, and infrastructure constraints and relative scarcity of research grants (Thorngate, 2008).

One notable difference in Iran is that university psychology departments are associated with the field of education rather than science faculties, such as the University of Tehran's Faculty of Psychology and Education (see http://ut.ac.ir/en/page/490/about-the-faculty). Research on CBT is conducted at universities and institutes, a number of which also have cooperation agreements with the Institute for Cognitive Science Studies (ICSS) to conduct joint research.

Much of the research is published in Iranian psychology journals, among them *Psychological Research*, the *Journal of Iranian Psychologists*, *Contemporary Psychology*, *Journal of Practice in Clinical Psychology*, and *Advances in Cognitive*

*Science* (*Taazeh-hay-e Oloum Shenaakhti*) which is the flagship of the Institute for Cognitive Science Studies (ICSS). Other journals include the University of Isfahan's *Research in Cognitive and Behavioral Sciences* and Bu Ali Sina University's *Journal of Cognitive Strategies in Learning*. There is also a great deal of unpublished research (e.g., masters and PhD theses) (Al Hadi et al., 2012).

Examples of research on CBT conducted in Iran that are not available through Western resources can be found on the Scientific Information Database (SID) (see http://www.sid.ir/En/Journal/). Research is also available in journals. For example, the journal *Advances in Cognitive Science*, which first appeared in spring 1999, is published quarterly, with the aim of informing both scholars and new professionals of the most recent developments in the field. In addition to presenting some of the latest research reports (giving priority to those conducted in Iran), issues contain book reviews, article reviews, and a list of the latest books and articles published both in Iran and elsewhere in the domain of cognitive sciences.

*Iranian Journal of Psychiatry* is a peer-review scientific journal published by the Psychiatry and Psychology Research Center at Tehran University of Medical Sciences in collaboration with Iranian Psychiatric Association (http://ijpcp.iums.ac.ir). The aim of the Journal of Psychiatry is to publish English-language articles of high scientific quality including in the areas of related to those domains which are presently of interest to psychiatry including psychotherapy, psychology, spiritual therapy, and cross-cultural topics (see http://ijps.tums.ac.ir).

## CBT with Special Populations in Iran

CBT has been used in treating patients with a variety of concerns in Iran. In addition to the special populations highlighted below, resources are included in references addressing CBT in treating post-traumatic stress disorder, post-disaster trauma, sexual abuse, and anxiety, among many.

## CBT and Drug Addiction

Addiction is one of the most serious social concerns in part because of the progressive nature of the damage experienced by individuals, including their physical, social, emotional, spiritual, and cognitive health. A study conducted with 201 drug addicts in the Shefa Drug Rehabilitation Center in the city of Isfahan concluded that due to the prevalence of depression among this population (at a rate of 24.4% in this study), treatment approaches for substance abuse should prioritize addressing depression, a condition especially well suited to CBT.

Another study aimed to examine the effectiveness of cognitive behavior therapy and pharmacological intervention on increasing efficacy and improving the quality of life in men with substance use. In addition to the pharmacological interventions

received by both the experimental and control groups, the experimental group received sessions of cognitive behavioral therapy. The study's results showed that the receipt of CBT enhanced self-efficacy and quality-of-life scores in the experimental group (Issazadegan et al., 2015).

## CBT and Obesity

CBT has been used in Iran to treat patients with obesity. One study aimed at determining the effectiveness of CBT in treating patients with obesity, carried out in two stages, found that CBT is effective in treating patients with obesity (Sadeghi et al., 2010).

## CBT and Children, Adolescents, Students

Children, adolescents, and students have been the subject of considerable attention by CBT researchers in Iran. One study examining the effectiveness of cognitive behavioral therapy-based play therapy on children with separation anxiety showed a meaningful difference in posttest scores of children who received the therapeutic program and those of the control group. In conclusion, the study was able to demonstrate that a significant decrease in separation anxiety occurred and was maintained in follow-up testing (Abdekhodaie & Ordoubady, 2012).

## Summary

The limited opportunity of this chapter only allowed me to touch on a few fundamental aspects of the depth, dynamic, and significance of cultural adaptation in relation to CBT. Any intervention about human cognition and behavior must be grounded in the context of the given sociopolitical and cultural setting. Throughout this chapter, every effort has been made to challenge the reader to look beyond any implicit biases, generalizations, or stereotypical thinking. The reader is invited to objectively and effectively evaluate the contextual element of adaptation. Although utilizing indigenous elements makes CBT more accessible, relatable, and effective, we must remain committed to updating and upgrading our intervention competency with an integration strategy to be responsive to the future demands of the community. Iran, with its rich cultural and intellectual heritage, has been a particularly successful example of utilizing indigenous cultural elements in the adaptation of CBT and demonstrates an ongoing curiosity and responsiveness to the needs of the community.

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# Chapter 18
# Cognitive Behavioral Therapy in the Republic of Ireland


**Gerard Butcher and Craig Chigwedere**

## Overview of Ireland

The island of Ireland, lying on the western seaboard of Europe, is geographically part of the British Isles. The island is divided, with the majority 26 counties being an independent state following a war of independence against the ruling British government from 1919 to 1921. A subsequent treaty negotiated with the British dividing the country in 1922, and led to the establishment of the Irish-Free State, but with six northern counties remaining under the rule of the United Kingdom. There was an agreement that some of the ports of the "Free State" would have British troops stationed there. A constitution was established in 1937 allowing for a president to be head of state, and Ireland declared itself a republic in 1948, cutting all ties with the United Kingdom. Northern Ireland, consisting of 6 states, remained firmly within British rule.

A lower house ("Dáil") and a senate ("Seanad"), the main legislative bodies in the country, democratically govern the Republic of Ireland. Members of the Dáil are elected from within their local constituencies through a system of proportional representation (giving increased opportunities for independents and small parties to be represented), while Seanad members are either elected via university panels or nominated by the government. Although there is a largely nominally Roman Catholic population in Ireland, increasing secularization has brought about many changes in the country, with constitutional amendments by referenda in the last few decades leading to allowing divorce, equal marriage rights for the LGBTQ community, and most recently a constitutional amendment allowing for abortion rights.

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Following a referendum, Ireland became a member of the European Economic Community (now the European Union) in 1973 and in 1999 adopted the Euro as its currency. Ireland has a population of just under 5 million people and has weathered several recessions over the years. It has free education for all and at present, enjoys high employment and relatively good living standards for the majority of its citizens. Economic emigration has been a long-standing feature of Irish history, though in recent years, many immigrant communities have sprung up around the country and are generally positively received by the majority. Although access to basic health care is freely available, the health-care system has been under considerable strain for many years, with long waiting lists for appointments, access to treatment, and surgery experienced by many. Some 45% of the population pays for private health care provided by a small number of health-care insurers.[1]

## A History of Psychotherapy and the Initial Development of CBT in the Republic of Ireland

***"The mantle of my father's work has fallen on your shoulders."*** – Anna Freud, commenting on the psychoanalytic work of Jonathan Hanaghan[2]

***"It will take a Celt to start up psychoanalysis in Ireland"*** – Welsh psychoanalyst Ernest Jones to Jonathan Hanaghan in 1926 (Forrester & Cameron, 2017:163)

There are many established psychotherapy groups in Ireland, representing the majority of the disciplines related to mental health. Space does not allow for a full review of each of these traditions, but suffice to say, there is no shortage of representation of psychotherapy and psychotherapy groups in Ireland. The Irish Psycho-Analytic Association (IPAA), founded in 1942 by psychoanalyst Jonathan Hanaghan, is the oldest established psychotherapy body in Ireland (Irish Psycho-Analytical Association website). Hanaghan (1887–1967) was a formidable, controversial, and charismatic figure in Irish psychoanalysis circles in the twentieth century (Skelton, 1983). An Englishman, he came to settle in Ireland in 1926, having been "sent" by Ernest Jones, Freud's friend and biographer to start up psychoanalysis there (Forrester & Cameron, 2017:164). His focus, however, deviated from general psychoanalytical approaches, in that he laid strong emphasis on blending Christian principles into psychoanalysis while strongly condemning the Roman Catholic church rule and authority that had dominated Irish culture for many centuries (Hoffman, 2011:94). Hanaghan held regular meetings in his own home, gathering many adherents, and was influential in Irish psychoanalytic circles throughout the 1950s and 1960s up until his death in 1967.

In the early 1980s, others, influenced by the work of Freud, Melanie Klein, and Winnicott, for example, began to arrange their own study groups, eventually

[1] For more detail on Ireland and its history, see http://www.localhistories.org/irehist.html.

[2] www.psychoanalysis.ie/about/history/ The College of Psychoanalysts in Ireland Website

forming the Irish Forum for Psychoanalytic Psychotherapy (IFPP) in 1986, and creating their own register of practitioners in the early 1990s (the College of Psychoanalysts in Ireland website). Training became established by this group, leading to the formation of the Irish Forum for Child and Adolescent Psychoanalytic Psychotherapy (IFCAPP), and those involved in group psychoanalysis founded the Irish Group Analytic Society (IGAS). These groups eventually came together, leading ultimately to the founding of the Irish Council for Psychotherapy in 1999, which established itself as a representative umbrella body for numerous psychotherapy groups in Ireland, to include Psychoanalysis, Constructivists, Couples and Family Therapy, Humanistic and Integrative Therapy, and Cognitive Behavioral Psychotherapy. The main focus of this body was, and is, to promote high standards of training, practice, and ongoing education of psychotherapists, regardless of their core discipline.

Against this backdrop, Cognitive Behavioral Psychotherapy was developing on a number of different fronts within the Republic of Ireland, in part through the interest of individuals influenced by the growing evidence for the use of behavior therapy in psychiatric settings, and in part by the interest of some of the more forward-thinking leaders in the health authorities (at that time divided into various geographical groups known as "Health Boards"). As each Health Board had its own individual budget agreed upon within the Irish Government Department of Health, it could decide how to utilize this budget for various training purposes.

Among early developments in this sphere was the decision of the North-Western Health Board (NWHB) to send several psychiatric nurses to the United Kingdom for training in behavior therapy and behavior modification programs during the late 1970s and early 1980s. These included accredited courses in Scotland at Dundee Hospital under the tutelage of Prof. Phil Barker and separately at the Psychological Treatment Unit of the Bethlem Royal and Maudsley Hospitals, London, England, under the tutelage of Prof. Isaac Marks, Professor of Experimental Psychopathology, a leading expert and contributor to the development of CBT. Perhaps, in contrast to other countries, it was mental health nurses who were initially specifically trained in various forms of behavior modification and later cognitive behavioral interventions. Small regional courses were set up within the various health boards (academically approved of by the Irish Nursing Board, An Bord Altranais) in the 1980s and 1990s with the aim of increasing access to such therapies within different hospital settings, and such trainings generally lasted 6–12 months, the majority delivered on a part-time basis.

In the late 1990s, mental health nurses could access a full-time training in Cognitive Behavioral Psychotherapy lasting 18 months at a private psychiatric hospital, St. Patrick's Hospital, Dublin, which was overseen by an external examiner from the Psychological Treatment Unit of the Bethlem Royal and Maudsley Hospitals, London. The training was modelled along the lines of the English National Board Clinical Course 650, a CBT training course for mental health nurses, which had been running successfully since 1975 at the Psychological Treatment Unit in London. This particular course in Dublin only lasted for three years and a lack of funding brought about its demise. Then in the mid-1990s, a new course,

backed academically by Trinity College Dublin, was begun. This course provided training to a wider group of applicants including psychiatrists, psychologists, and other mental health professionals. It has gone through various iterations down through the years but remains as the leading training in CBT in the country which is discussed more in depth below.

## Current Regulations Regarding Psychotherapy Provision in Ireland

To begin, there is a lack of regulation as currently, there is no statutory regulation of CBT therapists in Ireland. This effectively means anyone can practice as a counsellor or psychotherapist without a requirement for evidence of appropriate training or competence. However, CBT therapists, like therapists from other major psychotherapy modalities, are accredited by professional bodies. For CBT therapists, these are Cognitive Behavioral Psychotherapy Ireland (CBPI) and the Irish Association of Behavioral and Cognitive Psychotherapy (IABCP), which is the Irish branch of the British Association of Behavioral Cognitive Psychotherapy (BABCP). CBPI is a Republic of Ireland-only organization, while IABCP is a cross-border organization, drawing its membership from both Northern Ireland and the Republic of Ireland in the south. Though one can be struck off from the registers of these professional bodies, one cannot be prevented from practicing. As such, it is currently not uncommon for therapists to practice without registration.

In CBT, for example, MacLiam (2015) found that of 43 CBT therapy graduates who responded to an Internet survey of their post-qualification practice, 20 (61%) were not members of any either the IABCP or the National Association of Cognitive and Behavioral Therapy (NACBT; latterly CBPI). Though therapists practicing privately do not require registration with a professional body, employers of CBT therapists will usually require proof of registration with CBPI or IABCP/BABCP. This looseness of regulation potentially leaves those seeking CBT in a difficult situation, where they may be uncertain of the level of training and competency of a therapist helping them. Consequently, changes to the regulation of counsellors and psychotherapists have been proposed.

Taking its lead from European Union principles of free movement enshrined in the 1992 Maastricht treaty, the Strasbourg Declaration on Psychotherapy stated a commitment to the creation of a profession of psychotherapy across Europe (European Association for Psychotherapy, 1990). Accordingly, in 2006, the Irish Council for Psychotherapy (ICP) proposed the adoption of the title of psychological therapies with two protected titles of "counsellor" and "psychotherapist," which was submitted to the Irish government's Department of Health and Children in September 2008 (ICP, 2008). Following a formal public consultation process in 2016 (with written submissions from no fewer than 79 interested bodies), the minister decided to proceed with the designation under the Health and Social Care Professionals Act 2005, of two distinct professions, counsellor and psychotherapist, each with its own register, under one registration board, including putting forward a

timeline for the statutory regulation of psychotherapists in Ireland. This included the constitution of the registration board, which was projected to be completed during 2017, to be in position by early 2019. The proposed regulations will prescribe required qualifications to practice as a counsellor or psychotherapist, and also to protect these titles. This will effectively mean those wishing to use these titles will not be able to do so, unless they have successfully completed the registration process through the Health and Special Care Professional Council (CORU). Following the opening of the register, there will be a 2-year transitional period to allow existing practitioners time to apply for registration and satisfy the registration board that they meet the requirements for the profession.[3]

The proposed minimum qualifications for consideration for registration will be those proposed by the Quality and Qualifications Ireland (QQI), an independent state agency responsible for accountability in Irish training and education services. QQI promotes, maintains, and develops a 10-level framework for the development, recognition, and awarding of qualifications in Ireland. This national framework maps onto similar Europe-wide frameworks, the European Qualifications Framework (EQF) and Qualifications Framework for the European Higher Education Area (QF-EHEA). Thus, qualifications gained in Ireland should, in theory, be transferable to other European countries, allowing Irish registered psychotherapists to work in different European countries. Within this framework, counsellors will be required to be trained to QQI Level 8 (i.e., honors bachelor's degree level), while those holding a QQI Level 9 qualification (i.e., postgraduate or master's degree) will be eligible for registration as a psychotherapist. Like all other psychotherapists in Ireland, CBT therapists will be required to meet the same standards of training under CORU. QQI is very clear that meeting the educational standards entitles a person to an educational qualification, but entitlement to practice requires an individual to meet (and continue to meet) a distinct professional standard. An approved academic (accredited) qualification is thus recognized as necessary but insufficient for professional practice.[4]

Though noble and widely accepted, the regulation of psychotherapists is not without its difficulties for CBT therapists. For example, apart from training to the stated levels, the proposed regulatory framework will require therapists to complete at least 250 hours of personal psychotherapy work or equivalent. Though therapist personal development work is acknowledged as important (e.g., IABCP/BAPCP and CBPI), CBT has not historically adopted a culture of mandatory personal therapy for therapists. In addition, training programs in CBT have historically been

[3] Reference and further information about this process and recent developments is available at www.coru.ie/en/about_us/what_is_coru
http://www.irishstatutebook.ie/eli/2018/si/170/made/en/pdf https://www.kildarestreet.com/committees/?id=2018-03-07a.457

[4] See www.qqi.ie/Publications/Publications/Counselling%20and%20Psychotherapy%20-%20QQI%20Award%20Standards%202014.pdf and
www.qqi.ie/Articles/Pages/National-Framework-of-Qualifications-(NFQ).aspx for further details.

shorter than other modalities. For CBT graduates to comply with regulations and be able to practice, these changes may require training institutions to make radical changes to their training courses. As such, currently, many CBT training institutions' courses and graduates may fall short of these requirements.

## Professional and Cognitive Behavior Therapy Organizations

There are many groups in Ireland that represent differing psychotherapy traditions. We will limit ourselves here to those mainly representing the CBT tradition.

(a) The **Irish Association for Cognitive and Behavioral Psychotherapy (IABCP)** is an all-Ireland branch of the British Association for Cognitive Behavioral Psychotherapy (BABCP) and is a representative body of those with a variety of mental health trainings who have an interest in CBT. Because of the close links established during training with their British counterparts, many of those trained in CBT in the United Kingdom joined the BABCP (founded in 1972 and the lead body for CBT in the United Kingdom) and at a later stage set up an Irish branch in 1981, which enjoyed the assistance and encouragement of their British colleagues. IABCP organizes its own CBT workshops, and, as part of the BABCP, is affiliated with the European Association for Cognitive and Behavioral Therapies. As part of the BABCP, the IABCP is involved in accrediting training courses both in the Republic of Ireland and in Northern Ireland. Although an interest in the area of CBT is sufficient to be a member of IABCP/BABCP, there is a substantial process involved in becoming an accredited therapist.[5]

(b) **Cognitive Behavioral Psychotherapy Ireland (CBPI)** was originally established among a group of Irish mental health nurses who had been trained in various courses in Ireland in the 1980s and 1990s, formerly calling itself the National Association of Cognitive and Behavioral Therapies (NACBT). It mainly consists of therapists from the Republic of Ireland and includes both mental health nurses and psychologists. From its early days, it allied itself with the umbrella body of the Irish Council for Psychotherapy (ICP), which represents over 1500 psychotherapists in Ireland from a variety of psychotherapy traditions, which itself is a member organization of the European Association for Psychotherapy (EAP), a representative body of psychotherapy associations from 41 European countries. The only way to be a member of CBPI is to be an accredited member, and applicants must go through a rigorous process to become accredited. As an accredited member, it is then possible to be awarded the European Certificate of Psychotherapy by the EAP which gives access to members for mutual recognition and equal conduct of psychotherapy in Europe.

[5] See http://www.babcp.com/IABCP/iAbout.aspx and http://www.babcp.com/IABCP/ for a more detailed history and information regarding the IABCP.

CBPI is also an accrediting body for CBT training courses in the Republic of Ireland.[6]

(c) The **Institute of Cognitive Behavioral Therapy–Ireland** was formed in 1999 and is mainly made up of a small group of therapists who have trained in Rational-Emotive Behavior Therapy (REBT), as pioneered by Albert Ellis. Their practitioners also run short CBT-focused training courses.

(d) The **Irish Association for Counselling and Psychotherapy (IACP)**, previously the Irish Association for Counselling, was established in 1981 and, as its name suggests, represents the interests of both counsellors and psychotherapists in Ireland. Many of its members are CBT-oriented through their various trainings, though the particular trainings may not in the future be sufficient for their registration as CBT therapists once statutory regulation is in force. The IACP is an accrediting body for counsellors, psychotherapists, and various psychotherapy training courses in the Republic of Ireland.

## Training Opportunities/Programs in CBT

**Varied Training Opportunities.** There are many training opportunities across the length and breadth of Ireland. However, due to the current lack of regulation and standardization of training and accreditation, there is huge variation in the length, depth, and content of training and requirements for accreditation as a CBT therapist. This variation in quality of training is demonstrated by a simple search of the Internet, which reveals courses ranging from a 5-day course, after which therapist are required to engage with 20 h of supervised client work to gain a professional certificate in CBT, to an approximately 10-week diploma course, delivered over two hours, one evening a week with no apparent clinical assessment, to a 2-year master's course, with theory, clinical practice, research theory and practice, and supervision by accredited supervisors.

Many of these courses are unlikely to meet minimum recognized criteria for accreditation as a CBT training course. For example, the BABCP (2010) recommends minimum training standards. These include a minimum of 450 h of study of theoretical knowledge and skills teaching, 200 of which "should be directly provided by experienced trainers through a recognized program of study." The remaining 250 hours can include monitored, nondirected study. Additionally, students from BABCP-accredited courses are expected to have completed "200 hours of assessment and therapy during their training" and see "at least 8 cases (covering three problem types)," 3 of which should be closely supervised (BABCP, 2010). Many courses that train CBT therapists or therapists and counsellors who describe themselves as CBT therapists are unlikely to meet these minimum training standards. For this reason, and for the purposes of this chapter, only university-based

[6] Further information at www.cbpi.ie ; www.psychotherapycouncil.ie/ and www.europsyche.org/

courses will be reviewed here. This is not a statement on the quality or acceptability of other courses but rather, an expedient approach to make the description of courses manageable.

**The Trinity College Dublin (TCD) Course.** In Dublin, there are several courses. Trinity College, Dublin (TCD), part of the University of Dublin offers three courses at three different levels (TCD, 2018). The courses offer a prospective student an incremental experience of learning CBT. The Foundation Course offers entry-level training for health-care professionals without a background or experience in CBT. The Foundation Course offers a certificate-level training in CBT over approximately 21 days, over three semesters. Each semester starts with 3-day block, followed by four workshops 1 day a week. The aim of the course is to endow trainees with declarative knowledge of CBT. Though trainees can apply some of their learning to their current mental health practice, the course is not a "clinical" course due to not having a supervised clinical practice component.

Graduates of the Foundation Course are eligible to apply for the second-level training course, a 1-year postgraduate diploma (PgDip) in CBT. This is a clinical course which builds on the declarative knowledge gained from the foundation-level course, endowing trainees with procedural skills in the practice of CBT. Trainees are required to engage in supervised clinical practice, treating at least five completed cases, and to submit three session recordings for assessment, along with written case studies. They are also required to demonstrate a deep critical understanding of the theory of CBT in a theory essay. Trainees completing the PgDip can go on to apply for the 2-year master's training (MSc) in CBT. The MSc aims to develop diploma-level trainees to the "expert" level critical understanding of CBT. Trainees are required to complete 12 supervised clinical cases in the 2 years. They are also required to submit and pass three recordings of clinical sessions and three case studies for assessment, and expected to demonstrate a deep critical understanding of the theory and research related to a single disorder. As such, trainees are encouraged to focus on a single disorder of their choice, thereby developing a sub-specialism in CBT for that particular presentation. All trainees engage in self-practice and self-reflection, and trainees on the MSc, also engage in personal therapy with a therapist.

**The University College Cork (UCC) Course.** In Cork, at UCC, there is a 2-year postgraduate diploma and an MSc in CBT, which meet BABCP accreditation standards. This is a part-time course, involving a full week's block in the first year and then evening workshops once a week between September and May of each year. The course draws from disciplines allied to mental health, such as medicine, social work, nursing, psychological therapies, and special needs education. To be eligible, applicants are required to have an honor's degree in a relevant subject and be registered with a relevant professional body or be eligible for such registration.

There is an option for PgDip students to exit after the first year with an award of a postgraduate certificate in cognitive behavioral therapy, effectively providing a similar structure to the TCD courses outlined above. Graduates of the UCC courses structure are expected to be competent in the delivery of CBT for a range of

disorders. Students gain knowledge of the declarative, theoretical principles of CBT and gain procedural knowledge and skills through supervised clinical practice. The structure is that in year 1, students gain knowledge and skills of the core competencies of CBT and the supervised treatment of anxiety and depression, with year 2 focusing on research methods, the treatment of depression and its comorbidities, and the treatment of complex cases.

**The Queens University Belfast (QUB).** Though our focus here is on the Irish Republic and Queens University Belfast (QUB) is located across the border in Northern Ireland, many prospective CBT trainees from the republic cross the border to access training and vice versa. Though there are other courses in Northern Ireland, the QUB courses' close collaborative ties with those in the south of Ireland mean that it may have a significant influence on Irish CBT practice, which deserves special mention. For example, educators and trainers from QUB and TCD collaborate on teaching, research, and other activities. QUB offers a range of CBT courses which meet at least the BABCP's minimum accreditation standards. These courses include a Foundation Certificate in CBT, a PgDip, an MSc, and a Specialist CBT Master's Degree in Trauma.

**Training in Variants of CBT.** To enhance their CBT therapy knowledge and skills, many CBT therapists will undertake further training in specific variations of CBT, including schema therapy, dialectical behavior therapy, CBT for psychosis, CBT for eating disorders (CBTe), and mindfulness-based cognitive therapy. Variants of CBT are delivered by both trained CBT therapists and non-CBT therapists. For example, many non-CBT-trained mental health nurses have been trained in DBT through the National DBT project (HSE, 2018) and help to deliver the approach in groups as part of the DBT teams. The HSE's National DBT project provides training for DBT therapists, often using invited international trainers (e.g., Flynn et al., 2017). Schema therapy has only recently become popular in Ireland, and CBT therapists are undertaking further training in the modality. For example, in 2016, it was announced at the International Schema Therapy Conference in Vienna that there were only 13 schema therapists in the whole of Ireland. Part of the reason for this low uptake of training in schema therapy was the lack of access, with interested therapists having to seek training abroad. However, this has changed with the recent accreditation of a schema therapy training course run in Dublin. Many CBT therapists are accessing this training. Many CBT therapists are also trained in other modalities, such as MBCT and ACT, and training opportunities are available.

## Providers of CBT

As is the case around the British Isles, in Ireland, CBT draws therapists from a range of professional backgrounds. For example, the UCC course accepts applications from those with a background in medicine, psychiatric or learning disability

nursing, social work, arts therapies, psychology, psychotherapy or counselling, probation services, occupational therapy, and special needs teaching (UCC, 2018). Likewise, prospective candidates for the TCD courses are required to have a mental health profession, such as medicine, nursing, psychology, and social work, and be employed in a health-care setting (TCD, 2018). In her study, MacLiam (2015) surveyed a sample of trained CBT therapists from one institution. They identified their professional background as psychiatrists, mental health nurses, social workers, dieticians, counsellors, speech and language therapists, occupational therapists and psychologists. Other courses accept prospective students without a mental health background at all. Thus, due to the current poor regulation of all psychotherapies in Ireland, there is a diverse range of therapists delivering CBT.

Graduates of CBT-specific courses such as those described above form the bulk of "specific" CBT therapists. These CBT therapists may be from a range professional backgrounds, as identified above. Clinical and counselling psychologists, who complete CBT modules as components of their training, form a significant proportion of the population of clinicians delivering CBT (Inspectorate of Mental Health Services, 2012). For example, in 1998, the Health Service Executive (HSE) employed 307 psychologists of various grades, with a 20% increase by year 2000 (HSE, 2002). Some of these will have completed CBT-specific training after postgraduate psychologist doctoral training. CBT therapists with a nursing or other background can work in the HSE. However, they are likely to be working as a clinical nurse specialist, occupational therapist, and so on, with a focus on CBT. It is not uncommon for counsellors and therapists who have brief CBT training modules as a component of their counselling and therapy training to advertise themselves as CBT therapists. For example, a brief search of the Internet reveals counsellors/psychotherapists from an integrative, humanistic, or alcohol counselling background describing themselves as CBT therapists. Thus, in Ireland, CBT is also delivered by counsellors with varying degrees of CBT training, many of which would be considered inadequate. Other graduates of what could be described as brief CBT courses also practice CBT, along with those that complete courses offering an academic or declarative understanding of CBT, without the important supervised clinical practice component as described in the BABCP's minimum standards of training (BABCP, 2010).

## CBT with Specific Populations in Ireland

CBT therapists in Ireland work with a range of disorders, from specific phobias to personality disorders. Overall, most therapists work with anxiety- and depression-related disorders. The HSE's National Clinical Programme for Mental Health made proposals to standardize and increase access to evidence-based practice in mental health services. Consequently, clinical care pathways were proposed for disorders such as eating disorders (HSE, 2018), and first episode psychosis and those

presenting in emergency departments following self-harm (HSE, 2010). In 2018, an HSE Model of Care for eating disorders services in Ireland was published by the HSE's National Clinical Programme for Eating Disorders (HSE, 2018). Consequently, there is a significant population of those suffering with eating disorders who now receive CBT. The population of those receiving CBT for psychosis is also growing, and services are being developed across Ireland. As such, in the HSE's publicly funded services, a significant proportion of populations of patients receiving CBT will do so under the umbrella of service delivery associated with the National Clinical Care Programmes. The public services also offer CBT for anxiety and depression and a range of other presentations.

Compared to the United Kingdom's NHS, the public health service in Ireland is not comprehensive in its service delivery. Consequently, some 45% of the population access private health care and pay into health insurance schemes. Private health providers like Dublin-based St. Patrick's Mental Health Services, the oldest independent psychiatric hospital in Ireland, offer CBT to a significant proportion of those seeking help. Those receiving CBT from St. Patrick's Mental Health Services include adolescent clients, adults, and older adults. Their services include a specific adolescent service, programs for the treatment of anxiety disorders, depression, substance misuse, eating disorders, psychosis, and personality disorders, all of which have a degree of access to CBT. Along with St. Patrick's Mental Health services, other providers of private mental health care, including CBT, include institutions such as Highfield Hospital, St. John of God Hospital, and Lois Bridges (dedicated solely to treating eating disorders), all in Dublin. Many CBT therapist work as private therapists, seeing the population of sufferers with the ability to pay. Many private therapists operate sliding scales to make CBT access affordable for those in need.

## Use and Adaptation of CBT in Ireland

Ireland's unique history of conflict has required that CBT is adapted to the needs of those seeking help. Of particular importance is the treatment of trauma and adaptations of trauma models to meet the needs of victims of conflict and sectarian violence, both in terms of CBT in the north and south of the island. For example, Hillyard et al. (2005) estimate that 3500 people died and 35,000 were injured in over 30 years of conflict in Northern Ireland, with 34,000 shootings and 14,000 bombings. These staggering statistics have called upon the CBT world to stand up and be counted in helping those in need as a result of trauma. CBT for post-traumatic stress disorder (PTSD) has been adapted to terrorism-related contexts, with the conclusion that it is effective in the treatment of PTSD related to terrorism and other civil conflict (Duffy et al., 2007). Adaptations to CBT have also been made in terms of the delivery of DBT skills programs in Ireland (Booth et al., 2012) and alcohol treatments (Farren et al., 2015). Currently, adaptations to

CBT are continuing in Ireland including the development of Internet-based programs (Richards et al., 2015).

Delivering CBT in Ireland poses unique challenges. It is a small country with a history of strong religious beliefs. Consequently, CBT therapists often need to be highly sensitive to the needs of clients, who may have concerns about the stigma associated with being considered to have a mental health problem. An anecdote may serve and may help to illustrate this. When the second author (CC) first emigrated to Ireland from the United Kingdom, he had to treat a patient who had been admitted into inpatient care. During the CBT work, it became apparent that in order to challenge some of the client's beliefs, it would be necessary to plan some time at home to perform behavioral experiments. The client explained that this would only be possible after having made significant improvement. The rationale was that if she was not fully better and returned home, "what would the neighbors say?" Her illness was considered to be shameful, and it was better to keep her out of sight than to risk such shame. Being a small country, it is easy for one to run into known people, and attending a CBT service for treatment risks coming into contact with known others while seeking help, a possible source of shame for many. Along with shame is the issue of fear. For example, patients who may be victims of conflict have been known to cross the border from the north into the south, for treatment for fear of reprisals if they seek CBT help in their own communities.

## CBT Research in Ireland

Research which adds significantly to the body of knowledge of CBT continues to come out of Ireland. Collaborations between practitioners in the north and south have produced important works in the area of PTSD and CBT theory and treatment (e.g., Gillespie et a., 2002; Duffy et al., 2015). McCarthy et al. (2013) have conducted some innovative research work into the treatment of social anxiety. In the treatment of personality disorders, Booth et al. (2012) and Flynn et al. (2017) have shown that a brief DBT-based skills program can be effective in reducing self-harming behaviors and admissions to hospital. Cuppage et al. (2017) showed that an intensive 5-week compassion-focused therapy-based group could be effective in improving psychopathology, fear of self-compassion, and social safeness in a transdiagnostic population. Therapist self-practice and therapist development have recently become a focus of study in Ireland. Important publications continue to emerge, including the development of a measure of therapist self-reflection (Chigwedere et al., 2018b), a qualitative comparison of the goals of SP/SR in CBT and personal therapy in psychotherapy in general (Chigwedere et al., 2018a), and a comparison of the self-perceived impact of SP/SR and personal therapy with a therapist (Chigwedere, Bennett-Levy, Fitzmaurice, and Donohoe, 2021).

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# Chapter 19
# Cognitive Behavioral Therapy in Israel

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## A Bird's Eye View of Israel and Its History of Psychotherapy

The state of Israel was established in 1948. It was marked by massive immigration from Europe by absorbing survivors of the Holocaust (many of whom were the sole survivors of their families, like "a brand plucked from a burning tree") and Jewish exodus from Arab and Muslim countries. From the very beginning, heterogeneity characterized its population – a multicultural society: Jews (Ashkenazi and Sephardi origin), Arabs (Muslim and Christian), secular, and religious. The vision of building a homeland for immigrants, many of whom were refugees, encouraged innovative projects to absorb newcomers, such as collective settlements, a universal health-care system, etc. In 1948, there were 800,000 inhabitants, and since then, the population has increased to about 9.3 million citizens in 2018. In regard to health care in Israel, the system is universal with "cradle to grave" coverage, and presently, all Israeli citizens are entitled to basic health care as a fundamental right based on the National Health Insurance Law of 1995 (Segel, 2009). In 2012, Mental Health Reform was introduced by means of the National Health Insurance order by the Minister of Health, "with the objective of transferring the responsibility of the provision of

The chapter is dedicated to the memory of Michael Rosenbaum

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mental health services from the Ministry of Health to the HMOs. This change was aimed towards the planned unification of the system that offers treatment for bodily ailments and that which treats mental crises through the HMOs (Kupot Cholim)" (State of Israel, Ministry of Health, 2012).

In Israel, there is a high proportion of clinical psychologists who practice psychotherapy; furthermore, clinical psychology is high on the list of the desired professions. Typically, psychotherapy in Israel is practiced by clinical psychologists, social workers, and also art therapists, but to a lesser extent. Although many psychiatrists practice psychotherapy, there is an increased tendency among them to focus on biological treatments. Moreover, in recent years, CBT has been included in their syllabus and in the final examination in psychiatric specialization.

## History of Psychotherapy in Israel

Historically, one can identify two basic kinds of psychotherapeutic orientations among Israeli psychotherapists. The first kind of psychotherapists view psychotherapy as a long process, not necessarily specified nor focused, aimed at increasing the person's awareness of his or her emotions and motives and gaining insight into the origin of their problems. In a majority of cases, this approach does not include an evidence-based assessment tool neither at the beginning of therapy nor at its termination, while its goals are clearly not defined in resolving specific problems. The most representative examples of this kind of psychotherapy are psychoanalysis and existential psychotherapies. The second kind of psychotherapy practiced in Israel can be characterized as being more focused on specific issues followed by the diagnosis of the client's presenting problem. These therapies include short-term psychodynamic psychotherapies of several varieties, Adlerian, strategic, hypnotic, biofeedback, family, behavioral, and cognitive therapies (Ronen & Rosenbaum, 2010). As can be seen from this description, in Israel, unlike the UK or the Netherlands, for example, in many cases (in the past and to a certain degree in the present), the path to becoming a CBT psychotherapist begins with psychodynamic training of clinical psychologists and social workers. Although it hasn't been studied nor openly discussed, it seems that this unique course of professional development may have contributed to yet another tendency of Israeli therapists, i.e., integrative psychotherapy. Presently, there is a growing demand for CBT forms of therapy in public and in private practice.

## The Introduction and Beginning of CT and CBT in Israel

CBT first appeared in Israel in the seventies of the twentieth century by a group of psychologists and social workers who studied in the USA and who brought back new ideas to be applied academically and clinically. During these years (1970s and

1980s), behavior therapy was met with resistance by the majority of clinicians, almost all of them psychodynamic-oriented professionals who expressed reservations regarding its practice, claiming it was too superficial, mechanistic, or outright dangerous. For example, Michael Rosenbaum, a psychologist who returned from the USA after specializing in child therapy, was invited to work in a psychiatric hospital where the head of the hospital argued that it was too dangerous to apply behavior therapy to children. During those days, the field was very conservative and traditional, and training and practice focused on dynamic therapy. At that time in university departments of psychology and social work all over Israel, some people started teaching behavior therapy (BT). However, it was not easy to teach behavior therapy while the field insisted on training in dynamic orientation. It then appeared as if the only settings where CBT [in those days actually behavior therapy (BT)] could be "tolerated" were settings with clients who suffered from severe psychopathology and with whom psychodynamic therapy was not possible. For example, a CBT pioneering project in Israel was a token economy program at a youth institute and another one with prisoners. Another important area for introduction and implementation of BT and CBT has been a joint collaboration of researchers and practitioners with the Mental Health Department of the IDF (Israeli Defense Force), which has developed numerous CBT-based treatments for chronic combat-related PTSD and shell shock among soldiers, veterans, and their families.

One such project – the Koach project – which gained publication was designed and implemented by the Mental Health Department of the IDF (Israel Defense Forces) Medical Corps as a treatment program for chronic PTSD veterans. The project was aimed to reduce the prevalence and severity of PTSD and to improve functioning in the military, the family, and the community. It was comprised of a 1-month residential stay at an army base, followed by mutual self-help groups in the veterans' communities. The project combined CBT and group approaches into an integrated therapeutic program. The treatment approaches that were utilized included gradual exposure of soldiers to a return to military activities and group therapy of their wives aimed at increasing their function as a supportive resource in overcoming dysfunctional behavior (Solomon et al., 1992).

Along with the pioneering efforts of practicing BT and CT, the first academic courses in CBT were introduced in the 1970s at the Psychology Department of the Hebrew University of Jerusalem, at Tel Aviv University, and at Haifa University.

An important event for CBT in Israel was hosting the First World Congress of Behavior Therapy chaired by Michael Rosenbaum, which took place in Jerusalem in 1980. Its great success and attendance by many people from around the world (Ellis, Lazarus, Marks, and Eysenck were among keynote speakers) sparked the initiation of the Israel Association for Behavior Therapy's active work and was a stimulant for the development of CBT in Israel.

## Current Regulations Regarding Practicing Psychotherapy

In 2012, the Minister of Health issued the Mental Health Reform referred to as the National Health Insurance Order.

Professional registration and licensure to practice is carried out in accordance with each profession's organizational requirement. For example, psychiatrists, psychologists, and art and speech therapist's registration is done through the Ministry of Health and Ministry of Social Affairs and Social Services for social workers. Psychiatrists and psychologists receive their license from the Ministry of Health after an internship of several years and an examination. According to the guidelines of the Ministry of Health's Clinical Licensing Board for psychologists and psychiatrists, all internship-training settings have to offer the interns the possibility of receiving supervision in CBT. Psychiatrists are examined on a CBT case as an obligatory part of their examinations. Several HMOs, in cooperation with the Hebrew University of Jerusalem, are developing CBT training programs for supervisors and licensed clinical psychologists who work for HMOs. The procedure in Schools of Social Work is slightly different as fieldwork is an integral part of the training and is part of the curriculum. CBT courses are part of the syllabus. At Tel Aviv University, specialization in social work with children includes CBT.

According to the new regulations of the Ministry of Health, both psychiatrists and psychologists are required to train in psychodynamic models and can choose between CBT and family therapy as a second choice during their internship. CBT is also included in the final examination. Unfortunately, these regulations are not easily applicable, notably among psychologists, due to a lack of CBT supervisors in the public services. An additional obstacle is related to "old establishment" psychologists' criticism of CBT as being a technical and "superficial" mode of treatment. Nevertheless, since the Mental Health Reform demands shorter waiting lists for many more patients and therefore time-limited treatment, CBT will no doubt gain in strength as one of the few proven, efficacious, and efficient short-term therapies.

## The Israeli Association of Cognitive Behavior Therapy (ITA)

There is one professional CBT association in Israel, ITA (Israeli Association for Behavioral and Cognitive Therapies). Since the history and development of CBT in Israel is closely linked to the establishment of the ITA, we will provide a short description of ITA and its activities.

ITA was formed in the 1970s by a group of psychologists and social workers who trained in the USA in behavior therapy and introduced the novel therapeutic model into Israel. The formal establishment of ITA as an NGO was in 1980 and very early ITA became a member of European Association of Behavioral and Cognitive Therapies (EABCT). Currently, ITA has 570 registered members, the majority of whom are psychologists, psychiatrists, and social workers who work in public and

private clinical settings. ITA is constantly growing as manifested by the number of members being added each year. ITA's aim is to encourage the use and expand the practice of CBT among professionals and potential clients. There are currently several CBT training programs in Israel. Most of these are approved by ITA, the formal association that also licenses members to become specialists and/or supervisors in CBT. At present, there is no law regulating psychotherapy as a profession, thus the licensing has no formal or juridical validity, but the general public recognizes ITA as the de facto licensing authority in the field of CBT.

ITA aims to be involved in community settings, in special populations as well outside Israel (e.g., training CBT therapists in Kosovo and Albania), and its members take an active part in international CBT conferences. ITA organizes conferences and workshops, seminars, and study days with well known, leading international and local experts, and its activities are very successful and well attended by therapists. For many years, ITA organizes an annual 3-day national CBT conference with a variety of workshops. Following the example of the European Association of Behavioral and Cognitive Therapies, the Israeli association added the term "cognitive" to its name.

As of 2018, all ITA's registered dues-paying members have fulfilled the requirements for becoming CBT therapists, which are based on the "Minimum Training Standards" as published on the website of the EABCT. Most ITA members identify themselves as CBT therapists, as defined by the EABCT.

In 2015, ITA hosted the annual EACBT conference in Jerusalem entitled "CBT: A Road to Hope and Compassion for People in Conflict." International and local leading CBT researchers and clinicians participated in the congress. In some ways, the first WCBT congress held in1980 and the EACBT congress held 35 years later, both of them held in Jerusalem, have come full circle.

ITA has its own website (www.itacbt.co.il) which provides a wealth of information on what is happening in the field of CBT in Israel and has a link to international CBT websites. A group forum and Facebook are active channels for discussions and provision of information to ITA's members.

## Training Opportunities for CBT in Israel

Importantly, academic training is a requirement for practicing therapy by all licensed mental health professions: psychiatrists, psychologists, and social workers. CBT and CBT training have become more popular in recent years. In the 1990s, the first 2-year training course in behavior therapy was established at the School of Social Work in Tel-Aviv University with trainees representing a variety of professions, including psychiatrists, social workers, psychologists, and nurses. For financial reasons, this program was stopped, but eventually, additional training programs were introduced.

Nowadays, courses in CBT are part of academic programs at all Israeli universities for students studying clinical psychology , social work, and counseling

education. All graduate and postgraduate clinical psychology training programs include supervision on CBT in addition to supervision in traditional models. At present, 2-year postgraduate training programs that train professionals in CBT are offered privately and are accredited by ITA. An important step toward incorporating CBT as part of public services is the inclusion of CBT training programs that run under the auspices of several HMOs.

Over three decades, the training and practice of CBT has spread considerably and is clinically and empirically gaining strength while at the time adopting the new waves within CBT. In its early days, the most practiced mode of interventions were Beck's cognitive therapy and Ellis's REBT, the "first wave." Throughout the years, what has become known as the "second" and "third wave" have become popular and attracted many CBT therapists who have completed the basic and advanced training. Most of them work with adults who suffer from anxiety disorders, OCD, PTSD, pain, stress, mourning, health problems, aggression, learning difficulties, etc. Some have also been trained in marital and family therapy.

What started with behavior therapy and followed with Beck's and Meichenbaum's CBT and Ellis's REBT pioneering models (Dr. Ellis, Dr. Meichenbaum, and Dr. Judith Beck visited Israel and conducted workshops), presently ACT, DBT, SFT, schema therapy, mindfulness, and positive psychology, are also incorporated in the majority of CBT training programs. As CBT has gained more popularity, the need for textbooks and literature in Hebrew led to translating English textbooks into Hebrew, including texts about REBT, CT, BT, and ACT with children and adults. This trend has gradually grown into the publications by clinicians and researchers of texts in Hebrew of CBT-related topics so that there is now a large Hebrew library of CBT books and protocols (e.g., Marom et al., 2011, 2016; Mor et al., 2011). In 2019, the English prestigious IAPT model of D. Clarck and with his help, was initiated in the public service, directed by J. Huppert. Hopefully this will lead to a greater implementation of CBT in the public mental health service.

## Who Delivers CBT?

Academic training is required for practicing therapy by the three licensed mental health professions who are officially recognized by the Ministry of Health: psychologists, social workers, and psychiatrists who may deliver CBT. Now that CBT is becoming professionally and publicly more recognized and accepted, training courses in CBT are now included in the syllabus of many academic faculties among which are medical schools, counselor education, and nursing. As the need for therapy is so great while the availability of academically trained professionals is limited, and because CBT is more open to training by other professions, Israel is witnessing a wave of CBT professionals from fields like criminology, education, dieticians, nurses, general practitioners, rabbis, speech therapists, and others. This is both a blessing and a curse: a blessing as many more potential clients can be helped without having to wait a long time before accessing therapy and a curse

because often the theoretical and clinical background of these professionals is by far not enough to offer responsible CBT treatments.

## CBT with Specific Clinical Populations in Israel

### *The Current Practice of CBT in Israel*

As mentioned before, CBT is becoming more common in public mental health settings, and its practice is increasing while a similar trend already exists in private practice. Over the last few years, national and local institutions have substantially modified their attitude toward CBT by accepting CBT methods and sometimes preferring the short-term, structured, goal-directed options that they offer.

In many public and private settings, there is a CBT unit for the treatment of anxiety disorders, OCD, and PTSD. In a number of anxiety units, CBT is the treatment of choice with or without combined medication treatment. We will mention a few examples of such units. For example in Geha Mental Health Center (a well-known mental health center located in central Israel), there is a special unit for treating and research on social anxiety disorder. The unit was established in 2003 and is a leading one for this disorder. It practices CBT for SAD in both individual and group therapy. The center provides evidence-based treatment, training, and research studies carried out in affiliation with universities in Israel and abroad (Marom et al., 2009). Another example of combining practice and research in mental health outpatient clinics is located at Mirpaat Ramat Chen in which a special unit operates for treating PTSD where the majority of patients are Israeli army veterans. Other units of CBT outpatient clinics within hospitals operate throughout the country. Ichilov, a general hospital in central Israel with a multidisciplinary pain clinic that provides psychological CBT-based treatment, the anxiety clinic at Hadassah Hospital in Jerusalem, and a DBT clinic in Tzefat Government Hospital in northern Israel are also research-focused therapy**.** The security situation in Israel with its continuous and acute exposure to terror and war has triggered the developments of CBT interventions for reducing stress among civilian populations and work with individuals – soldiers and civilians who suffer from acute stress disorder and post-traumatic stress disorder. These interventions are especially tailored and widespread in Israel within military, public, and private mental health agencies and welfare settings. Two examples of centers that have developed services with CBT orientation for traumatized populations are the Community Stress Prevention Center (CSPC) (2020), a center for crisis and emergency services and increasing community resilience in northern Israel founded and headed by Dr. Mooly Lahad, whose Basic Ph model combines assessment and intervention tools based on CBT (Lahad et al., 2013). The CSPC is world renowned for its cross-cultural work with a variety of communities locally and abroad and the development of intervention programs following man-made and nature-made disasters. Another center is Metiv-Herzog Israel Center of Treatment

of Psychotrauma founded and headed by Dr. Danny Brom to provide psychological help to adults and children following terrorist attacks who were exposed to psychological stress and trauma (Danieli et al., 2005; Metiv, n.d.). Both centers have extended their services beyond providing services to war- or terror-related psychological trauma to include bereavement and violence of all kinds while conducting research and training programs.

Another area where CBT has shown positive outcomes is work with children in the national schools and institutions. For example, the Ministry of Education trains educational counselors to work as behavior modification trainers and to help teachers utilize observation and reinforcement methods in class. This has become a special program for behavioral analysis in colleges for training teachers, and the profession is now part of the staff occupied in schools. Many special education institutions now include CBT programs that help change childrens' behavior. Another development for children's educational settings, still in its infancy, is a project designed to implement an innovative CBT milieu for children in boarding schools by creating a supportive community employing CBT and positive psychology orientations.

The most frequently applied CBT strategies are for individuals diagnosed with anxiety disorders, OCD, PTSD, and pain. A possible explanation is related to the collaboration between public mental health clinics affiliated with the academia by applying protocols to people affected with these symptoms and treatment that is evidence-based. To a lesser extent, mostly in private clinics, people affected by personality disorders are treated specifically by DBT, SFT, ACT, and REBT.

## *CBT Research in Israel*

The outstanding and most developed field regarding CBT in Israel is that of research in the academic sphere. Cognitive psychology as an area of theory and research is prominent in most of the major universities. The development of theory and research on CBT in Israel can be traced back to the work on cognitive psychology by internationally leading psychologists, Daniel Kahneman and Amos Tversky, from the Department of Psychology at the Hebrew University. Another cornerstone in CBT research was laid by the late Aaron Antonovsky, who was a medical sociologist at the Ben Gurion University in Beer Sheba, who developed a cognitive theory with a core concept which he called the "sense of coherence" (Antonovsky, 1987). The sense of coherence refers to a set of personal beliefs that guide people's coping with stress. A sense of coherence expresses the belief that life is comprehensible, manageable, and meaningful. The distinction proposed by Ronen and Rosenbaum (2010) between basic theory and applied theory indicates not only the different focus of each but also represents the progress in decreasing the gap between the "ivory tower" of cognitive psychology and its practice in combining clinical and empirical evidence-based studies.

Research on different aspects of CBT is currently conducted at universities and in some hospital-psychiatric departments affiliated with universities. CBT research studies includes a variety of subjects among which are theory and practice of OCD, ROCD, PTSD, grief therapy, GAD and social anxiety, ACT, schema therapy, mindfulness, self-efficacy and self-control, and cognitive grief therapy. The studies are carried by researchers and doctoral and MA students and can be categorized into three main areas:

1. Basic research that is aimed to develop theoretical models for explaining the contribution of cognitive components such as internal components of self-control, social support, self-efficacy, and hope and environmental components such as social and family support and meaningful figures to increase the individual's ability to cope better
2. Control studies that compare CBT to medication, no treatment, or other mode of therapy for learning the effect of therapy on clients
3. Brain studies focusing on FMRI to better understand the way a disorder influences individual as well as in the way therapy can be seen in the brain simulations.

These studies are conducted with children, adolescents, adults, families, and elderly individuals and contribute to our understanding of the role of therapy in changing one's ability to cope with stressors.

## *CBT with Special Populations Children and Older Populations*

EFRAT and KOACH models for training teachers, adolescents, and children in emotional regulation are based on Beck's cognitive therapy and Albert Ellis's ABC model of emotional disturbance. These models are approved by the Ministry of Education and focuses on the centrality of cognitions and interpretations as a source of modulating stress. These appear in the form of course outlines adopted by different educational settings.

Ronen et al. (2013, 2014) and Shachar et al. (2016) developed a self-control model for reducing aggression and increasing well-being in children. The project has been adopted by the Ministry of Education and is now conducted all over Israel in elementary schools by trained educational counsellors.

In 2014 the National Council for Suicide Prevention of Suicide was established aimed at developing training and intervention programs. Mental health and school counselors are involved with at-risk populations: children, adolescents, young and old (70–80 years old), old-old adults (with the rising longevity, more people will live to ninety years and older, a group that attracts scientific attention in order to assist life span), and new immigrants (State of Israel, Ministry of Health, 2014). One of the programs, "the gatekeepers," recruits volunteers who are key figures in the community (teachers, social welfare workers, parents, friends, nurses, caregivers in old-age nursing homes) and trains them to identify people at risk so they can

provide first aid support and be liaison figures with social and mental health services. The training programs focused on short-term interventions such as CBT, problem-solving strategies, and positive psychology strategies (Ministry of Health Israel, 2017). One such intervention program, "Wellness and Mental Fitness Kit for Positive Aging," for elderly people combines REBT and positive psychology (Bar-Tur & Malkinson, 2014; Malkinson & Bar-Tur, in press).

## Concluding Remarks

In Israel, CBT has been developed to become a unique and independent domain of psychotherapy combining clinical practice and research to provide solutions to a variety of mental health problems. There is also an increasing demand for problem-solving focused, short-term psychotherapy such as CBT. The inclusion of CBT training as part of the curricula in medical and nursing faculties indicates the progress of CBT within the field of mental health, and yet it is also a challenge for CBT practitioners and ITA.

The age of personalized medicine with its focus on tailoring medical treatment to the individual characteristics of each patient will certainly challenge the field of psychotherapy. Notwithstanding the differences between the two (medicine relies on the person's unique genetic), and psychotherapy (relies mostly on traditional understanding of human behavior), the former will effect psychotherapy. Individualized psychotherapy is therefore a challenge with additional areas to be considered including the development of the field of brain studies, virtual technologies, computerized therapy, and increasing numbers of individuals participating in clinical studies as collaborators in understanding human behavior (salutogenic and pathogenic). These trends raise the question: Should CBT retain its traditional framework of accrediting and certifying therapists or spread out the philosophy underlying CBT as a way of life by encouraging Low-Intensity Cognitive Behavior Therapy (LICBT) to be practiced by non-therapists. It is a stream in CBT done by moderators to make evidence-based simple psychological interventions more available for the community (Bennett-Levy et al., 2010).

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# Chapter 20
# Cognitive Behavioral Therapy in Italy


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## Psychotherapy Practice and Emotional Disorders in Italy

In Italy, a graduate degree in psychology or medicine is necessary in order to attend a 4-year specialization school in psychotherapy (Borsci, 2005). Psychotherapy can be practiced in both the private and public sector. Public services that provide psychotherapy are departments organized inside the National Health System. Public services are free, or people have to pay a nominal amount for access to all healthcare services including mental health. Theoretical pluralism and the progressive decline of psychoanalysis have favored the development of different therapeutic approaches (Borsci, 2005; Gemignani & Giliberto, 2003).

In Italy one person of five meet diagnostic criteria for at least one emotional disorder across the lifespan (Alleva, 2017; De Girolamo et al., 2005). More specifically, 11% of people interviewed has suffered from an affective disorders or anxiety disorder across the life. Women seem to be more affected by psychological problems (10.4%) compared to men (3.9%) and that in terms of risk factors for predicting a disorder, they identified being unemployed, a housewife, and disabled increased the risk (De Girolamo et al., 2005). Recent research indicates that the prevalence of emotional problems among youngers in Italy shows a decrease of

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mental well-being and that 75% of psychological problems that before 25 years of age (Alleva, 2017; Frigerio et al., 2009).

## Beginnings: Behavior Therapy

The practice of cognitive therapy in Italy has at least four distinct traditions which have both interacted which each other and developed separately at different points. We will briefly describe the behavioristic tradition, constructivist tradition, a rational emotive behavior therapy (REBT) tradition, and cognitive behavioral therapy (CBT) tradition. More recently, a "third wave"-oriented tradition has emerged with a focus on mindfulness, metacognitive interventions, acceptance and commitment, and compassion to name a few approaches.

The development of behaviorism in Italy begins with Virgilio Lazzeroni, who in 1942 published a paper focused on behavior as a subject of psychological research (Lazzeroni, 1942). The Italian behaviorism movement had two main roots: the Pavlovian-reflexological-psychiatric tradition and the Skinnerian-psychological tradition (Meazzini, 1978; Moderato & Presti, 2006). These groups focused on both experimental and clinical research specifically in the fields of intervention for regular and special education. Since Lazzeroni's early lessons, behaviorism has reached a fairly good critical mass within psychology in Italy in terms of both experimental research and clinical application and is mainstream in many areas such as anxiety disorder therapies, special education, organizational behavior, and ergonomics (Moderato & Presti, 2006). The Italian behavioristic movement was interested in experimental research on neural reflex arc reactions, behavioral models of classical and operant conditioning, and behavioral modification clinical with a relevant interest in clinical applications regarding special education (Caracciolo & Rovetto, 1988; Meazzini, 1978).

## Standard Cognitive Therapy: REBT and CBT

In considering the development of more traditional cognitive therapy in Italy, the seminal figure is Cesare De Silvestri who disseminated REBT in Italy from the 1970s. In 1972, De Silvestri attended the REBT Practicum that took place in Villars-sur-Ollon (Switzerland) conducted by Dr. Albert Ellis in 1979. De Silvestri, along with a German psychology student Carola Schimmelpfennig, founded an affiliated REBT Institute in Rome in 1981. From the 1990s onward, REBT also spread outside Rome, thanks primarily to the efforts of Franco Baldini and Mario Di Pietro. The work of De Silvestri, Schimmelpfennig, Baldini, and Di Pietro is integral to the development of REBT in Italy (Ruggiero et al., 2014).

In comparison to REBT, the development and dissemination in Italy of CBT has been somewhat delayed. In 2001, after a training at the Beck Institute of Philadelphia, Antonella Montano has founded the Institute of Cognitive Behavioral "Istituto A.T. Beck" Therapy in Rome and Caserta, recognized by the Philadelphia Beck Institute.

## Constructivism

Victor Meyer is not only one of the seminal figures in the behavioral tradition but also that of constructivism. In fact, the two founding fathers of Italian constructivism, Vittorio Guidano and Giovanni Liotti, were trained by Victor Meyer in London, with whom they learned behavioral techniques, among which the most famous was "exposure and response prevention" (ERP), used to treat agoraphobic and obsessive-compulsive symptoms (Meyer, 1966). However, Guidano and Liotti were also strongly influenced by REBT, constructivism, and evolutionism (Ruggiero et al., 2014). In fact, in Italy REBT also interacted with the birth of the constructivist root of the cognitive psychotherapeutic practice. Guidano and Liotti were aware of some theoretical limitations of the behaviorism model and were looking for a new model that included cognitive mediators between a stimulus and response, and REBT helped them in finding an answer (Guidano & Liotti, 1983). Through their contact with De Silvestri and REBT, Guidano and Liotti became acquainted with a clinical model that was, in the end, quite compatible with their future constructivist path. Further, Mike Mahoney's theoretical development toward constructivism was encouraged by his encounter with other constructivist theorists during his sabbatical mainly spent in Europe at the end of the 1970s. In particular, he cooperated with Vittorio Guidano and encouraged his publications (Guidano & Liotti, 1983; Guidano, 1987, 1991).

Guidano, Liotti, and Mahoney posed the need for a more sophisticated definition of cognition at the ground of the notorious and self-defeating distinction between a "rationalist" and a "constructivist" approach (Mahoney, 1995). The constructivist theorists considered the Beckian style of verbal assessment and reattribution of beliefs as a form of crude computationalism and inapplicable to the complex fluidity of mental reality, preferring to talk about personal meanings (Kelly, 1955). Unlike beliefs, personal meanings would be more closely tied to the personal life history of the patient and to his or her emotional experiences. Personal meanings were not a single set of beliefs about a situation but a vision of the self and the world (Guidano, 1987, 1991; Mahoney, 1995).

From a clinical viewpoint, constructivist therapist interventions focused on personal meanings, reconstruction of the patients' life story, and treatment of recursive vicious circles of discomfort with emotions and fear of fear. This intervention was an earlier model of a metacognitive approach, in a way akin to REBT's concept of secondary ABC (Sassaroli et al., 2005).

Constructivism appeared to be more speculative and it did not focus on research to empirically test the model. For this reason, it's inferior to the evidence-based support of CT and REBT.

## Integration of Constructivism and Standard Cognitive Therapy

Efforts to integrate constructivism with standard cognitive therapy have led to a number of important theoretical work on goals in therapy in Italy. Castelfranchi and Paglieri (2007) and Mancini (Capo et al., 2010; Mancini & Gangemi, 2015) defined the importance of aims and goals in the cognitive process and distinguished them from beliefs and schemata. A further integration of REBT and constructivist models is that of Lorenzini and Sassaroli (1987) who borrowed from George Kelly's model, namely, personal constructs psychology (PCP) (Kelly, 1955), the dilemmatic construct concept, and the assessment technique called "laddering," and included them in the cognitive assessment procedures. In addition, Lorenzini and Sassaroli (1995) stressed the importance of interventions focused on personal meanings, reconstruction of the patients' life story, and treatment of recursive vicious circles of discomfort with emotions and fear of fear (Sassaroli et al., 2005).

## Process-Oriented Cognitive Therapies

The "third wave" of cognitive behavioral therapy is quite popular in Italy. Process therapy perhaps is viewed as more acceptable from the Italian perspective which has often deemed questionable standard rationalistic interventions of CBT and REBT. There are a number of important Italian psychologists who have helped promulgate these approaches. In Italy, mindfulness-based treatments are perhaps the most popular third wave psychotherapies, and they are promoted by Fabio Giommi and Fabrizio Didonna (Didonna, 2012) who are authors of important publication. Acceptance and Commitment Therapy (ACT, Hayes, 2004) and contextualism as an approach are promoted by Roberto Anchisi, Paolo Moderato, and Francesca Pergolizzi (Anchisi et al., 2017). Perhaps the Italian interest in metacognitive structures may be traced back to the strong importance given to the so-called "secondary" problem in the Italian interpretation of REBT. Generally speaking, the secondary problem is a vicious circle among Italians in which the client has a biased negative belief toward their own mental states. For many Italian theorists, there is the tendency to think that all emotional disorders are, in fact, always generated by a secondary process (De Silvestri, 1989; Lorenzini & Sassaroli, 1987).

In sum, the new models propose that emotional disorders do not depend on mental representations of the self as Beck thought (Beck, 1975), but on the "process" (i.e., dysfunctional mechanisms in which voluntary attention and executive control play various roles in different models). These models have maintained a strong relationship with the behavioral tradition and represent a return to contextualism and functional analysis (Jacobson et al., 2001). This may explain why process models recruit practitioners from either the behavioristic or the constructivistic tradition. In addition, we may quote a genuinely Italian approach to process therapies which is

the *Metacognitive and Interpersonal Therapy* (MIT, Dimaggio et al., 2007, 2015; Semerari et al., 2007, 2014) which can be considered a development of the constructivist model of Guidano and Liotti (1983) and Mahoney (2003). In the MIT model, the emotional pain would depend on the metacognitive deficits in the skills to identify emotions, to interpret our own mental states, to distinguish them from those of others, and finally to behaviorally master them (Semerari et al., 2007, 2014).

## Adaptation of CBT in Italy

As we wrote in the previous section, CBT in Italy has been influenced by different approaches, and it integrated all of them. What a CBT therapist does is to analyze symptoms, with particular attention for internal structure of pathology (Chiesa & Pizzone, 2005) and beliefs of the client. Great attention has been given to irrational beliefs and automatic thoughts, emotions, and dysfunctional behaviors that cause psychopathology. Italian CBT therapists start clinical work using the ABC model of Ellis, to better understand the problem of the client. This is a very important part of the work, because it allows for the development of a sound case formulation to guide clinical planning.

What characterizes the first part of psychotherapy is to define what in the history of the client made the client more vulnerable to specific beliefs and themes (these are called "historical factors of psychopathology") and then examination of what may have happened that "broke the balance" in the life of the client and when the symptoms of psychopathology started (these are called "collapse factors of psychopathology"); lastly, therapist analyzes what is happening inside the client that blocks resolution of the problem (these are called "maintenance factors of psychopathology") (Perdighe & Mancini, 2010). These elements make up the case formulation.

Then, what is typical of the work of Italian CBT psychotherapist is to more closely look at the irrational beliefs (IBs) and automatic thoughts (ATs) of the clients. In working with the client to understand their faulty thinking, great attention is given to consider if the client experiences difficulties because he thinks in terms of demands ("I must reach that goal in my job"), awfulizing ("It's terrible if my partner leaves me"), frustration intolerance ("I can't stand if my friend doesn't like what I think"), or self/other downing ("If I cannot have the work I want, it means I am a loser"). Secondly, it's important to find out if there are any automatic thoughts that characterize the way of thinking of the client. These could be over-generalizing ("I seem to fail at a lot of things"), emotional reasoning ("I feel depressed; therefore, my marriage is not working out"), etc.

Another part of the work of the Italian CBT therapist is the attention given to the therapeutic alliance with the client. Many psychotherapists effectively use the therapeutic relationship as an instrument for intervention. They analyze behaviors that the client shows during sessions with the psychotherapist and they use this material to discuss with the client about their behavior outside of the session, with other people, in order to help them to change their dysfunctional relational behaviors

(DiMaggio et al., 2007). This is important especially with clients who suffer for personality disorders, who involuntarily create what is called "interpersonal cycles" (DiMaggio et al., 2007) that are dysfunctional behaviors that they repeat, based on irrational ways to consider their relationships ("Everybody will leave me").

Another important intervention that is often used at the beginning of CBT psychotherapy in Italy is to share case formulation and aims of the psychotherapy with the client. This intervention is important because the client can understand disturbance and the rationale of the clinical approach to psychotherapy. In this part of the work, attention is given to how a client may experience a meta-disturbance (i.e., getting upset about being upset), because it could influence the process of psychotherapy. When a psychotherapist considers: "Does the client feels specific emotions about the problem?" and "Could these emotions influence psychotherapy?"; if the answer is "Yes", this meta-emotion problem may be among the first part of the clinical work focused on.

Italian CBT psychotherapists will provide psychoeducation about the clinical problem to make the client more aware about psychopathology. At the same time, they will provide information about the nature of the clinical intervention. Specific clinical work is made to debate the irrational beliefs and automatic thoughts that provoke psychopathology. Finally, these approaches are then integrated with behavioral intervention in order to work on changing dysfunctional behaviors.

An important role played in psychotherapy in Italy is that of the use of language. In Italy, language that is used in CBT therapy is provided to be consistent with British and American English. What has been done is to translate from English to Italian names of irrational beliefs, automatic thoughts, emotions, etc. An important area to consider the influence of language is the use of names of emotions. They are all labeled with specific words, but some words are a little bit different in the Italian language. For example, in English "sadness" is considered to be a functional emotion, whereas in Italian, its meaning is more similar to depression. In Italian, it's better to use "depression/sadness" as dysfunctional emotion and *dispiacere* (regret) to name a functional emotion.

Surprisingly, there are not many significant differences in the use of names of irrational beliefs and automatic thoughts. They have been translated into Italian and are similar to the original American English. Italian clients can understand their meaning, and it's possible to debate them using the same terms.

An interesting observation of CBT work in Italy is that to work on beliefs needs time, especially for those that are crucial for the client. More specifically, in Italy beliefs connected to guilt are difficult to change. This, probably, may depend on the Italian Christian background that influences culture and as a result psychotherapy. It's often difficult for the clients to change their irrational beliefs about guilt, because they are strongly reinforced by their cultural and historical background. Further, it may be difficult to change demands about themselves, because there are social rules that support this way of thinking.

Another aspect connected to debating is the concept of "acceptance" based on REBT tradition (Ellis, 1962). In Italy, clients often confuse acceptance with resignation. It's difficult to draw the distinction between the two as it relates to acceptance.

Often Italian clients confuse the two concepts and they think that, to feel better, they have to be passively subjected to negative events of life. It's particularly difficult for them to judge only one part of self or of the others or of the life and to practice the idea of unconditional self, others, and world acceptance (Dryden, 2008).

Clinical sessions in Italy for CBT psychotherapy typically are between 45 and 60 min in length; it depends on psychotherapist choice and the needs of the client. If a client is struggling considerably and may need more time, the psychotherapist may modify the structure as a result. What's important is to share the language with the client and to adapt it to the specific client with whom psychotherapist is working. This is particular important when the work is focused on emotions. What we can see is that for clients it is often difficult to find the "right" name for emotions. Italian is a complex language, and there are many words and expressions that can be used to define emotions. What CBT psychotherapist does, at the beginning of psychotherapy, is to use words of the client to name emotions, in order to reinforce therapeutic alliance and to help the client better understand his emotional world, and then the creation of a common emotional vocabulary for this client may assist in clinical work.

## Professional and Cognitive Behavioral Therapy Organizations

In 1972, Vittorio Guidano, Giovanni Liotti, and other scholars founded the *SITC-Società Italiana di Terapia Comportamentale (Italian Society of Behavior Therapy)* (Chiesa & Pizzone, 2005). The SITC was one of the first societies of behavioral therapy across Europe, but, during the first part of its existence, its impact was primarily local (Sanavio, 2012). Beginning in 1973, Guidano and Liotti received a number of requests to organize trainings to disseminate behavioral therapy knowledge and techniques throughout Italy. In the national conference of Italian Society of Cognitive Therapy in 1981, the formal change of the name from SITC to SITCC by adding the term "cognitive" (Chiari & Nuzzo, 1982).

In 1977 in Verona, a second society of behavioral therapy was founded, called *AIAMC, Associazione Italiana di Analisi e Modificazione del Comportamento (Italian Association of Analysis and Modification of Behavior).* Quickly, AIAMC developed across Italy and internationally with the first international conference being held in 1978 in Venice, during which a number of influential participants attended. In 1992, AIAMC also added term "cognitive" to its name to highlight the attention toward the cognitive aspect of therapy (Sanavio, 2012).

The first journal of behavior therapy in Italy was founded in 1979, *Italian Journal of Analysis and Modification of Behavior*, that has published many important national and international studies. Another important journal is the *Italian Journal of Behavioral and Cognitive Psychotherapy*, born in 1995. The journal publishes Italian and international papers about different arguments like clinical assessment, rehabilitation, behavioral medicine, methodology, and research connected to psychotherapy (Sanavio, 2012).

## Organization of Trainings

Practical lectures include lectures about different theories and models of CBT from the seminal work to present scholarly and professional activities as well as practical lectures during which case formulation and techniques are explained. The training aims are to teach participants how to do the work of psychotherapist, to have a good knowledge about themselves, and to be aware of how certain characteristics of the psychotherapist could influence the therapeutic relationship with clients. One important part of the practical training is moments where trainees can share with the group their experience and thoughts about the clients with particular attention to beliefs and emotions of the trainees themselves. There are two important components during the training lectures: (1) group work and (2) clinical supervision (Pelliccia et al., 2005). Clinical supervision is a fundamental experience where each student can discuss about his/her client with the supervisor and other students. A collaborative atmosphere is promoted, and all participants can express their point of view and thoughts about cases that are presented (Pelliccia et al., 2005).

## Current Regulations Regarding Psychotherapy Provision

In Italy, psychotherapy can be practiced in both the private and public sector. Public services that provide psychotherapy are departments organized inside the National Health System. Public services are free or people have to pay a nominal amount for access to all health-care services including mental health. In Italy, there are, also, private services that provide psychotherapy and include private family counseling and social coops or private practice.

Another type of private service provided has been organized by a private school of psychotherapy (SPC, School of Cognitive Psychotherapy) and in the last years is called "ethical psychotherapy" (APC, 2018). This project developed as a result of the increased need of psychotherapy but inadequate access to services due to a myriad of reasons, chief among them is the fact that therapy is too expensive. As such, this model allows clients to have access to psychotherapy where costs are lower. Ethical psychotherapy is conducted by students who are in the third and fourth year of a school of psychotherapy under the supervision of certified supervisors. The cost for every session is cheaper than a "traditional" session of psychotherapy, and, at the same time, students have the opportunity to gain clinical experience in their work with clients.

## CBT with Specific Clinical Populations in Italy

While the approaches of the varied models of CBT differ in structure and focus, they often share some common expectations in terms of delivery of service. However, different countries and cultures may have specific clinical populations that may warrant further elaboration in terms of how CBT is applied. This section describes different approaches that are used in Italy to work with groups of clients with specific disorders. Clinical models and work with schizophrenia and psychosis, personality disorders, OCD, developmental psychopathology, and anxiety disorders will be reviewed.

## Residential Interventions for Psychosocial Rehabilitation

During the 1960s, Italy dismantled the psychiatric system based on hospital confinement and introduced a system of social integration of patients. Psychosocial programs include meetings with families, social skills learning programs, and integration between rehabilitations and are integrated with psychotherapy (Gigantesco et al., 2007).

CBT techniques are delivered as part of a rehabilitation program for clients with psychiatric diseases in either inpatient or residential settings with the aim to reinforce social, relational, and working autonomy. Psychotherapy focuses on having clients learn adaptive behaviors and will use reinforcers and motivational training (Gigantesco et al., 2007).

Clinical work with this population involves helping clients understand and evaluate dysfunctional behavior as well as what may be a helpful alternative behavior. Clients are taught a number of coping strategies as well as problem-solving and self-instructional training and through the use of reinforcement will hopefully generalize and maintain these skills (Gigantesco et al., 2007).

Rezzonico and Ruberti (1996) suggests that it is important to consider the attachment style of this group of clients. The affective behavior of a client may be influenced by attachment difficulties that may make behavior that is more difficult to manage by the clinician.

Clinically, clients work to help to develop new competencies to discriminate between internal and external world, to improve metacognitive, communication, and relational abilities (Dimaggio and Semerari, 2007). Another important part of the protocol is the work on deficits of short-term memory, focalization of attention, and elaboration of logical reasoning (Scrimali, 2006).

## Interpersonal Metacognitive Therapy/TMI and the Treatment of Personality Disorders

TMI-interpersonal metacognitive therapy is an integrated approach for treatment of personality disorders developed by Third Centre for treatment of Personality Disorders in Rome that is used at different centers across the country (Carcione et al., 2008). What TMI asserts is that personality disorders are characterized by impairment in metacognition ability (Semerari et al., 2014). Metacognition is the ability to reflect and to modify representations of mental objects that humans create from what they think, image, remember, dream up, and predict (Carcione et al., 2008). Proponents of TMI argue that personality disorders are characterized by metacognition disorder and that malfunction in specific areas of metacognition influence how disorders are expressed. Metacognitive skills include *monitoring*, the ability to recognize emotions and thoughts, motivations, and goals that drive behavior and to understand the relationship between beliefs and emotions; *integration*, the ability to reflect about different mental states and mental processes in order to organize them on the basis of their relevance and to make behavior uniform with goals; *differentiation*, the ability to discriminate between internal representations and external world; *decentering*, the ability to put ourselves in the other persons' shoes, to think about how others could think, and to think about other minds; and *mastery*, the ability to regulate internal states of psychological suffering and interpersonal conflicts (Carcione et al., 2008).

## Developmental Psychology and CBT

The constructivist roots of Italian CBT (Guidano & Liotti, 1983; Mancini & Romano, 2010; Semerari et al., 2014) have favored the integration with the model of d*evelopmental psychopathology* applied to children and adolescent (Cicchetti & Cohen, 1995). Treatment involves changing variables of the child or of the environment where child lives. From this point of view, the child is considered a central part of this dynamic system, and the main aim of treatment is the adjustment of the young client. So, it's necessary to consider personal vulnerability, stress sources, protection variables, and the presence of social support and how all of these factors interact with each other (Mancini & Romano, 2010).

Another important model of children and adolescents psychopathology is attachment theory that asserts importance of relationship between mother and child as crucial factor for development (Bowlby, 1988). The development of the child is influenced by support and care provided by the mother that creates a regulatory and interactive system (Malagoli Togliatti & Zavattini, 2006). The work with children and adolescents includes the use of different behavioral and cognitive techniques, like psychoeducational interventions, cognitive restructuring, conditioning, techniques to manage anxiety and anger, exposure and response prevention,

self-instructions, relaxation, social skills training, and parent training (Fabbro, 2016). This part of treatment is integrated with the clinical work with the family. The model used for the work with parents is *Family-Based Cognitive Behavioral Therapy* and includes psychotherapy with the child and the family where dysfunctional relations and situations are changed and the work is focused on all family members (Barrett et al., 2008).

## Obsessive-Compulsive Disorder (OCD): A Goal-Focused Model

Another development of CBT in Italian cognitivism was the analysis of its relationship with the psychological theory of goals and the latter's existential aspects. Castelfranchi and Paglieri (2007) and Mancini and Gangemi (2012) defined the importance of aims and goals in the cognitive process and distinguished them from beliefs and schemata. The focus of Italian cognitive approach on aims, goals, and purposes makes it possible to conceptualize patients as individuals following a functional (or dysfunctional) life plan. This focus provides a breath of existentialism to the clinical view of cognitive therapy (Mancini & Gangemi, 2012). A life plan is the long-term set of goals that an individual pursues in his or her life and which enables him or her to give a direction and a meaning to life. Mancini applied this model specifically to obsessive-compulsive disorder: his model asserts that obsessions and compulsions depend on the specific biased beliefs of the client whose goals are to prevent guilt to be irresponsible and to protect from contamination risk (Mancini & Perdighe, 2010).

## Anxiety Disorders: A Developmental Approach

Another example of constructivist influence is the model that describes anxiety disorders in Italy in terms of attachment theory (Sassaroli et al., 2006). In this model clients who present anxiety problems are included in two groups of people: *dependent* and *autonomous*. The first group includes patients who are worried to lose love and significant relationships because they think they *cannot stand* a life without significant others or they think *they are so loser* and without value that everybody will leave them. The second group are individuals who apparently are not interested in relationships. They seem to have strong character and tend to do everything by their own, looking for independence from all relationships (Sassaroli et al., 2005). From this perspective, the onset of anxiety disorders occurs when important goals for the client are threatened: separation or loss of significant others or demanding experience that threat autonomy and avoidance. Strategies that clients use to protect themselves are control, avoidance, and worry that contribute to maintain irrational

beliefs and anxiety. Another important factor that contributes to maintain anxiety is the secondary ABC: patients worry about anxiety as a danger in itself (Sassaroli et al., 2005). Therapy aims to improve awareness of the client about anxiety and beliefs underneath and to improve metacognitive abilities. Through challenging automatic thoughts and irrational beliefs such as need of control or clinical perfectionism (Sassaroli et al., 2008a, b) that maintain the disorder, the clinician then works with the client to conduct exposure to anxiety situations and to work on acceptance of the risk not to have total control of the situation. Finally, the clinician works to increase client awareness about where he/she learned irrational beliefs during his/her history (Sassaroli et al., 2006).

## Research on CBT in Italy

Interest for research in psychotherapy in Italy began in the 1980s and rapidly increased (Dazzi et al., 2006). Within the cognitive field, Francesco Mancini conducts research on obsessive-compulsive disorder (OCD) and analyzing what type of reasoning influences this group of clients. Specifically, this group examined what they call "obsessive thinking" and a specific type of guilty, called "ontological guilty" that characterizes people with OCD. "Ontological guilty" is a specific type of guilty that derives from the idea to transgress moral rules or natural order of things (Mancini & Gangemi, 2004; Gangemi & Mancini, 2007; Gangemi et al., 2010).

Other research has focused on characteristics of personality and cognition of people who suffer from eating disorders. The role of control, criticism, clinical perfectionism, and worry in eating disorders has led to the development of a standardized protocol to work with this group of clients (Sassaroli et al., 2008a, b; 2010). Relatedly, this has led to research within this group that examines metacognitive factors of addictions (Spada et al., 2013) and a study about "night eating disorder" (Vinai et al., 2009).

Another line of research in cognitive psychotherapy is focused on the role of metacognition in the development of personality disorders and schizophrenia. Recent studies show that metacognition includes two factors: one is related to theory of mind (decentration and differentiation), and the second is related to self-reflection (monitoring and integration) (Dimaggio et al., 2007; Carcione et al., 2008; Lysaker et al., 2010; Semerari et al., 2012).

Research in Italy on CBT has examined and refined international approaches and has also created new instruments and areas that have been utilized internationally (Dazzi et al., 2006). In order to achieve these aims, in the field of research in psychotherapy, different international collaborations have been developed with support from different professional organizations such as the Italian section of the Society for Psychotherapy Research (SPR) that publishes the bilingual journal called *Research in Psychotherapy: Psychopathology, Process and Outcome* (Gemignani & Giliberto, 2003).

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# Chapter 21
# Cognitive Behavioral Therapy in Japan


**Hisataka Takasugi**

## Japan: An Overview of the Country

Despite massive losses during World War II and having very little natural resources, Japan is now the third largest economy (IMF, 2018) with the population of 126.5 million, roughly 39% of the United States and 9% of China, and is also at the forefront of a super-aging society.

In order to understand the evolution of psychotherapy in Japan, it is helpful to understand Japan's historical relationship with the outside world as the evolution is heavily influenced by it. After 250 years of isolation policy by the Tokugawa shogunate, in 1854, Commodore Matthew Perry of the US Navy negotiated a trade agreement between Japan and the United States. Japan was forced to agree to lopsided demands of the United States threatened by the technologically advanced and heavily armed fleet of steam frigates (Gordon, 2003).

In 1868 the Tokugawa shogun, that ruled Japan in the feudal period since 1603, lost his power, and the emperor, backed by two powerful clans, was restored to the supreme position. The emperor took the name *Meiji* (enlightened rule) as his reign name: an event known as the *Meiji Ishin* (Meiji Restoration). The Meiji Restoration spelled the beginning of the end for feudalism in Japan and would lead to the emergence of modern Japanese culture, politics, and society (Gordon, 2003).

Meiji Restoration marks Japan's first encounter with the Western psychology. The discipline was introduced at the Imperial Universities by Japanese scholars who had studied in the West and by scholars invited from the Western countries (Harding 2015; Sato, 2007).

After the end of World War II and after the occupation by the Allied Forces ended in 1951, Japan's government shifted from imperial and military rule to a

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parliamentary democracy. Post-war period marks the renewed encounter with the Western psychotherapeutic theories and practices (Sato, 2007). People in Japan often visit medical doctors rather than clinical psychologists for somatic symptoms such as chronic fatigue, sleep-related problems, and inability to concentrate which may well be coming from psychological issues. As Iwakabe (2008) notes after they visit medical doctors they are then usually referred to clinics of *shinryonaika* (psychosomatic internal medicine which is very popular in Japan) where they are typically given pharmacological treatment for their physical symptoms.

When the mental symptoms seem severe, people tend to visit psychiatrists rather than psychologists. On the part of psychologists, there is the preference to call their services as counseling rather than psychotherapy. This is because psychotherapy carries stronger connotation of treatment, which connotes mental illness. Such practice makes the definition of counseling versus psychotherapy unclear (Iwakabe, 2008). On the other hand, psychiatrists usually refer to their services as psychotherapy, which conjures medical cure.

Currently, psychotherapeutic treatments are covered by the national health insurance system only when administered by medical doctors or by trained registered nurses and certified clinical psychologists under medical doctors' direction (Iwakabe, 2008).

## History of Psychotherapy in Japan

According to Yoshinaga (2014), in modern era – post Meiji Restoration of 1868 – the earliest forms of psychotherapy were various spiritualized practices of hypnotism known as *reijutsu*, the origin of reiki healing today, which boomed in the early 1900s. The boom gave rise to as many as 30,000 so-called *reijyutsuka* (reijutsu practitioners). Many medical doctors who felt threatened by the rise of these more popular techniques demanded legislation to limit the practice of *reijutsu*. The boom ended with the legislation passed in 1908. However, many "therapists" continued practicing under various other titles according to Yoshinaga.

Apart from *reijyutsu*, one homegrown more lasting method is Morita therapy founded in 1919, which is still practiced today. Formulated by Dr. Masatake Morita (1874–1938) who had himself suffered from psychological symptoms since adolescence, the therapy is centered on the notion of gaining an insight of *arugamama* or acceptance of the world as they are (Kondo & Kitanishi, 2014). Morita advocated resting as a major part of his therapy. He chaired a department at Jikei University's School of Medicine in Tokyo where his students further developed Morita therapy.

However, it had been uncommon for Japanese people to seek psychological assistance as emotional and mental disturbances had historically been regarded as stemming from a lack of self-discipline, signs of weakness in one's will power or of one's personality (Griffiths et al., 2006). In severe cases such as schizophrenia, they were considered "lunacy" and were subject only to confinement at home in the earlier days and in mental institutions later rather than treatment. Unfortunately, there

continues to be some stigma attached to those with mental disorders, which has not been fully eradicated (Ando et al., 2013).

After the end of World War II in 1945, under the occupation by the Allied Forces, the Shintoism-based education was replaced by a new democratic system in which psychology, among other disciplines, was given a prominent place as a fundamental part of scientific education (Sato, 2007). Counseling, guidance, and group dynamics, among other methods, were introduced mainly from the United States (US). Many psychologists were granted scholarships to study in the United States. In the late 1950s, Carl Rogers and his nondirective counseling together with behavioral therapy were introduced and attracted many post-war Japanese clinical psychologists (Sato, 2007). In 1962, rational therapy (now REBT) formulated by Albert Ellis was introduced by psychologist Yasutaka Kokubu (1930–2018). The number of clinical psychologists gradually increased, and as a result, the Japanese Association of Clinical Psychology (JACP) was established in 1964.

Along with the introduction of many types of psychotherapy from the West, Ishin Yoshimoto (1916–1988), a devout Buddhist, developed Naikan therapy, which is often seen as one of the two major indigenous psychotherapies along with Morita therapy mentioned earlier. The first Naikan Center was opened in 1953 in Nara prefecture. Adapted from Buddhist practice of *mishirabe* (looking into oneself), the therapy is based on the concept of *naikan* (introspection). In this approach, clients are encouraged to revisit and focus on their past relationships with others in their lives in order to nurture one's ability to see the world from the perspectives of others and to shed one's self-centeredness. This is seen to be consistent with the Japanese culture valuing other-orientedness over self-centeredness.

In the 1960s, Morita therapy continued to prosper in Japan through the efforts of his former students, attracting attention from American psychologists, notably from a neo-Freudian Karen Horney who befriended the Japanese Buddhist reformer D.T. Suzuki and the Christian theologian Paul Tillich. Later, Erich Fromm became interested in the relationship between Zen Buddhism and psychotherapy and co-authored *Zen Buddhism and Psychoanalysis* in 1970. The 1970s was a decade during which the rediscovery of self-identity and confidence emerged among the Japanese public against the backdrop of remarkable post-war economic recovery. Such attention by Western scholars given to the compatibility of Buddhism, which is at the heart of the Japanese society with modern psychotherapy, boosted the interest in the rediscovery (Harding, 2015).

However, much of the credit for the popularization of psychodynamic theory and practice in Japan can be attributed to the work of Takeo Doi (1920–2009) a Freudian trained psychiatrist and in particular to his book *Amae no kozo* (The Anatomy of Dependence) published in 1971. His book helped to popularize psychodynamic theories and practices through the analysis of the national psychological identity with the notion of *amae*: a drive for dependency said to be prevalent in the Japanese psyche (Harding, 2015).

Another figure that was extremely influential in the recent history of psychotherapy development was a Jungian trained analyst Hayao Kawai (1928–2007). A prolific writer with over 70 books to his credit for both academic and general

audience, he is referred to as "a pioneer of Japanese clinical psychology" (Umemura, 2015). His interpretation of Japanese culture and folklores through the Jungian theory not only was widely accepted by the general public but also had immense influence on psychologists across different orientations in Japan. Kawai was a longtime professor of psychology at Kyoto University and held many public positions including the director of the International Research Center for Japanese Studies (1995–2001) and the Chief of the Agency for Cultural Affairs (2002–2007).

Additionally, Kawai helped to establish the Association of Japanese Clinical Psychology (AJCP) in 1982 and was elected its first president. AJCP was a spin-off of the Japanese Association of Clinical Psychology (JACP) established earlier in 1964. AJCP is the largest psychology-related association in Japan today, and it led to the accreditation of certified clinical psychologist (CCP) in 1988. CCP is the most recognized credential for psychotherapy practitioners today. For example, MEXT (Ministry of Education, Culture, Sports, Science and Technology) endorses CCP accreditation as the requirement for school counselors. By 2016, 32,914 clinical psychologists had been accredited with CCP among which 603 were medical doctors.

Despite the earlier introduction of Western theories and the existence of some indigenous methods, the real development of psychotherapy is relatively a recent phenomenon dating back to the 1990s. The prolonged recession since the bursting of the bubble economy in 1991 exacerbated by the global financial crisis in 2008 and the rapid social changes have escalated the need for psychological services (Iwakabe, 2008; Kanazawa, 2008). Additionally, incidents such as the Aum subway sarin gas terrorism in Tokyo (1995), Kobe-Awaji earthquake both in 1995, and the Great Kanto earthquake accompanied by tsunami and nuclear power plant disaster (2011) have all contributed to the increase in the PTSD care (Wolters Kluwer Health, 2017).

At present, the majority of Japanese psychotherapists use Western developed models rather than indigenous methods such as Morita and Naikan therapy. However, it is very difficult to pinpoint any one dominant approach that therapists practice. Despite Kawai's strong Jungian influence, most therapists practice a mixture of psychoanalytic and client-centered approach. Often, especially with the secondary school population, family therapies are employed.

Cognitive behavioral therapy (CBT) has expanded in Japan since its introduction in the late 1980s. According to survey conducted by the Japanese Society of Certified Clinical Psychologist (JSCCP) in 2007, 73% of CCPs who responded wanted to learn more about CBT. Led by Hiroshi Ono, a CBT trained psychiatrist, the Japanese Association for Cognitive Therapy (JACT) was established in 2001 with a membership of roughly 2000 in 2017.

In recent years, with the prolonged recession and rapid social changes, the number of patients who were diagnosed with mood disorders has reportedly increased from 60,300 in 1996 to 112,200 in 2014, which is an increase of 86% according to Ministry of Health, Labour and Welfare (MHLW, 2014).

The need for psychological services is also further reflected on youths in schools. Because of the growing problems with *futoko* (school attendance refusal syndrome)

and "ijime" (bullying) among adolescent, in 1995 the Ministry of Education, Culture, Sports, Science and Technology (MEXT) began efforts to place one trained school counselor in each public junior high school. It is estimated that in 2014 about 23,800 primary and secondary schools are staffed with school counselors. MEXT aims to increase the number of such schools to 27,500 by FY2019 (MEXT, 2015).

In addition to the school setting, another area of need is the mental health problems of corporate employees where *karoshi* (deaths due to overwork) has become a major occupational health issue. Against the backdrop of such a trend, MHLW issued comprehensive guidelines on workplace mental healthcare in 2006. These guidelines identify the effective use of outside resources such as external employee assistance program providers (EAP) (MHLW, 2006). Furthermore, in 2015, MHLW made it mandatory for corporations with more than 50 employees to conduct an annual stress check for their employees based on which corporations are required to provide counseling services (MHLW, 2015). This adds to the importance of EAP in mental healthcare for workers and the need for more trained psychotherapists.

## Current Regulations Regarding Psychotherapy Provision

While physicians, nurses, social workers, and occupational therapists such as physical therapists are nationally licensed by the Ministry of Health, Labour and Welfare (MHLW), accreditation and certification of clinical psychologists are still in the process of evolution. As described below, a national accreditation process for clinical psychology in Japan has just started in 2018. It remains to be seen how effective the national system will be in regulating the practices of psychotherapy. Presently, anyone is free to call themselves counselors, therapists, or psychologists with or without any training or credential. At present, numerous professional associations are offering a significant number of their own private credentials based on varying degree of formal training. This could be a source of confusion on the part of those seeking psychotherapeutic help.

To date, the most recognized credential is the certified clinical psychologist (CCP) (*ninteishinrishi* 認定心理士) designation by the Foundation of the Japanese Certification Board for Clinical Psychologists (FJCBCP). Although not a national licensure, the Ministry of Education, Culture, Sports, Science and Technology (MEXT) granted official approval of the board and thus officially gave recognition to the CCP in 1990 (FJCBCP, 2014a). CCP came into fruition in 1989 owing to an influential Jungian analyst Hayao Kawai who was instrumental in organizing the Association of Japanese Clinical Psychology (AJCP) in 1982 that drove the effort for the creation of CCP. CCP candidates are required to have a master's degree in clinical psychology from one of the 174 board certified graduate level institutions. Course requirements include ethics, various theories, assessment, practicum, etc. (FJCBCP, 2014b). Under the current regulation, CCPs are permitted to apply psychotherapy only under the direction of medical doctors.

In 2015, after a long debate spanning over decades, a bill entitled Certified Psychologists Act was finally passed at the National Diet to establish the national licensure for psychologists (House of Representatives, 2015). The bill was formalized in 2017, and national board certification examination will start beginning in 2018. The license will be under the co-responsibility of the Ministry of Health, Labour and Welfare (MHLW) and the Ministry of Education, Culture, Sports, Science and Technology (MEXT). Going forward, only nationally certified psychologists will be allowed to call themselves certified public psychologists (*konin-shinrishi*, 公認心理師). Certified psychologist candidates will be required to possess both bachelor's degree in psychology and master's degree in psychology, whereas certified clinical psychologist (CCP) candidates are only required to have master's degree in psychology. It is still unclear whether the new national license would allow an application of psychotherapy independent of medical doctor's direction.

## Professional and Cognitive Behavior Therapy Organizations

There are over 30 professional associations related to psychology and psychotherapy in Japan. While not exhaustive, the following represents major associations and CBT-related associations.

### *The Japanese Psychological Association (JPA)*

日本心理学会 https://www.psych.or.jp/

JPA was established in 1927, making it the oldest psychology-related association in Japan. In 2017, its total membership numbers 8153 including 35 honorary and 220 lifelong members.

### *The Japan Industrial Counselors' Association (JICO)*

日本産業カウンセラー協会 http://www.counselor.or.jp/

Established in 1960 and with registered membership of nearly 31,000 in 2015, it is the largest industrial counselors organization in Japan. The association has its own counselor development programs and awards its own certification.

### *The Japanese Association of Clinical Psychology (JACP)*

日本臨床心理学会 https://www.ajcp.info/

JACP is the first association of clinical psychology in Japan founded in 1964. Once a dominant association of clinical psychologist until a large portion of its members broke off to form AJCP. JACP now has about 300 members.

### *The Japanese Association of Counseling Science (JACS)*

日本カウンセリング学会 http://www.jacs1967.jp/

Founded in 1967 to promote research, education, and practice of a broad field of counseling. JACS has approximately 5000 counselors as its members in 2017. The association offers its own certificate for qualified counselors.

### *The Japanese Association of Behavioral and Cognitive Therapies (JABCT)*

日本認知・行動療法学会 http://jabt.umin.ne.jp/index3.html

Originally founded as the Japanese Association of Behavioral Therapy Research in 1975, the organization adopted “cognitive” onto its name in 2014. This reflects its efforts to promote the dissemination of cognitive behavioral therapy. JABCT accredits behavior therapy specialists as well as cognitive behavior specialists. Its reported membership amounts to 2147 in 2017 including 17 honorary members.

### *The Association of Japanese Clinical Psychology (AJCP)*

日本心理臨床学会 https://www.ajcp.info

Founded in 1982, the Association of Japanese Clinical Psychology is currently the largest psychology-related association in Japan with a reported membership in 2017 of 28,760, including 318 honorary members. Hayao Kawai, a Jungian trained therapist, helped to establish the association and was elected its first president. AJCP was a spin-off of the Japanese Association of Clinical Psychology (JACP) established earlier in 1964, and its establishment led to the first accreditation of clinical psychologist in 1988.

### *Foundation of the Japanese Certification Board for Clinical Psychologists (FJCBCP)*

日本臨床心理士資格認定協会http://fjcbcp.or.jp/

Established in 1988, the Foundation of the Japanese Certification Board for Clinical Psychologists (FJCBCP) develops and administers the certified clinical psychologist (CCP) accreditation examination. The foundation also designates graduate programs in clinical psychology from which CCP candidates must graduate.

### *The Japanese Society of Certified Clinical Psychologists (JSCCP)*

日本臨床心理士会 1989 http://www.jsccp.jp/about/concept.php

JSCCP was established in 1989 as an organization to contribute to the psychological well-being of people by developing the quality and the skills of certified clinical psychologists (CCPs) accredited by the Japanese Certification Board for Clinical Psychologists. It has a membership of 20,425 in 2017.

### *The Japanese Association for Graduate Programs in Clinical Psychology (JAGPCP)*

日本臨床心理士養成大学院協議会 http://www.jagpcp.jp/

Established in 2001, the Japanese Association for Graduate Programs in Clinical Psychology (JAGPCP) aims to promote graduate study environment for the effective training of CCPs among the board designated graduate schools. Its members comprise some 170 such designated schools today.

### *The Japanese Association for Cognitive Therapy (JACT)*

日本認知療法・認知行動療法学会
http://jact.umin.jp/

Founded in 2001 under the leadership of Hiroshi Ono, a CBT trained psychiatrist, the Japanese Association for Cognitive Therapy (JACT) comprises a membership of roughly 2000 in 2017. While its English title remains as the Japanese Association for Cognitive Therapy, in 2016 its Japanese title has been changed to the Japanese Association for Cognitive Therapy and Cognitive Behavioral Therapy reflecting increasing acceptance of cognitive behavioral therapy in Japan.

### *The Japanese Association for REBT (J-REBT)*

日本人生哲学感情心理学会
http://j-rebt.org/

J-REBT was founded in 1996 originally as the Japan Association for Rational Therapy lead by Kenji Suganuma, a certified REBT supervisor therapist of the Albert Ellis Institute based in New York. Its reported membership was 250 in 2010. A portion of the membership span off in 2011 to form the Japan REBT Association.

### *The Japan REBT Association*

日本REBT協会
http://rebt.sakura.ne.jp/association/Home.html

In 2011, the Japan REBT Association was formed by way of breaking away from the Japanese Association for REBT (J-REBT).

## Training Opportunities and Programs in CBT

Owing to the rapid development of the field of clinical psychology as well as the growing popularity of CBT in Japan, CBT training opportunities are increasing. Many universities, psychology-related associations, and private companies offer training courses including CBT in Japanese often issuing their own private certifications. While not exhaustive, representative examples of such growing opportunities are presented below centered around non-profit organizations. In addition to universities and non-profit organizations, there are a number of profit organizations that provide CBT training programs and award their own certifications.

As of 2017, more than 170 graduate level institutions now offer masters' degree required for the accreditation of CCP. CBT-related courses are generally included in their curriculum. However, because they are part of the 2-year graduate program, it is difficult to attend only the CBT-related section of the whole program.

At the same time, there are university extension courses that are available for the general public. For example, Waseda University in Tokyo offers CBT-related courses through its open college extension program (www.wuext.waseda.jp) taught by CBT trained professors from the Graduate School of Human Sciences, Waseda University, a department where there are many CBT trained professors. Another such course would be the course provided by the Human Lab Open Lecture by the Department of System Design and Management, Keio University (www.sdm.keio.ac.jp/2017/07/05-082331.html.) This program is also held in Tokyo and is centered on the acceptance and commitment therapy (ACT).

The training opportunities broaden when various psychology-related associations and other non-profit organizations are included in the scope. For example, major CBT training programs include that which is sponsored by the Center for the Development of Cognitive Behavior Therapy Training認知行動療法研修開発センター (http://cbtt.jp), a foundation established in 2012, in Tokyo designed for mental professionals with 2 years or more experience in treating mood disorders.

The National Center for Cognitive Behavior Therapy and Research認知行動療法センター (http://cbt.ncnp.go.jp) established in 2011 provides similar training programs for healthcare professionals ranging from basic CBT training to specific applications.

The Japanese Association of Behavioral and Cognitive Therapies (JABCT) 日本認知・行動療法学会 (http://jabt.umin.ne.jp) holds an annual workshop in which participants receive the certificate for the participation. A JABCT-sponsored workshop is accredited as a short-term training session for certified clinical psychologist qualification.

Founded in 1965, a public foundation company Kansai Counseling Center関西カウンセリングセンター (https://www.kscc.or.jp/) located in Osaka offers the public CBT seminars among other modalities. The center awards its own private counseling psychologist certification.

The Tokyo Academy of Cognitive Behavior Therapy東京認知行動療法アカデミー (http://www.tokyocbt.com/), a non-profit organization, offers CBT-related workshops in Tokyo three times a year for mental health professionals. It awards its own private certification.

Located in Nagoya, the Japan Association of Cognitive Behavior Counseling (JACBC) 日本認知行動カウンセリング協会 (http://jacbc.org) offers specialized courses in CBT and provides its own accreditation.

The Japanese Association for REBT (J-REBT) 日本人生哲学感情心理学会 (http://j-rebt.org). Originally founded as the Japan Association for Rational Therapy, J-REBT offers its own rational emotive behavior therapy certification programs.

Japan REBT Association 日本REBT協会 (http://rebt.sakura.ne.jp) is founded in 2011 by breaking away from the Japanese Association for REBT. It offers courses in rational emotive behavior therapy and awards its own certification.

## CBT with Specific Clinical Populations

In Japan, the application of CBT reflects the broad range of CBT's utility across a variety of psychological issues as evidenced in the CBT research section of this chapter. At the same time, populations most frequently worked with using CBT appear to be those with mood disorders and more specifically depression. This may be due to the fact that CBT was originally introduced in Japan as a therapy to treat depression, thus giving an impression that it is most effective for depressive disorders (M. So, personal interview, January 24, 2018).

## Adaptation of CBT in Japan

In Japan, a sense of shame exists in exposing one's mental difficulties and problems to outsiders including psychotherapists (Iwakabe, 2008). Because of this, clients tend to expect therapists to conjure and understand client's predicaments without explicit explanations or detail. Thus, therapists would be well advised to able to infer clients' issues and to ensure that clients consider the therapy environment as a truly safe place in which there is virtually no risk in sharing one's emotional problems both in being judged by the therapist and in confidentiality.

There are a number of ways CBT is being adapted to the Japanese environment by clinical psychologists. One way is via incorporation of CBT with other models of psychotherapy (Iwakabe, 2008). As mentioned earlier, many psychotherapists are influenced by Jungian as well as client-centered Rogerian methods and thus practice eclectic forms of therapy. It is common therefore to find CBT being applied along with other models (Iwakabe, 2008). Especially in the school and educational counseling setting, family systems therapy is often incorporated with concurrent therapy with the mother in tandem with CBT reflecting the strong bond between a child and the mother in the Japanese culture.

In line with such an integrative adaption, many nonverbal approaches are also often practiced. They may include, but not limited to, drawing and sandbox play. As Morita therapy and Naikan therapy demonstrate, historically in Japan, emotional and behavioral change is theorized to occur through nonverbal interactions and silent introspection. Therefore, it is not surprising to find therapists to employ nonverbal methods together with talking therapy such as CBT.

In terms of adaptation directly related to the application of CBT, it is not yet clear how the method is being adapted to suit the Japanese clients given relatively short period of time since its introduction. At the same time, we can, based on the culture and the psyche of Japanese clients in general, speculate what factors might be important to be addressed in its application in light of the nature of CBT.

One factor to consider would be the importance of nonverbal interaction (Llewelyn & Shimoyama, 2012). As mentioned above, given cultural importance placed on silence and reticence, and given the procedural value of talking in CBT, a therapist would benefit from managing these conflicting factors in order to successfully navigate through the therapeutic process. On the other hand, one advantage of CBT might be the self-observing aspect of its method exemplified by, for example, the column analysis analogous to the ABC analysis of rational emotive behavioral therapy (REBT), in which one reflects on one's irrational beliefs. This process is quite compatible with Japanese culture, which places high value on self-introspection as evidenced in Naikan therapy.

Another factor to consider from a cultural perspective is a strong desire to belong. This may come in conflict with independent and critical thinking encouraged through the process of CBT. Clients may regard independent and critical thinking as a cause for being excluded from a group in which conformity is encouraged.

The hierarchical therapist-client relationship assumed by Japanese in engagement with professional authorities may invite passivity or even obsequiousness on the part of clients (Nippoda, 2012). Since CBT is predicated on verbal interaction between therapists and clients, promoting active client involvement would be one of the crucial factors. Furthermore, since CBT is also predicated on cognitive restructuring which may require significant level of agency on the part of clients, passivity may undermine the therapeutic efficacy.

The tendency to identify thoughts with their sense of self may be a challenge clinically for CBT practitioners as clients may find it difficult to separate cognitions with the notion of who they are. This can lead to self-downing for having irrational thoughts as well as not being able to change such thoughts easily. Thus, teaching clients to separate thoughts from their sense of self would be an important factor.

## Research on CBT in Japan

In Japan, the number of outcome research studies in CBT is quite small. This is true for randomized clinical trials (RCTs) in particular. Ono and colleagues (Ono et al., 2011) found 13 case series or case-control studies and 27 case reports related to treatment of depression using CBT during the 1983–2009 period. In fact, according to Ono, the first RCT with depressive patients using CBT was conducted by the Study Group for the Procedures and Effectiveness of Psychotherapy in 2004 which suggested that the manualized CBT treatment may achieve favorable treatment outcomes among Japanese patients with major depression.

For anxiety disorders, the same research found no RCTs in CBT, but notes two studies for panic disorders involving group CBT (Kobayashi et al., 2005; Nakano et al., 2008). For social anxiety disorder, an uncontrolled open trial group of CBT (Chen et al., 2007) found that Group CBT can bring about a similar degree of symptom reduction among Japanese patients as among Western patients. No controlled CBT studies were found by the research for OCD, PTSD, or personality disorders.

Since the original review by Ono, the number of studies on CBT has been increasing owing to the rising interest in mental health issues and the popularity of CBT. For instance, Fujisawa and colleagues (Fujisawa et al., 2010) conducted a single-group study on CBT for depression among adults in Japanese clinical settings and found the CBT may be effective among Japanese patients with depression. Recently, a RCT protocol was developed to evaluate the effectiveness of CBT as an augmentation to pharmacological treatment in major depression treatment (Nakagawa et al., 2014).

Furthermore, in 2016, a pilot study on evaluation of the feasibility of CBT for Japanese Parkinson's disease patients with depression using a manga-based (a type of Japanese comic novel) CBT program was carried out (Shinmei et al., 2016), and it found preliminary evidence that CBT is feasible among such patients.

Other research on treatment of depression that involved CBT include a single-group feasibility study on group CBT for depression combined with compassion

training (Asano et al., 2017) which found it feasible and acceptable in a Japanese community.

In addition to CBT for depression, further examination shows that a number of studies have been conducted indicating the feasibility of CBT in the treatment of social anxiety disorder (Yoshinaga et al., 2013), insomnia (Okajima et al., 2017), and bulimia nervosa (Setsu et al., 2018).

In terms of research specific to certain clinical populations, two studies for children (Kameoka et al., 2015; Urao et al., 2016) indicate CBT's feasibility. A study conducted for late adolescents with subthreshold depression (Takagaki et al., 2016) also found CBT effective for this population.

Furthermore, there have been a number of studies suggesting the cost-effectiveness of CBT (Seki et al., 2016; Watanabe et al., 2015).

There have also been studies indicating the effectiveness and limitations of providing CBT on the Internet (Shirotsuki et al., 2017; So et al., 2013; Suzuki et al., 2008). In 2018, a study was conducted where the standalone effects of a CBT using a mobile phone app was examined (Hamamura et al., 2018). The authors reported that an increase in app usage was associated with more problematic drinking. They hypothesize that while this may have increased awareness, it did not offer solutions to the behavior. This may be important to consider in the integration of technology in the application of CBT.

## CBT with Special Populations

One noteworthy special population in Japan where CBT is used to treat a specific disorder might be the *taijinkyofusho* (対人恐怖症) or interpersonal relations fear disorder. Here, CBT is applied to change irrational beliefs associated with such fear. *Taijinkyofusho* is a Japanese form of social anxiety disorder, stemming from the fear of offending others through inappropriate behaviors and being criticized. Patients with *taijinkyofusho* were and still are one of the main clinical populations for the indigenous Morita therapy described earlier.

Furthermore, CBT is used to treat behavioral disorders such as addiction, obsessive-compulsive disorder, eating disorder, and criminal behaviors. In terms of the behavioral disorders, special populations might be those suffering from *futoko* or school refusal syndrome: non-attendance at school for more than 30 days in an academic year due to reasons other than illness and/or poverty.

Additionally, not totally unrelated to *futoko* is the clinical population with *hikikomori* or social withdrawal syndromes. These are reclusive individuals who have severed communication with society, typically confining oneself to the home or a single room of one's parents for more than 6 months. Cases are not uncommon where the client population with *futoko* later turns into *hikikomori* (Borovoy, 2008). This population can also be viewed as representing special population in terms of demographics as they are often found in adolescents and younger generations.

Going forward, another special population for CBT would most likely be the elderly clients as Japan is at the forefront of super aging society. It is expected that by 2030, one out of three will be older than 65 years of age. This population will likely pose many challenges to the field of clinical psychology including modification required for CBT, as they may be long-term care residents with cognitive impairments and comorbid physical or chronic pain.

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# Chapter 22
# Cognitive Behavioral Therapy in Mexico


**Erick Jesús Acevedo Martínez and María Esther Flores Sosa**

## General Description of Mexico

Mexico is a country which is abundant in area, population, cultural heritage, and diversity. Since its colonial past, Mexico has been characterized by a huge social gap, huge differences between the few who have a lot and the many who barely have anything; 20%of the population earns more than 13 times than what the population that occupies the lower 20% receives. This inequality has repercussions in the economic, social, cultural, and political spheres. Being clearly appreciated, a huge mass of dispossessed marginalized from having knowledge and power, which is expressed in a large number of people who do not have access to high-quality health services nor education because they have to work (children, adolescents, and adults). Another sector has had to leave the countryside, its businesses and homes, and migrate to flee social violence and misery, with the dramatic consequences that this mobility entails (e.g., loss of social networks and support, family separation, alterations in the mental health, among others).

Today (2018) Mexico is suffering a situation of structural violence mixed with organized (and disorganized) criminal violence, public and private, official and clandestine. Many people see it as a war situation due to the control of the territories, the dispossession, the transfer, and the market of drugs, a situation that has reached a particular visibility as of 2007. In addition to structural violence, violence is also expressed within families, in gender inequality. Children, now more than ever, are exposed to witnessing violence within their home, as well as being victims of emotional, physical, and sexual violence.

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Poverty correlates positively with the prevalence of chronic degenerative and mental disorders due to inadequate social support, violent and chaotic environments, low parental supervision in families (permissive or authoritarian parenting styles), family dysfunction, lack of affection, multiplication of harmful lifestyles, and unhealthy environments that result in disruptive behaviors and risky behaviors such as drug use and participation in illicit behavior. The social climate is one of insecurity and violence, which prevents many people from going out (to the streets, to parks and other open places) to live, to have fun, and to exercise (60% of children and adolescents are considered inactive), which, in turn, impels them to watch television and use screen games, which, rather than promoting civic and social values, present violence as a model to be followed.

In the midst of this complex problem, mental health has been and continues to be a subject of great social relevance. The big problem is that it is not so much for the social actors and political leaders, so even the general psychology, and behavioral therapy in particular, has not permeated neither the epistemologies nor the university curricula as required.

## History of Psychotherapy in the Country

The teaching of psychology in Mexico began in 1893 with the subject called moral psychology, integrated into the curriculum of the National Preparatory School, a subject that met the precepts of philosophy, logic, and approaches of the English psychology of Herbert Spencer. Lic. Ezequiel A. Chávez, distinguished thinker (and twice rector of the National Autonomous University of Mexico (UNAM)), was responsible for introducing it.

However, professional training did not begin until 1937, when a psychology degree was offered by the Faculty of Philosophy and Letters of UNAM. This plan of studies, the first in the country, took 8 years to be approved; this academic program demanded 3 years of training, at the end of which the student was awarded the degree of Masters in Psychology. In 1956, the first PhD in Psychology was also offered at the same faculty. The Universidad Iberoamericana was the first private university that offered a career in psychology and began its courses in 1950, under the statement that it was incorporated to the UNAM.

In 1959, psychology began to be taught as an autonomous discipline in the country, and with that, a step was taken toward its recognition as a profession. That date constitutes the historic milestone that marks the end of the period of formation of psychology in Mexico. At that moment, the period of expansion began (Galindo, 2004).

In 1967, the influence of American psychology of those years, which was experimental in nature, was already observed. The 1970 curriculum of the Faculty of Psychology of the UNAM showed a structure that prevailed until the end of the 1990s. The bias toward behaviorism was very strongly criticized. As a result, a

greater plurality was sought in the content and in the type of subjects taught. Behaviorism was considered reductionist and very limited to solve social problems.

In an exquisite review, Dr. Héctor Martínez (2006) recounts the great thrust of the Universidad Veracruzana for the establishment of behavioral analysis in Mexico. Derived from the invitation of the Secretary General, Salmerón Roiz, to Víctor Alcaraz, to join the faculty of UV, Emilio Ribes, Antonio Gago, and Serafín Mercado soon joined the project to create the Psychology faculty in 1964. Three years later, in the city of Xalapa, Dr. Florente López had established a special training and education center that later led to the opening of a master's program in behavior modification. The creation of laboratories and the bibliographic collection obtained in this faculty together with the research presented exposed in an International Congress of Psychology in Moscow (Mercado et al., 1967) drew the attention of the president of the APA, Mowrer, who visited the laboratories and invited members of the faculty to study in the United States alongside researchers such as Bijou, Azrin, Allyon, etc. There were very fruitful exchanges with visits from Bijou in Xalapa about his interest in behavioral therapy. In just 5 years, the Xalapa Group had leveled the psychology of behavioral orientation with that of the United States. Quantitatively they were not comparable, but qualitatively they approached (Ribes, 2015). In 1971 the First International Symposium on Behavior Modification was held there.

Within the process of expansion of psychology, in 1975–1976 the psychology schools of the brand new Autonomous Metropolitan University (UAM) and the UNAM opened two new university headquarters for the health sciences, where psychologists are also trained: the National School of Professional Studies Campus Iztacala (ENEP-Iztacala) and the ENEP-Zaragoza.

It can be said that in 1975, the flowering of behavior analysis in Mexico took place: the consolidation of the graduate program in Coyoacán, the degree program in Iztacala, the celebration of the second Mexican congress of behavior analysis, the publication of the Mexican Journal of Behavior Analysis (RMAC), and the foundation of the Mexican Society of Behavior Analysis (SMAC).

Continuing with the chronology, it stands out that in 1975, when it was held in Mexico City, the Third Latin American Congress of Behavior Analysis had the very exciting participation of B.F. Skinner, who visited and motivated the new group of researchers to work on applied behaviorism, including Benjamín Domínguez (Domínguez et al., 1975); Héctor Ayala and his group (Ayala et al., 1982); and Xóchitl Gallegos and Víctor Alcaraz in the 1980s (Alcaraz et al., 1981 cit. Rodríguez Ortega, 2010) in the Laboratory of Brain Plasticity (1984), founded under the coordination of Jorge Palacios.

The Xalapa group, which had now expanded its work, founded the Center for Studies and Research in Behavior CEIC in Guadalajara in 1992. At present, it continues to train teachers, doctors, and researchers in the area.

In the Iztacala National School of Higher Studies (FES-I, UNAM), Rocío Hernández Pozo founded the Complex Human Behavior Laboratory, and in the School of Psychology of the UNAM, the working group coordinated by Graciela Rodríguez carried out the first studies on organ and tissue transplants in the Mexican population (Rodríguez et al., 2004) as well as Benjamín Domínguez on the

management of chronic pain in the area of psychoneuroimmunology. In the area of environmental psychology with a focus on behavioral medicine, the works of Serafín Mercado, Patricia Ortega, and Javier Urbina have been highlighted.

In 2001, the Mexican Society of Behavioral Medicine was founded, with its founding president, Graciela Rodríguez Ortega, and various representatives of behavioral medicine such as Javier Urbina Soria, José Luis Ibarrola, and, more recently, Laura Hernández Guzmán, who made the dream of spreading this area through Latin America and other countries a reality.

Coupled with this movement, in Mexico City and totally apart from the university, in 1984 the Institute of Rational Emotive Therapy of Mexico (ITREM) was founded, the first private institution representative of this approach and the first to prepare professionals under the direction of Patricia Leal who could, together with her students, be called the pioneer in the officialization of the paradigm shift in this country.

In 1998, the 2nd World Congress of Cognitive Behavioral Therapy sponsored by the Mexican Society of Behavior Analysis, the Mexican Society of Psychology, the Mexican Federation for Mental Health, National Association of Psychologists, and the Faculty of Psychology of the National Autonomous University of Mexico frankly set the amalgamation of work considered cognitive and behavioral well as a large participation of researchers and Ibero-Americans and American psychotherapists (WCBCT, 1997).

By this time, an important figure who pushed particularly hard the cognitive behavioral approach in this country was Dr. Samuel Jurado, a graduate psychologist of the Iztacala group who, from personal interest and self-taught, went into the study and understanding of the cognitive behavioral therapy (CBT) materializing its interest in the proposal, structure, and creation of a master's program that would allow clinical professionals to know the strategies of cutting-edge therapeutic work. So, going to the head of department in the clinical area of the Faculty of Psychology of UNAM, Dr. Gilberto Limón Arce, he was allowed to make a subprogram within the master (which in its foundation was psychoanalytical cut) offered training specific in CBT. For political reasons, only two generations of students graduated from this, the first and only program fully designed for training in the approach. Of these psychologists Liz Basañez, Arturo Heman, Claudia De Mendieta, Rebeca Robles, Piedad Aladro, and Ma. Esther Flores, among others, obtained a master's degree accompanied by three highly committed teachers with the spread of the approach, Samuel Jurado Cardenas, Lolita Mercado, and Arturo Martínez-Lara who, by the way, was at that time a direct student of the Albert Ellis Institute in NY.

Due to the great acceptance of this program, and the enormous effort that he had deserved to create the program, organize, direct, and teach in this subprogram of the master's degree, Samuel Jurado convened for about a year the academy of the Faculty of Psychology to finalize the project of the Master in Cognitive-Behavioral Psychotherapy, but the interests of the participants were different, and it was not possible to establish this program. Instead, the Masters in Behavioral Medicine was opened, which is still in force, opened since the 2000s and training psychologists to date in both the Faculty of Psychology and Iztacala. To this group of pioneers in the

CBT adhered a number of psychologists who already paraded in the behavioral school and that were complemented with the contributions of cognitive theories, among them, Juan José Sánchez-Sosa, Laura Hernández, Lucy Reidl, etc.

## Current Regulations on the Provision of Psychotherapy

The provision of psychotherapy in this country is carried out at a public and private level. The body that grants the licenses for the professional practice of the psychologist in Mexico is the Secretariat of Public Education (SEP). The formal process for obtaining a graduate license (professional license), including those of counselors or psychotherapists, is carried out through the same official channels as the basic entry level (practice). Once a university degree or doctorate is issued, in order to be legally valid, it is necessary to register in the corresponding office of the Ministry of Public Education, the General Directorate of Professions, DGP. After authenticating the corresponding official documentation, the DGP issues a license or professional license that it legally authorizes to exercise. Unfortunately, penalizing people who practice illegally for not complying with this process has not been easy, since it usually depends on the formal complaint of a user or consumer.

The task of accrediting Mexican degree programs in Psychology has passed between two periods. The first, with the creation of the Accreditation Coordination within the National Council for Teaching and Research in Psychology (CNEIP) in 1971, thanks to the concern and efforts of the Xalapa and CD Mexico group to improve training programs as well how to strengthen research activities. The appearance in 1991 of the Interinstitutional Committees for the Evaluation of Higher Education (CIEES) made possible the integral assessment of the institutions coupled with the creation of the Council for the Accreditation of Higher Education, AC (COPAES) in the year 2000. This has favored the rise of the accreditation process in its second period: from the recognition granted by COPAES to the CNEIP as an accrediting body, achieved in 2002, which has caused immediate effects related to several fundamental changes in its conception and exercise. Thus, the CNEIP delegated to the Accreditation Committee (hereinafter CA-CNEIP) such an important function in order to make it independent of the decisions of the Assembly and to give accreditation greater transparency and credibility. It is worth mentioning that this process is voluntary in each university and institute, so in only a few instances it is carried out.

On the specific regulation of the practice of psychotherapy and the provision of services for mental health, in Mexico City, the Mental Health Law published for the first time in the Official Gazette of the Nation in 2012 consists of 72 articles whose general objectives are to regulate the bases and modalities; guarantee access to mental health services; establish adequate mechanisms for the promotion, prevention, evaluation, diagnosis, treatment, rehabilitation, and promotion of mental health in public health institutions as well as for individuals or corporations of the social and private sectors that contribute in the provision of services in the terms and

modalities established in this law; as well as define the mechanisms and guidelines to promote the participation of the population, in the development of the mental health programs of Mexico City.

## Professional CBT Organizations

The whole country has grown in academic formation regarding the study of CBT. For example, in 1999 the Mexican Institute of Behavioral Cognitive Psychotherapy was born in Mexico City at the private level thanks to Arturo Heman and Guadalupe Habach; the INCOSAME (Cognitive Behavioral Institute of Mental Health of Mexico by Nicolás Hernández, the Center of Cognitive Therapy in Quintana Roo, the Institute of Behavioral Cognitive Therapy, the Graduate Institute in Cognitive Behavioral Psychotherapy with offices in at least six states of the Mexican Republic, the Center for COGNOS Studies in the Cd of Durango, the Enrique Díaz University of León in Guadalajara and Xochicalco University in Baja California, all of these centers, offering Master's training in CBT, and many more, with graduates and hundreds of others for clinical care.

## Opportunities for Training in CBT

In the development of cognitive behavioral therapy, each of the contributions of the aforementioned institutions as well as others has been decisive. This has been achieved through research, books, dissemination of scientific articles, and, of course, academic activities such as congresses, diploma courses, workshops, specialties, master's degrees, or conference days, which try to create a culture around the continuous training of professionals in the area of CBT in the country. It is known that the cognitive behavioral therapist practices a whole set of specific skills perfected with the theoretical knowledge that sustains this approach to psychotherapy, the modeling of techniques and strategies, with practice and supervision, as well as with the counseling of cases. These precise elements are found in the different training opportunities.

In this sense, Mexico has been, and is, witnessing different events, with the participation of multiple experts from the CBT community who are invited from different parts of the world to share their knowledge with Mexican psychologists. It is encouraging that the movement of training has been on the rise. However, the bad news is that despite the great diffusion that CBT has worldwide, in many states of Mexico it is still minimally addressed by the associations of psychologists and by the university programs, causing psychology students to be inclined to other schools and traditional psychological theories. However, centers and institutes have increased efforts to spread the cognitive behavioral approach throughout the country.

In relation to the different approaches of the world of CBT, it is important to say that rational emotive behavior therapy (REBT) is one of the most widely received in recent years through certifications endorsed by the Albert Ellis Institute of New York and provided by international supervisors of Affiliated Training Centers such as PSICOTREC of Lima, Peru, CETREC of Costa Rica, and Sensorium of Paraguay. These certifications are given frequently in different states of the Mexican Republic, having as headquarters the Mexico City with the Institute of Behavioral Cognitive Therapy (ITCC) led by Dr. Arturo Heman Contreras, the only center in Mexico affiliated with the Albert Ellis Institute of New York; in the State of Mexico by the Institute of Cognitive Humanistic Therapy by the psychologist Aarón Albarrán García; in the city of Puebla the Center of Specialization and Psychological Care AC (CEAP) led by Ma. Esther Flores; in the north of the country with the Cognitive Behavioral Psychology Center of Monterrey (CPCCM) led by Minerva Cazares; as well as in southern Mexico where the opportunities for certification and training have emerged at the Guerrero Institute of Behavioral Therapy (IGTC) in the state of Guerrero. The LIBER center of Cognitive Behavior Therapy with Mtro. Carlos Becerra Rebelo is currently also a great reference in terms of training in REBT. It should be mentioned that the Nayarita Institute of Cognitive Behavior Therapy (INTCC) with Professor Antonio Vizcarra has some years of training opportunities in the state of Nayarit.

Among the opportunities that exist in Mexico for psychologists to continue their training in CBT, these institutions, in addition to others, have programs of diplomas, specialties, and master's degrees with official recognition and validity. For example, the Sociedad Mexicana de Psicología A.C. founded in 1950, with headquarters in Mexico City, offers a diploma in “Evaluation and Cognitive Behavioral Treatment" consisting of 8 modules with a total of 192 hours of theoretical and practical seminars, which is currently in its 7th edition. In the same city, the Institute of Cognitive Behavioral Therapy (ITCC), which has a presence in different international associations such as the Latin American Association for the Modification of Behavior and Cognitive Therapy (ALAMOC), among others, makes available in its academic offering its diploma in CBT. It consists of 72 effective hours, divided into five theoretical-practical modules; the teaching methodology includes clinical sessions, supervised practice, group discussion, and research. On the other hand, the ITCC master's program aims to train professionals specialized in the CBT approach as well as to increase the alternatives of clinical treatment in the field of mental health.

In Cancun, the southern area of Mexico, CBT has a great representative with the Cognitive Psychotherapy Center led by Ari Ben Ortega Aguilar who was the first Mexican psychologist graduated from the Beck Institute for Cognitive Behavior Therapy. This center has an online and blended master's program divided into six semesters, where the participant is provided with various teaching methods to promote their learning, such as the modeling of real sessions through videos, study of clinical cases, interview tools, classes through videoconference, etc.

CBT has had a great evolution throughout its history, from the first interventions emerged from the methodological behaviorism, specifically Systematic Desensitization of Joseph Wolpe and all the interventions in the field of exposure

therapies known now as the first generation of the Behavioral Therapy, to later integrate contributions from cognitive therapies of Albert Ellis' REBT and Aaron T. Beck's Cognitive Therapy, classified as the second generation of cognitive and behavioral therapies. Nowadays, what Steven Hayes calls third-generation therapies or contextual therapies has been disseminated in relation to the above; the Guerrero Institute of Behavioral Therapy (IGTC) offers graduated psychologists and university students the opportunity to go through each of the main interventions of these three generations within the framework of their diploma program that has a total of 200 hours of training divided into 14 theoretical and practical seminars over a year.

## CBT with Specific Clinical Populations

Knowledge about CBT in Mexico has opened the doors for more mental health professionals to use the strategies and techniques proposed by these treatment models within their interventions, directing them to users who approach the psychotherapeutic service to work with their problems. The appearance of the Clinical Practice Guidelines has provided updated information, which has been based on the best available scientific evidence and has benefited the dissemination of CBT, as well as its use with specific clinical populations. These guidelines have been designed in general for health professionals, among which are the psychologists of the clinical area, and aim to help the professional in making decisions regarding the most appropriate interventions for a given individual. These Guidelines can be found in the "Master Catalog of Clinical Practice Guidelines" (CENETEC, 2019). In the elaboration of this Master Catalog, authorities and professionals affiliated with the Ministry of Health of Mexico, the Mexican Institute of Social Security, the Institute of Security and Social Services of State Workers, and Secretary of the Navy – Navy of Mexico – participated.

The Master Catalog contains a large number of Guidelines that are classified according to the type of conditions they address. One of these classifications corresponds directly to mental and behavioral disorders where intervention guidelines for anxiety disorders such as generalized anxiety disorder and post-traumatic stress disorder, mood disorders such as depression in adolescents and adults, sleep disorders, autism spectrum disorders, and attention deficit hyperactivity disorder in children, among others, are noted. Currently in Mexico, there are no clinical guidelines for the diagnosis and treatment of problems commonly seen in a psychotherapeutic clinic, such as specific phobias, obsessive-compulsive disorder, panic disorder, or social anxiety, as they have not been authorized by the National Committee of Clinical Practice Guidelines.

The Clinical Practice Guideline for the diagnosis and management of post-traumatic stress disorder directly points to CBT as the strategy that has proven to be the most effective in reducing symptomatology and preventing relapse. In Mexico, the results of the National Survey of Psychiatric Epidemiology (ENEP) report a prevalence of 1.45% with a higher prevalence in women (2.3%) and of 0.43% in

men. The programs in which cognitive behavioral therapy is incorporated are classified into three groups: (a) focused on trauma (individual treatment), (b) focused on stress management (individual treatment), and (c) group therapy (NICE, 2005).

To quote one more example of the applications of CBT in specific populations, the Specialized Center for Obsessive Compulsive Disorder (TocMéxico) has professionals trained in the application of CBT treatment programs and contextual therapies focused on obsessive-compulsive disorder and related disorders such as generalized anxiety disorder, panic disorder, post-traumatic stress, and phobias. According to TocMéxico and the World Health Organization (WHO), 2.6% of the Mexican population (approximately 3,068,000 people) suffer from OCD, and 70% of people who suffer from it do not know it.

It is of great knowledge that having support networks can enhance the effectiveness of psychotherapeutic treatments; therefore TocMéxico periodically performs training for parents providing a space with the aim of providing psychoeducation on the condition and function of treatment through sessions that are performed twice a month. Finally, the "OCD camp" is an excellent strategy that aims to make friends and find additional support, spend an excellent time, and receive specialized treatment.

## Adaptations of CBT in Mexico

Working with CBT requires solid training on the part of the clinician. The theoretical knowledge is extremely important, and this is complemented by the psychotherapeutic skills of interventions. Currently, a large number of professionals in Mexico have received training in CBT, from cognitive procedures such as restructuring to more traditional behavior modification procedures with their clear principles. Some professionals even have the ability to train abroad or have taken advantage of the opportunities that new technologies provide. In spite of all this, because Mexico has a great variety of cultures among its inhabitants, clinicians must make adaptations to the application of CBT procedures in order to reach the therapeutic objectives that have been established with certain patients.

It is important to point out that in many parts of Mexico, myths about psychotherapy continue to be maintained. For example, psychotherapy is believed to be a context in which one will only talk in the purest psychoanalytic free association style or during the session will only receive advice from the professional. In this sense, establishing a way to evaluate, as well as to intervene and a philosophy of therapy is incomprehensible to some people in the first instance so in various cases simply establishing the above points requires a greater number of sessions. At the same time, this implies exercising empathy, creativity, and patience on the part of the psychotherapist, that is, all those skills for which she/he has received training and supervision.

Within the psychotherapeutic process, it is common to find other types of complications as well, so specific adaptations should be made regarding the tools used

such as thought journals or self-help forms. Frequently, clinicians face the problem that patients do not perform these activities as homework, so a part of the session time is intended to perform this activity or to identify the causes of this omission, having hypotheses of catastrophic thinking and the intolerance for the frustration to do the homework. This aims to increase the probability that the patient will do homework in the future. Thought self-recording sheets and ABC sheets should be as concrete as possible considering some elements such as the situation or event, thoughts, emotions, and behaviors, a diary of thoughts where other factors such as the degree of credibility of the belief, the pattern of problematic thinking, re-evaluation of the belief, discussion, etc. makes it much less likely that patients will complete them.

In cognitive restructuring through Socratic dialogue, there are challenges, among which we must first mention the fact that the patients do not identify their beliefs, before the classic question: What happens in your mind when X happens? It is not uncommon to get an answer such as "I feel angry" or "I just do not think anything." In these cases, it is common for the clinician to pause and practice psychoeducation with her/his patient so that she/he can discriminate between thoughts, emotions, and behaviors and then relate it to the ABC model of disturbance. Another difficulty for the professional in the use of Socratic dialogue is the application of words that are used in the CBT language in training, articles, or reference manuals, but not in certain cultural contexts. A very clear example of this are the words "horrible" and "horrifying" used to label catastrophic beliefs. In some parts of Mexico, these words do not have an emotional impact, even for some people they are incomprehensible. As a result, they are exchanged for words like "unpleasant," "ugly," or "painful," achieving with these words a greater connection between the emotions and behaviors of patients. A further obstacle within the traditional cognitive restructuring procedure is the poor feedback that the therapist receives from some patients regarding the questioning of their beliefs and as a result will have to resort to powerful experiential exercises to reach the objectives set at the beginning of the treatment.

The perspective of the irrational belief of demandingness in REBT, are characterized by their rigidity. These demands can be directed toward oneself, others, or the world in general. For example, "I must achieve this," "she should have done it," or "life should be simpler," such attitudes lead to unhealthy emotions and dysfunctional behaviors that patients report in session. In relation to this, it is precisely the demanding thoughts or absolutist demands that result in a greater understanding and internalization for some sectors of the Mexican population. Adapting in most cases quickly to the concept and use of this classification verbally, patients usually accept this used language, and it is common to hear phrases like "I think I'm demanding too much," "yes of course, I understand that I'm demanding that X do what I want," "it's true life does not have to adapt to what I'm demanding," etc. By integrating the issue of demands in a simple way, the professional usually begins to make his/her interventions more successful.

## Research on CBT in Mexico

Mexico currently has various research in the field of CBT; the main educational and health institutions have focused their efforts to also include different disciplines to approach psychological disorders from various approaches, looking for an understanding of these phenomena at different levels. The field of psychopathology is increasingly complex because of the great variations that exist between the suffering which in turn complicates the desired progress. However, great recognition is given to those who are involved in the area of research, as well as the contributions they offer to the clinical area.

López et al. (2012) developed, implemented, and evaluated a cognitive behavioral treatment in adults with mild and moderate anger with the aim of reducing and preventing the dysfunctional manifestations of anger.

Lugo et al. (2015) carried out a research work that aimed to evaluate the effect of a cognitive behavioral intervention on symptoms of depression and anxiety, as well as the severity of asthma in adults. An intervention consisting of three procedures, guided imagery, psychoeducation, and problem solving, was implemented. The treatment was divided into eight sessions. Among the most important results was the statistically significant increase in peak expiratory flow (FEP), as well as a decrease in symptoms of anxiety and depression. With these results, it was concluded that the psychological intervention was effective for the participants.

Rodríguez-Moran et al. (2014) proposed an intervention of cognitive behavior therapy in the treatment of adolescents with obesity where physicians, psychologists, nutritionists, and experts in physical education and sport participated. The main objective of the study was to evaluate the efficacy of CBT for this problem that affects a large percentage of Mexicans and from which multiple diseases diminish the quality of life. The study involved 115 adolescents corresponding to the support groups with CBT and control. The percentage of adolescents who adhered to the indications of diet (73.7% versus 41.4%) and exercise (61.4% vs. 19.0%) with the group that received support through CBT was found to be significantly higher. Importantly, this was the first study in Mexico that showed in its results the benefits of using CBT in weight reduction programs focused on a group that is difficult to approach, such as adolescents.

The results of a study conducted by Flores Plata et al. (2014) on the application of a program of cognitive behavioral therapy via the Internet for patients with depression showed positive changes. Conclusions revealed a significant influence of the intervention on the participants, as well as on the psychotherapeutic procedures used, in addition to the viability of their incorporation in a social and cultural context such as the Mexican culture. Currently, psychotherapy services via the Internet are an excellent option for patients who have presented various obstacles such as living in remote areas, not having enough financial solvency to pay for the transfers, or due to limitations of the psychological disorders such as seen in depression, panic disorder, and agoraphobia.

## CBT with Special Populations in Mexico

According to the National Institute of Public Health, since the year 2000, diabetes mellitus in Mexico is the leading cause of death among women and the second among men (Rojas et al., 2015). In 2010 this disease caused about 83,000 deaths in the country.

González-Cantero and Oropeza Tena (2016) conducted a study with the aim of analyzing various cognitive behavioral interventions for diabetes mellitus, seeking to synthesize results and conclusions of publications on their applications, as well as analyze their methodological characteristics. Reliable sources were consulted, such as databases, specialized journals, books on diabetes mellitus published between 1990 and 2014, and experts and specialists in the subject. Nineteen studies were selected. Conclusions show that CBT techniques received positive results on labels such as treatment adherence, quality of life, and psychological well-being. Diabetes mellitus generates complications that affect the quality of people's lives and causes problems for their families. In addition, it generates great expenses for the sanitary systems, hence the importance of knowing the functionality of the CBT to work on this national problem.

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# Chapter 23
# Cognitive Behavioral Therapy in the Netherlands


**Arnold van Emmerik and Pier Prins**

## An Overview of the Netherlands

The Netherlands is a small, but densely populated country, with a little more than 17.5 million people living at 519 inhabitants per km$^2$ in 2021. There are 8 million households with an average size of 2.1 persons (3.1 million households are single persons). A total of 6.3 million people live in 31 municipalities with more than 100,000 inhabitants. In terms of ethnical diversity, 25.1% have a migration background. Regarding income and general health, in 2019 the average household had 44,400 euro to spend, and 7.7% of households were classified as low-income households. Life expectancy at birth was 79.7 years for men and 83.1 years for women in 2020 (Statistics Netherlands, 2021).

In terms of mental health and mental healthcare use of the Dutch population, 43.5% received a life-time diagnosis of any DSM-IV mood disorder (20.1%), anxiety disorder (19.6%), substance use disorder (19.1%), or attention-deficit or disruptive behavior disorder (9.2%).[1] 33.8% of patients with these disorders received some form of formal or informal care in the past 12 months, while – disturbingly – two-third remained untreated. In terms of disease burden or disability-adjusted life years (DALY's), anxiety disorders are the highest-ranking mental disorder (180,272 DALY's), after coronary heart disease (282,834 DALY's), diabetes (194,312 DALY's), and stroke (191,320 DALY's) (DALY's are a measure for total disease

[1] Prevalences of the separate disorders do not add up to the total of 43.5% due to comorbidity.

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burden, with one DALY referring to one lost year of healthy or disability-free life, see http://www.who.int/healthinfo/global_burden_disease/metrics_daly/en/). In 2013, the Netherlands spent approximately 6 billion euro (0.9% of its gross domestic product) on mental healthcare (Veerbeek et al., 2015).

## History of Psychotherapy in the Netherlands

Psychotherapy has always been relatively accessible in the Netherlands, although waiting times have become a serious problem in recent years (Kiers, 2018). In the mid-1960s the number of people who were in psychotherapy in the Netherlands began to increase substantially. The number of admissions per year at one of the largest psychotherapeutic centers in the Netherlands at that time (the Institute for Medical Psychology-Amsterdam), for example, increased from 227 in 1965 to 2196 in 1975 and 2430 in 1977 (Lemmens & Schnabel, 1994). Indeed, from that moment on, psychotherapy had become a central part of mental healthcare and is currently covered by mandatory basic healthcare insurance.

CBT as a particular form of psychotherapy is especially widespread in the Netherlands (see Table 23.1). Specifically, taking the number of members of CBT associations as an anchor, the absolute number of cognitive behavioral therapists in the Netherlands ranks third in Europe and presumably worldwide, after the United

**Table 23.1** Absolute and relative presence of CBT therapists in Europe (Top 10) plus the United States

| Country | Number of members of CBT organization(s) | General population[a] | Ratio of general population to CBT members (rank) |
|---|---|---|---|
| Netherlands | 7,000 | 17,656,831 | 2522 (1) |
| Iceland | 121 | 374,830 | 3098 (2) |
| Norway | 1,296 | 5,402,171 | 4168 (3) |
| Finland | 1,223 | 5,516,184 | 4510 (4) |
| United Kingdom | 11,776 | 67,081,234 | 5696 (5) |
| Sweden | 1,718 | 10,427,296 | 6069 (6) |
| Austria | 1,206 | 8,950,544 | 7422 (7) |
| Germany | 10,462 | 83,129,285 | 7946 (8) |
| Italy | 6,409 | 59,108,671 | 9223 (9) |
| Switzerland | 884 | 8,696,088 | 9837 (10) |
| United States | 4000[b] | 332,689,363 | 83,172 (29) |

*Note.* Source: http://www.eabct.eu/about-eabct/member-associations/ [accessed: 11-11-2021]. *CBT* cognitive behavioral therapy

[a]https://en.wikipedia.org/wiki/List_of_countries_and_dependencies_by_population [accessed: 11-11-2021]

[b]Personal communication

Kingdom and Germany. Relative to the general population size, the number of cognitive behavioral therapists in the Netherlands ranks first in Europe and presumably worldwide.

Behavior therapy as a psychotherapeutic school of thought emerged in 1958, inspired by Joseph Wolpe's *Psychotherapy by reciprocal inhibition* (Wolpe, 1958). Remarkably, various places in the world followed suit at more or less the same time during the 1960s. In Europe, important developments with regard to behavior therapy such as the early formation of behavior therapy groups were especially found in the United Kingdom, the Netherlands, and Germany (www.eabct.eu).

On May 20, 1966, the Dutch Association for Behavior Therapy (DABT) was founded by presumably a few dozen initial members. To our knowledge, this makes the DABT the first of its kind in Europe and, with the American Association for Advancement of Behavioral Therapies (AABT) which was also founded in 1966, the oldest behavior therapy association in the world. As of the mid-1960s, together with Rogerian client-centered therapy, behavior therapy gradually entered Dutch psychotherapeutic practice, where until then psychodynamic therapy was the dominant form of psychotherapy (Lemmens & Schnabel, 1994). In Dutch-speaking Flanders, Belgium, the Flemish Organization for Behavior Therapy was founded in 1973. While psychodynamic therapy was still the dominant school of therapy in 1980, 10 years later it was succeeded by behavior therapy as indicated by the proportion of referrals to behavior therapy in one of the largest mental health centers in the Netherlands (Lemmens & Schnabel, 1994). The DABCT's membership increased to about 1900 members in 1995 and in 2018 – the adjective "cognitive" had been added in 2002 – to more than 5500.

As of 1968, the "Behavioral Therapeutic Bulletin" began to appear regularly, from which the peer-reviewed journal 'Gedragstherapie: Tijdschrift voor gedragstherapie en cognitieve therapie' (*Behavior Therapy: Journal for Behavior Therapy and Cognitive Therapy*) developed in 1982. The journal's editorial board consists of Dutch and Flemish CBT representatives and in 2017 the journal celebrated its 50th anniversary.

The founders of behavior therapy aimed at developing scientifically validated clinical procedures and therapeutically applying fundamental behavioral principles based on laboratory research. This included using functional analyses, single-case methodology, and laboratory studies to investigate the therapeutic application of learning principles. For the first time, applied methods became available that were theoretically and experimentally validated (Hayes, 2016). Behavior therapy in the Netherlands was firmly established on these foundations and joined in subsequent international developments over the past 50 years, which have been characterized by three waves or "generations" of behavior therapy (see recent special issues of *Behavior Therapy* and *Cognitive and Behavioral Practice* in 2016).

As elsewhere in the world, the first generation of behavior therapy in the Netherlands was dominated by the principles of classical and operant conditioning and was exclusively focused on directly observable behavior and the relations between problem behaviors (and emotions) and environmental stimuli. In this initial, exciting and vibrant period behavior therapy emphasized that (1) development

and change in symptoms are based on learning models, (2) therapy is focused on treating these symptoms directly, (3) efficacy of treatment should be evidence-based, and (4) psychodynamic and other approaches such as client-centered approach not based on learning principles are to be rejected (Ollendick, 2016).

In the Netherlands, a prominent behavior therapist of this first generation (and beyond) was dr. Hans Orlemans, who promoted the behavior therapeutic way of thinking in clinical practice for many generations of behavior therapists to come in his writings and teaching efforts. In 1968, he founded the first Clinic for Behavior Therapy in the Netherlands, where phobic and other anxiety disorders were treated. His "Inleiding tot de gedragstherapie" (Introduction to Behavior Therapy) (De Moor & Orlemans, 1971) became the most important publication on behavior therapy in the Netherlands, integrating the experimental perspective (which conceives the behavior therapeutic process as an empirical cycle and as the application of experimentally verified principles) with the clinical perspective. The book has been revised seven times since it first came out in 1971 and the fourth edition (1976) ranked seven in the top-ten of most influential Dutch psychology texts in the period 1893–1992 (Bernard, 2016), illustrating the broad impact of behavior therapy on psychology at large.[2] Hans Orlemans also edited the "Handboek gedragstherapie" (*Handbook for Behavior Therapy*), a long-running series of specialized chapters on the behavior therapeutic process (e.g., Brinkman, 1978) and on various theoretical and practical aspects of behavior therapy (Eelen et al., 1978–1992). Other international books that influenced behavior therapy in the Netherlands in this initial period were *Principles of Behavior modification* (Bandura, 1969), *Behavior Therapy: Appraisal and Status* (Franks, 1969), *Behavior Therapy* (Yates, 1970), and *Learning Foundations of Behavior Therapy* (Kanfer & Phillips, 1970).

The importance of cognition became increasingly emphasized and inspired the second generation of behavior therapy in the Netherlands, which originated with the publications of Albert Ellis (1962) on rational emotive therapy (RET) and Aaron Beck (1967) on cognitive therapy. The cognitive idea was further expanded by Michael Mahoney (1974) and Donald Meichenbaum (1974), among others, illustrating that the cognitive revolution had enduringly changed the practice of behavior therapy. The focus of behavior therapy shifted from directly observable behavior to cognition and inner experiences, and cognitive factors were introduced into the behavior analyses (e.g., Mahoney & Arnkoff, 1978). The central idea became that negative thoughts elicited negative feelings which in turn resulted in maladaptive behaviors. Through restructuring negative, dysfunctional cognitions with the patients, the belief was that these feelings and behaviors became more adaptive. Cognitive therapy was thus integrated with first generation behavior therapy into cognitive behavior therapy, which became the second generation of behavior therapy. In the Netherlands, in the 1990s, "the cognitive revolution" was gradually embraced by behavior therapists (e.g., Bögels & van Oppen, 1999), but there also

[2] Later editions were co-authored by a number of Flemish authors, including Paul Eelen and Dirk Hermans from Leuven University and only recently (2018) Filip Raes from Ghent University, illustrating the close ties between Dutch and Flemish-Belgian behavior therapists.

was some hesitation and questioning of the precise status of cognition in behavior therapeutic theory and practice by leading behavior therapists (see Orlemans et al., 1995).

Several clinical models of cognition were developed, and concepts such as "schemas," "cognitive errors," and "irrational cognitions" found their way into cognitive behavior therapy, together with various procedures and instruments to assess these entities. Fundamental laboratory principles were replaced by less precise and clinically based ideas. For example, cognitive behavior therapy is based on the assumption that feelings and behavior are "caused" by cognition, and that the content of these cognitions must be changed in order to change feelings and behavior. According to Hayes (2016), this central assumption has not yet been rigorously tested, and the reliance on it by second generation cognitive behavior therapists is best described as a "sleepy confidence."

In the Netherlands, RET was introduced by dr. René Diekstra (1976) in the 1970s, while Beck's cognitive therapy only gained ground in the mid-1990s. This is perhaps explained by the increasing influence of the DSM taxonomy in the Netherlands around that time, with which Beck's principle of cognitive specificity (i.e., different clinical problems are characterized by specific cognitive contents) perhaps made a better fit than the more generic RET. Such a fit with the DSM taxonomy may also explain the fact that it is Beck's and not Ellis' approach that has become the dominant cognitive method in CBT practice and research in the Netherlands (see van den Bout, 2016).

While the "cognitive revolution" emerged in the 1970s, its evolution continued until 1992 when it received formal recognition as the European Association for Behavior Therapy (EABT) changed its name into European Association for Behavioral and Cognitive Therapies (EABCT). Even later, the American AABT became the Association for Behavioral and Cognitive Therapies (ABCT) only in 2005 (Barlow, 2016). In the Netherlands, a similar development began a few years before, when the Dutch ABT (only after a long and fierce debate) changed its name into Association for Behavioral Therapy and Cognitive Therapy in 2002 and into Association for Behavioral and Cognitive Therapies (plural) only as recently as 2018, to acknowledge the pluriform collection of techniques that CBT has become to date.

An important origin of what came to be known as the third generation of behavior therapy was the publication of the book *Acceptance and Commitment Therapy* (ACT) by Steve Hayes in 1999. Central in the ACT approach to mental and behavioral problems is the emphasis on the context and function of negative internal experiences. Instead of changing the specific content of negative thoughts and feelings, the person is taught to change his or her "attitude" toward these negative inner experiences toward a more mindful and accepting way and to identify and subsequently act according to cherished values in life. In its wake, several other acceptance- and mindfulness-based interventions emerged, such as mindfulness-based stress reduction (MBSR; Kabat-Zinn, 1996) and mindfulness-based cognitive therapy (MBCT; Segal et al., 2002). Also in dialectical behavior therapy (DBT; Linehan, 1993a, b) and schema therapy (ST; Young et al., 2003), which are considered

cognitive (behavioral) techniques, concepts of acceptance, and mindful awareness, have been integrated. Functional analytic psychotherapy (FAP; Kohlenberg & Tsai, 1991), based on functional contextualism and Skinnerian behaviorism, is also included in the third generation behavior therapy.

It is perhaps too early to identify key persons and developments of this third generation of behavior therapy in the Netherlands. Suffice to say that as elsewhere, third generation interventions have become highly popular in the Netherlands. With regard to mindfulness interventions, for instance, active academic research groups exist at the University of Amsterdam and at the Radboud University Nijmegen. Various platforms exist that offer mindfulness courses throughout the Netherlands year-round (e.g., www.centrumvoormindfulness.nl, www.aandachttraining.nl, www.verenigingvoormindfulness.nl, www.vmbn.nl). As recent as July 2018, Amsterdam hosted the third International Conference on Mindfulness, which was attended by more than 600 delegates from 50 different countries.

## Current Regulations Regarding Psychotherapy Provision

In terms of regulations, provisions, and funding, the mental healthcare field in the Netherlands has become kaleidoscopically complicated and confusing. This is a problem for clients navigating the healthcare system and only slightly less so – or so it often seems – for the average professional, referring agency, and policy or decision-maker in the field. Likely, in part because of this complexity, the system is plagued by a high administrative burden for professionals and long waiting times for clients. To illustrate, maximum waiting times in the Netherlands have been formally established at 4 weeks to intake and at 6 weeks from intake to start of treatment. In 2014, these waiting times were exceeded by respectively 45% and 26% of youth mental healthcare institutions and by, respectively, 29% and 11% of adult mental healthcare institutions (Veerbeek et al., 2015). On the positive side, mental healthcare is generally of good quality and affordable to most people due to its inclusion in the basic healthcare insurance that is mandatory in the Netherlands.

Adding to the confusion, the Dutch mental healthcare field is perhaps best described as a semi-regulated (or semi-free) market system. Psychotherapy is mostly delivered in private practices and in larger mental healthcare institutions (see e.g., www.zorgkaartnederland.nl/ggz), and – to a lesser extent – in hospital and forensic settings (see, e.g., Dienst Justitiële Inrichtingen, 2018). The provision of CBT is anchored in this system in two ways. First, mental healthcare professionals are in principle required to follow formally developed and accepted quality standards (see www.ggzstandaarden.nl), which for some disorders include multidisciplinary treatment guidelines that specify first-line interventions. As described in the beginning of this chapter, for many clinical problems, these guidelines identify CBT techniques as first-line interventions. It should be noted, however, that these same guidelines also allow clinicians to deviate from them based on their professional judgment. Also, it is unclear which deviations are acceptable and which are not. No

system is in place to monitor or correct professionals for not adhering to these guidelines (except in the case of violations of disciplinary law or professional ethical standards such as the Code of Ethics for Psychologists (NIP, 2015), when disciplinary colleges can take action). In fact, in the authors' experience, it is believed that treatment guidelines are *not* followed in many cases and that many clients do not receive first-line interventions as a result. A second way, in which CBT training is anchored in the mental health system, is through the curriculum of all government-licensed mental healthcare professionals (this will be addressed more in-depth later in this chapter).

Intriguingly and adding to the confusion, "psychotherapist" is a protected professional title under Dutch law, but practicing "psychotherapy" by other than licensed medical or mental healthcare professionals such as psychotherapists or psychiatrists is not prohibited. Stated differently, any lay person can say that he or she is doing psychotherapy, but not that he or she is a psychotherapist. Similarly, "cognitive behavioral therapist" is a protected title (held by the DABCT), but practicing CBT is not the exclusive right of DABCT members or licensed medical or mental healthcare professionals – although lay people attempting to provide CBT or other forms of psychotherapy may face legal action from disciplinary colleges if disciplinary law or professional ethical standards are violated, as noted above.

As noted above, basic healthcare insurance covering mental healthcare is mandatory in the Netherlands. This makes CBT accessible for everybody in the Netherlands. Accessing the mental healthcare system requires a formal referral by a general practitioner or family doctor, who may first decide to treat less complex problems (or complex but stable chronic problems that require long-term but low-intensity care) in his or her own practice. CBT and other psychotherapeutic interventions by a general practitioner are fully covered.

A topic of controversy is that once accepted in the Dutch mental healthcare system, a DSM diagnosis is required for basic health insurance coverage. Issues such as comorbidity aside, this is not a problem for disorders for which CBT is a first-line intervention, where it is fully covered except for an obligatory initial cost of (currently) €385. It is problematic in other cases however. For example, CBT may be useful for many problems or complaints that do not meet DSM disorder criteria, such as marital or sexual problems, burnout, test-anxiety, and adjustment disorders that may cause DSM disorders or serious non-DSM problems if left untreated. Also, preventive or early interventions based on CBT principles for symptoms that do not (yet) meet DSM disorder criteria are not covered, although such interventions are likely cost-effective in the long run (e.g., Layard & Clark, 2015).

## Professional and CBT Organizations

The Dutch Association for Behavioral and Cognitive Therapies (DABCT) has been steadily growing over the years to become one of the largest associations of its kind worldwide. With well over 7000 members, it is currently the largest psychotherapy

organization in the Netherlands, surpassing the Dutch associations for general psychotherapists (approximately 1700 members) and for psychiatrists (approximately 3500 members) in size. Despite its large size and long history, the DABCT managed to remain the only professional CBT organization in the Netherlands. Although it cannot be proven, the relative unity of the CBT field in the Netherlands may in part be the result of the open and accepting attitude of the DABCT towards the development of CBT into a pluriform collection of techniques and approaches.

The DABCT maintains introductory and advanced CBT registrations for academic and nonacademic mental healthcare professionals and requires re-registration every 5 years based on continuing education activities. Re-registration as a cognitive-behavioral therapist requires 3120 working hours in (mental) healthcare of which 1560 hours should be spent in doing CBT and 30 continuing education points (see www.vgct.nl). The DABCT is a member of the EABCT and of the International Federation for Psychotherapy. As noted above, it closely collaborates with the Flemish Organization for Behavior Therapy in the form of a joint quarterly scientific journal (*Behavior Therapy: Journal for Behavior Therapy and Cognitive Therapy*). As of 2015, the DABCT is a founding member of "P3NL," a broad national coalition of 10 mental healthcare organizations representing over 36,000 professionals, which aims to more effectively influence sociopolitical developments relevant for mental healthcare. This federation's membership represents different professional groups or psychotherapeutic competencies, but except for the DABCT, none of them is exclusively devoted to CBT (see www.p3nl.nl). Also as of 2018, the DABCT is actively pursuing more intensive collaborations with other professional organizations and associations that are based on empirically supported treatments or techniques, such as EMDR or Schema Therapy (van Emmerik, 2018a, b).

## Training Opportunities in CBT

As the Dutch mental healthcare system itself, the field of training and (continuing) education in CBT or other forms of psychotherapy is complex and difficult to describe succinctly. Generally speaking, CBT training – both for adults and children and youth – takes place in the context of obtaining and re-registering for registrations held by the government or by private associations such as the DABCT. The actual training is offered by commercial and noncommercial organizations, and supervision is provided by individual supervisors. The training is accredited by the governmental organizations or private associations that hold these registrations. The duration and content of CBT training vary across these registrations. Naturally, CBT training requirements are most stringent for registration as a cognitive behavioral therapist by the DABCT (see below).

The government currently holds postdoctoral registrations such as "healthcare psychologist," "psychotherapist" and (at a specialist level) "clinical psychologist,"

"clinical neuropsychologist," "psychiatrist," and "nurse practitioner in mental healthcare" (the latter two requiring training as a medical doctor and nurse, respectively, see www.bigregister.nl). CBT training is part of the curricula for each of these professions, albeit to varying degrees of intensity. The curriculum for healthcare psychologists, for instance, includes a 100-hour course in CBT, but CBT is also a topic in courses devoted to anxiety and other disorders that are part of this curriculum. Although these registrations formally qualify professionals to work with all age groups, in practice the various curricula are differentiated depending on the age group one wants to work with, such as children and youth, adults, or the elderly.

Children and youth-care professionals in youth mental healthcare who are not registered as a healthcare psychologist need to be registered with the government as well. For them, a new quality register, the "SKJ-register" (Foundation for Quality Register Youth), has been introduced as of January 2018 and is meant for all youth care professionals who are not registered as a healthcare psychologist. All professionals who are registered in this system – similar to healthcare psychologists – are subject to an independent system of disciplinary jurisdiction and are obliged to re-register every 5 years. The amount of CBT in the requirements of these registers is not specified, but, as in the Netherlands mental health practice working evidence-based is advocated, the role of CBT is substantive.

As noted above, the most extensive CBT training is required for postdoctoral registration as a cognitive behavioral therapist by the DABCT. The curriculum consists of 200 hours of coursework, 75 hours of supervision, 50 hours of mandatory personal psychotherapy, writing an extensive single case study, and working in mental healthcare for at least 12 hours a week, of which at least 6 hours are spent on CBT (see www.vgct.nl). As noted above, re-registration is mandatory after every 5 years and requires 30 continuing education points and 3120 working hours in (mental) healthcare, of which 1560 hours are spent on CBT. Derived from this is a lighter curriculum for registration and re-registration after post-vocational education. Although not resulting in a separate registration, CBT trainees may focus on specific age groups (e.g., children and youth) or CBT skills (e.g., schema therapy).

The introductory CBT course for children and youth for example requires 100 hours: 30-hr introduction in the behavior therapeutic process, developmentally sensitive therapeutic skills and working with parents, and 70 hours on specific CBT techniques and professional CBT attitude. The advanced CBT course for children and youth consists of special topics such as trauma and children, complex problems, families, eating disorders and CBT, etc. and consists of 50 hours of direct contact and 100 hours of self-study.

In line with a broader development in mental healthcare training and education in the Netherlands, the DABCT training requirements are currently being revised to better fit with a competency-based learning approach based on the CanMEDS model (Canadian Medical Education Directives for Specialists, www.royalcollege.ca). Seven main competencies and several sub-competencies are distinguished and will be used to evaluate competency for practice.

## CBT with Specific Clinical Populations

In the Netherlands, CBT is applied to virtually all major clinical problems ranging from anxiety disorders to substance use disorders and even psychosis, and there is no specific population or age group that stands out. There is CBT expertise on all major mental health problems as can be seen in the contribution of CBT in recently developed guidelines and treatment protocols (see Keijsers et al., 2017).

We should mention here children and youth as a specific clinical population where CBT is applied. Child behavior therapy from the operant conditioning perspective was initiated in the Netherlands by dr. Hans Cladder in the 1960s (Cladder & Truyens-van Berkel, 1974) and has been developing and expanding since, currently including cognitive and third generation techniques (Prins et al., 2018). CBT with children and youth now plays a major role in mental healthcare in the Netherlands. This is nicely illustrated by the three-volume "Protocollaire behandelingen voor kinderen en adolescenten met psychische klachten" ("Manualized treatments for children and adolescents with psychic complaints") by Braet and Bögels (2020). These three volumes describe and illustrate empirically supported cognitive behavioral treatments which are developed by Dutch and Flemish cognitive behavior therapists and clinical researchers for a wide range of youth clinical problems.

## Adaptation of CBT in the Netherlands

A typical characteristic of Dutch (and Flemish) CBT practice is the notion that the behavior therapeutic process, from intake to final session, is modeled after the "empirical cycle" which is used in science: defining the problem, making observations, formulating theory and predictions, testing, and evaluation. Behavior therapy, similarly, is not just the application of isolated techniques nor of a protocol or guideline, but an integrated process which consists of five steps: defining the problem, formulating a holistic theory and functional analyses, defining a treatment plan, application of therapeutic interventions derived from this plan, and finally an evaluation of their effects (e.g., Hermans et al., 2018a). The "holistic theory" (comparable to the more familiar case-conceptualization), and the functional analyses of behavior, emotion, and cognition are central in this therapeutic cycle. Together they form a personalized analysis of the behavioral and emotional problems of the patient and of the factors that may have caused or maintain these problems. They are conceived of as predictions (which are tested with the subsequent application of therapeutic interventions) and can thus be seen as an example of the integration of the experimental method and the behavior therapeutic practice (Hermans et al., 2018a).

The central role of the holistic theory and functional analyses in Dutch CBT practice and the notion of behavior therapy as an empirical cycle is reflected in the Dutch CBT-training requirements (see above).

Seemingly (but not truly, see below) at odds with this highly individualized approach, is the use of treatment protocols which are guided by diagnostic labels based on topographic behavioral descriptions. Originally intended as a means to standardize treatments in experimental treatment-outcome research, treatment protocols have, at least in theory, become the "modus operandi" in large parts of the Dutch mental healthcare system. They are readily available to clinicians in various forms, most notably in a three-volume handbook containing 29 empirically supported treatment protocols for adults (Keijsers et al., 2017). A three-volume handbook containing over 50 empirically supported treatment protocols has been published for treating children and youth (Braet & Bögels, 2020). These handbooks are currently the leading Dutch publications in this area; importantly, the majority of these treatment protocols describe a cognitive behavioral approach.

Throughout the history of CBT in the Netherlands, the value and usefulness of the individualized and protocolized approaches to treatment have been a topic of ongoing debate, and sometimes of unwarranted antagonism. We argue that individualized and protocolized treatments represent two extremes on a continuum that can be combined and may complement each other in useful ways.

## Research on CBT in the Netherlands

CBT in the Netherlands is characterized by a long and strong research tradition. CBT research encompasses all existing types of research, ranging from single-case experimental studies to randomized clinical trials and from meta-analytic research to fundamental laboratory studies. Most research is conducted in academic settings but often in close collaboration with mental healthcare institutions.

At the University of Utrecht, Walter Everaerd initiated the first research program on behavior therapy in the mid-1960s, and in 1979, he became the first appointed full professor in the field of "Psychological methods of behavior change from a learning theory perspective." One of his first PhD students was Paul Emmelkamp who wrote his dissertation in 1975 on treating agoraphobia through imaginary exposure versus exposure in vivo. He later became a prominent behavior therapy researcher himself (e.g., Emmelkamp, 2013).

Paul Eelen, in Flanders, founded the internationally renowned Center for Learning Psychology and Behavior Therapy in 1979.[3] He and his colleagues conducted programmatic research on (cognitive) learning and on the question on how learning principles demonstrated in the laboratory could be related to behavior therapy. The center's productive fundamental and applied research from the classical conditioning and cognitive learning perspective have been of great importance for the development of behavior therapy in Flanders and The Netherlands (Hermans et al., 2018b).

[3] Now the Centre for the Psychology of Learning and Experimental Psychopathology.

An early impetus to clinical psychology research in the Netherlands was the so-called Amsterdam Phobia Project which was launched at the University of Amsterdam in 1966. Headed by professor Johan Barendregt, this project was innovative in a number of ways. For one thing, it was dominated by psychologists in a time when the treatment of phobias and other psychic problems was the exclusive domain of medical doctors and psychiatrists. Also, rather than trying to explain a range of clinical phenomena from a single theory (e.g., learning theory), it did exactly the opposite: a specific clinical problem, in this case the phobia, was placed center stage and studied and treated from a wide variety of theoretical and clinical angles, including, but not limited to, learning theory and behavior therapy. Untroubled by present-day funding and publication demands, the Amsterdam Phobia Project is perhaps best characterized as a scientific and clinical "playground" for researchers, clinicians, and students, all centered around clients receiving CBT and other forms of psychotherapy for their phobias (van Zuuren, 2018).

Parallel to the Amsterdam Phobia Project, CBT research in the Netherlands really took off from the mid-1970s onwards with the work of several highly influential and productive researchers and cognitive behavioral therapists. Table 23.2 lists the CBT representatives from the Netherlands and elsewhere, who over the years have been appointed as honorary members of the DABCT and who are widely appreciated as having had a major impact on the study and practice of CBT in the Netherlands.

Since 1995, junior and senior researchers from eight universities in the Netherlands and Flanders, Belgium, are united in a joint Dutch-Flemish postgraduate research network that focuses on the experimental study of psychopathology (www.epp-research.eu). Although the network is not devoted to CBT per se, much work of its members is concerned with the mechanisms that underlie various forms of psychopathology and with CBT techniques as an experimental manipulation that targets these mechanisms.

**Table 23.2** Honorary members of the Dutch Association of Behavioral and Cognitive Therapies per 2018

| |
|---|
| Aaron T. Beck † (United States) |
| Judith Beck (United States) |
| Caroline Braet (Belgium) |
| Wim Brinkman † |
| David Clark (United Kingdom) |
| Paul Eelen † (Belgium) |
| Paul Emmelkamp |
| Walter Everaerd † |
| Mark van der Gaag |
| Else de Haan |
| Kees Hoogduin |
| Kees Korrelboom |
| Floris Kraaimaat |
| Alfred Lange |
| Isaac Marks (United Kingdom) |
| Hans Orlemans † |

## CBT with Special Populations

In terms of delivery or adaptations of CBT, it is difficult to select special populations or clinical problems in the Netherlands. Although this may not be very different from other countries, two phenomena perhaps deserve attention here. First, the Netherlands is (in)famous for their liberal drug policies. Perhaps in part as a result of this, its facilities for the study and treatment of substance use disorders are quite well developed. Although addiction research was slow to emerge compared to other countries, tens of doctoral theses have now appeared, and dedicated research and treatment centers include the Amsterdam Institute for Addiction Research (AIAR; www.aiar.nl), the Nijmegen Institute for Scientist-Practitioners in Addiction (NISPA: www.nispa.nl), and the Institute for the Study of Lifestyles and Addiction (IVO; www.ivo.nl) (Schippers & Van den Brink, 2016).

A second branch of the Dutch mental healthcare systems that deserves attention here is a range of services specifically devoted – at least originally – to victims of various forms of organized violence. Perhaps the oldest organization of this kind is the Sinai Centre (www.sinaicentrum.nl), which currently specializes in the treatment of adults and elderly patients suffering from psychological trauma. Traditionally, the Sinai Centre strongly focused on Jewish war victims and on victims of the war in the Dutch East Indies (a former Dutch colony consisting of what is now Indonesia). It is currently open to all traumatized patients but continues to attract Jewish and Israeli patients in particular. A second organization that specializes in treating the consequences of organized violence is Foundation Centrum ‘45 (www.centrum45.nl). It currently distinguishes, among others, as patient groups: veterans and military personnel; uniformed professionals, such as police officers, firefighters, and ambulance personnel; elderly survivors of World War II; adult refugees; and – more recently – survivors of sexual violence within the Roman Catholic Church and other institutions.

## Summary

Psychotherapy has been well accepted in the Netherlands since long. As a specific form of psychotherapy, CBT has had a long tradition in the Netherlands. From the early awakening of behavior therapy in the 1960s up to the third wave mindfulness and acceptance-based interventions in 2018, CBT now has become of central importance to Dutch mental healthcare. The Dutch Association for Behavioral and Cognitive Therapies (DABCT) is one of the first and largest CBT organizations in the world and has remained the only and undivided association for cognitive behavior therapists in the Netherlands.

CBT in the Netherlands can be characterized by the application of evidence-based treatment methods for a wide range of emotional and behavior problems and by an emphasis on the behavior therapeutic process as an “empirical cycle.” This

implies the formulation of a case conceptualization ("holistic theory") and of functional analyses of the problem behavior(s). At the same time, the use of cognitive behavioral treatment protocols for specific DSM disorders is increasingly widespread.

CBT training is part of the curriculum of all government-licensed mental health professionals in the Netherlands, and advanced CBT training is provided by the DABCT. As a result, CBT in the Netherlands is applied to all kinds of mental health problems and age groups, varying from anxious children to depressed elderly patients and from addicted adults to traumatized refugees.

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# Chapter 24
# Cognitive Behavioral Therapy in Paraguay


**María Celeste Airaldi**

## Overview of Paraguay

Paraguay is a country located in the center of South America. Its 402.752 m2 of surface is divided into two regions: the Occidental (with 60% of the territory, but only 2.5% of the total population) and the Oriental, where the greater amount of inhabitants is concentrated and the main socioeconomic and political activities are centralized.

It is an upper-middle income country with sustained economic growth, despite the marked social inequality (World Bank, 2021). It is the largest exporter of electric power (due to the Itaipú hydroelectric dam) and one of the main agricultural producers in the world.

With an estimated population of 8.5 million inhabitants, Paraguay has the lowest population density in the region. One of its most important characteristics is the bilingualism, since Guaraní and Spanish are official languages of frequent use, both in urban and rural areas. In fact, 28.8% of the population communicates only in Guarani, while more than half of the inhabitants use both languages without implying a real bilingualism, because the use of one of them predominates according to the context (Ortíz Sandoval, 2012).

Paraguay is a country where the practice of Christianity is deeply rooted as well as its culture and traditions, including those related to food, mythology, and natural medicine. These aspects guide, to a large extent, the daily decision-making of the Paraguayans, regardless of their socioeconomic status.

As historical background, it should be mentioned that Paraguay has been marked by two facts of great influence in the sociocultural, economic and scientific development of the country: Wars and dictatorships. In relation to the wars, the War against

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the “Triple Alliance" (of Brazil, Argentina and Uruguay) (1886–1870), the “Chaco War” against Bolivia (1932–1935) and the Civil War, in 1947, severely affected the gender balance in the country. Dictatorships were also crucial, since Paraguay went through two long totalitarian periods. The first, for almost 26 years (1814–1840), was under the command of José Gaspar Rodríguez de Francia, while the second dictatorial period had Alfredo Stroessner for 35 years in power, until the democratic era began in 1989 (Fretes Carreras, 2012; Giménez Guanes, 2008).

This brief introduction aims to position the reader to understand some of the most important characteristics of the country which have influenced its scientific development, including psychology, but also in the way of thinking of its inhabitants. The objective of this chapter is to present how cognitive behavioral therapies (CBT) have been developed, including their introduction in the country, the dissemination of the practice, and the challenges for their adaptation to the local culture.

## History of Psychotherapy in Paraguay

While it has been documented that there is interest in the study of psychology in Paraguay since colonial times, at that period it had a more philosophical and religious approach (García, 2005, 2009). The first universities that offered training in psychology began in the 1960s (García, 2011; Martínez Cáceres, 2008), and before that, professionals from other fields such as medical examiners managed all the necessities in mental health (García, 2011). It was just in 1978 when the first curricula in clinical psychology was offered as a graduate degree (García, 2011), a fact that shows psychotherapy is a young science still developing in Paraguay.

The research of the history of psychotherapy in Paraguay reveals that Carlos Luis Lafuente (1944–2000) was the first to promote the cognitive behavioral approach in the country, in the 1980s. His interest in CBT emerged after his training in Colombia, even though at that time his approach was more behavioral in nature (Garcia, 2011). As a university professor, Lafuente trained and mentored mental health professionals that had a great impact in the following generations, like psychiatrist José Daniel Escobar and psychologist Norma Beatriz Coppari, both who continue to promote CBT in the universities (García, 2011). It is also worth mentioning the relevance of Álvaro Pardo and María Mojica, two Puerto Rican professors that worked in Paraguay between 1986 and 1987. They introduced the ideas of behaviorism and rational emotive behavior therapy (REBT) in the university setting, arising interest in the cognitive behavioral spectrum and the use of diagnostic criteria according to the DSM (García, 2011).

In spite of these early efforts to introduce evidence-based psychotherapies in university settings, Britos (1999) and Caballero (2005) pointed out that these were isolated endeavors, since, to date, the curricula of clinical psychology and psychotherapy in most universities mainly depends on the professor in charge, rather than a higher educational setting that controls the updating and effectiveness of the

content presented. It is for this, among many other reasons, that the practice of psychotherapy in the country is extremely precarious and frequently far from scientific criteria.

Graduate programs in clinical psychology are typically oriented to psychodynamic and systemic approaches (García, 2011), with little knowledge of evidence-based psychotherapies. Humanistic and existential psychotherapies are also widespread, but not as much as psychoanalysis (Fernández-Álvarez, 2017). In fact, psychoanalysis was hegemonic until the 1970s, when gradual and isolated attempts to present different ways of practicing psychotherapy happened in Paraguay (Coppari, 2009, 2013). This tendency continued to be observed until the end of the twentieth century, since research found 29% of psychotherapists in the country referred to themselves as psychoanalysts and only 4% as behavioral therapists (Britos, 1999). Although his research did not include the CBT spectrum, it can be noticed that there is greater interest in CBT in the present day.

Although effective results are reported in private practice, there is no data supporting those therapeutic results rather than anecdotic reports (Caballero, 2005). This situation reflects a critical problem, since currently there are around 9000 registered psychologists in the country, and only a few provide services in the Public Health System, despite the high demand: the Institute of Social Prevision [Instituto de Previsión Social, n.d.-a, n.d.-b], one of the biggest health providers in the country, reported 25,000 consultations per year, with only 59 professionals in service; while the Mental Health Department of the Ministry of Health and Wellbeing (Ministerio de Salud y Bienestar Social, 2018) has 300 professionals (including psychologists and psychiatrists) distributed in 90 offices around the country, but mainly in capitals. This means that the people with fewer economic resources hardly receive the quality of attention they deserve and need. At this point, it should also be noted that there is an under-registry of psychologists in the country (Martínez Cáceres, 2008). An example of this matter is that, according to the Department of Degree Control and Registration, an office of the Ministry of Education and Science, psychology was ranked fourth in the number of registered undergraduate degrees in the country (Noguera, 2015). This data show there are numerous professionals in psychology in the country, but most of them are not registered to legally practice psychotherapy. Considering that the clinical field in psychology is usually the most preferred by professionals in Paraguay (Coppari, 2009), the records shows that many of them may practice without having a licensed registry.

## Current Regulations Regarding Psychotherapy Provision

As noted in the previous section, in Paraguay there is limited control over the practice of psychotherapy. This current status in the matter questions the quality of the services offered, which, as a consequence, leaves clients vulnerable to negligence and malpractice. Although Paraguay approved in 2019 a law for the professional

practice of psychology (Bill #6293), and that law has been in effect since 2020, there is little control over the practice, since there is no specialized departament controlling psychology services within the Ministry of Health and Social Wellbeing. The main control carried out is that practicing psychologists have a license, but not in terms of the quality of the services offered.

To practice as a psychotherapist in Paraguay, the only requirement is to have an undergraduate degree in psychology and a license issued by the Ministry of Health and Social Wellbeing. No specific training is required in psychotherapy, nor a graduate degree in the matter, and neither a minimum of hours of continuous education or supervision. At this point, as Fernández-Álvarez (2017) mentions, to practice psychotherapy in Latin America, no specific certification is required, but that is considered a "seal of quality."

Considering that there are universities graduating psychologists with as little as 4 years of study and that after carrying out merely bureaucratic procedures they will obtain their license to offer therapy without supervision, the quality of the education presented in undergraduate schools is a recurrent concern. According to the public report of the Paraguayan Ministry of Education and Science (Ministerio de Educación y Ciencia, 2018), 27 private and 5 public universities currently offer undergraduate degrees in psychology, but not all include the option of a major in clinical psychology or psychotherapy. It is critical to report that all of these programs are legally enabled to graduate professionals in the field of psychology, but none of them have been certified by the National Agency of Evaluations and Accreditation in Higher Education (ANEAES, for the Spanish acronym).

The training available is mainly theoretical in nature, because there is not a genuine interest in scientific research, and funds are not provided for this purpose (García, 2012; Martínez Cáceres, 2008). In fact, only 0.2% of the gross domestic product of Paraguay goes to research, which, according to UNESCO, is one of the lowest investments in South America (Ultima Hora, 2018, March 26). The result of an almost inexistent interest in research in mental health is clearly seen in the lack of psychological theories in Paraguay, the scarce standardized tests norms, and the absence of psychological analysis in most of the problems in the country (Coppari, 2013; Martínez Cáceres, 2008). Research in mental health essentially depends on the will and the self financial support of the researcher (García, 2006, 2012), and that is why most of the research published is the product of undergraduate and graduate dissertations and theses. This is often usually the only contact with research psychologists will have during their professional life. An example of this point is the reduced number of indexed journals in psychology in the country (Duarte Caballero & Duarte Masi, 2014) and the occasional publications in international journals by Paraguayan researchers.

In the aforementioned context, it is possible to describe the Paraguayan psychotherapist as a professional who applies imported knowledge (Coppari, 2013) in an absolute "cultural decontextualization" (Caballero, 2005), a common situation in Latin America and other developing countries (Vera-Villaroel et al., 2011).

## Professional and Cognitive Behavior Therapy Organizations

The most important professional organization in the country is the Paraguayan Society of Psychology (in Spanish, SPPs), founded in 1966 by the first graduates in the field (García, 2009). From that moment on, the SPPs act as a social and scientific association that promotes the ethical practice of psychology in general and psychotherapy in particular. It also worked consistently to legalize the practice of psychology by promoting the bill that now regulates the field. Another aspect to consider is that this organization has promulgated the "Code of Ethics for the Exercise of Psychology in Paraguay" (Sociedad Paraguaya de Psicología, 2004), which seeks to guide professional practice in the country, and although it does not have legal status, it aims to establish the guidelines of good practice in psychology.

Regarding CBT, it should be mentioned that in 2014, the Paraguayan Association of Behavioral Cognitive Therapy was founded (APTCC). This association was born within the first cohort of students of the Specialization in CBT, certified by the Paraguayan Society of Psychiatry. The APTCC is still an emergent association, and while it advocates scientific and academic activities, it has done little to stand out in Paraguay, despite the growing interest in CBT.

Another association still developing is the newly Paraguayan Academy of Cognitive and Behavioral Psychology (APPCC), founded in 2018. Its creation was encouraged by Dr. José Gaspar Britos and the students of the Master's Degree in Psychology of the Catholic University of "Nuestra Señora de la Asunción." According to their founding statutes, the APPCC is an academic and scientific association that will promote the cognitive behavioral paradigm, both in Paraguay and abroad.

In addition to these two associations, Paraguay has representation in international associations of CBT, such as ALAMOC (Latin American Association of Behavioral Analysis and Modification, and Cognitive Behavioral Therapies) and ALAPCCO (Latin American Federation of Cognitive and Behavioral Psychotherapies). These two associations differ in that the first is an association of students, professionals and associations that identify with the CBT paradigm, while the second is a federations of national CBT associations.

## Training Opportunities in CBT

Although CBT has seen an increased interest among university students since the 1980s (García, 2011), these first isolated efforts were not reflected in academic programs, research, or publications. Given the need to offer alternatives to the psychoanalytic approach that prevailed for decades, several private psychology institutes began to teach non-university courses in CBT. Two examples of these, in the mid-1990s, are the Institute of Behavioral Sciences (Instituto de Ciencias del Comportamiento), headed by Dr. José Gaspar Britos, and the Training Center on

Behavioral Approach (Centro de Formación en el Enfoque Conductual), by Dr. Norma Coppari (García, 2011), both centers still existing in the present day.

At the end of the first decade of the twenty-first century, CBT began to be more required within the professional community, which generated a bigger offer in trainings conducted by foreign professionals. An example of this was the training in Rational Emotive Behavior Therapy (REBT), certified by the Albert Ellis Institute's affiliated training of Buenos Aires, the Argentinean Center of Rational Emotive and Cognitive Behavior Therapy (CATREC). These trainings, organized annually by Sensorium since 2008, grew interest in the CBT spectrum in Paraguay. As a result, in 2014, Sensorium, which is a center specialized in psychology matters, also became an affiliated training center of the Albert Ellis Institute. It currently works as a regional reference in the certification of professionals nationally and internationally, with currently more than 400 trainees in Latin America.

There are two other specialization trainings in CBT worth mentioning, both offering updated academic programs. The first, organized by the Paraguayan Society of Psychiatry, is under the direction of Dr. Eduardo Keegan, from Argentina, and Dr. José Britez Cantero, from Paraguay, both renowned mental health professionals. The second postgraduate course is organized by the Specialized Center in Psychotherapy (CEP) and certified by Fundación Aiglé of Buenos Aires, Argentina, under the direction of the internationally recognized Dr. Héctor Fernández Álvarez. CEP also offers, together with Fundación ETCI of Argentina, the first Specialization in CBT with children and adolescents in the country.

Since 2012, Sensorium has offered a Diploma in Evidenced Based Psychotherapies, being the first program of its kind in Latin America. In fact, their curricula served to inaugurate the academic accreditation system of ALAMOC. It should also be cited that since mid-2013, the Catholic University of "Nuestra Señora de la Asunción" has offered the first Master's Degree in Psychology with a focus on cognitive behavioral interventions, coordinated by Dr. José Gaspar Britos.

Finally, it should be mentioned as an example of the growing interest in CBT in the country, that in 2018, CEP organized the first training in dialectical behavioral therapy (DBT), certified by Behavioral Tech and the Linehan Institute.

As can be noticed, there is significant growth in the amount and quality of the trainings in CBT offered in the last decade, which reflects the sustained development that the approach has in Paraguay. Although this is an encouraging scenario, there is still limited knowledge of the concept of evidence-based psychotherapies, since psychology undergraduates are unaware that not all therapeutic approaches are equally beneficial for all clients and disorders, as well as the ignorance about new approaches in psychotherapy (Coppari, 2013). In fact, it is still common to find courses of pseudo-scientific treatments in university environments, such as neurolinguistic programming (García, 2011) and projective testing such as HTP.

## CBT with Specific Clinical Populations

As has been mentioned throughout the chapter, psychotherapy in general and CBT in particular are still developing in the country, and therefore, its extent in Paraguay is emergent. However, in clinical practice, those clients seeking care within the CBT spectrum are predominantly children, adolescents, and adults, from medium to high socioeconomic level, living in larger urban populations, such as Asunción and some departmental capitals, like Ciudad del Este and Encarnación. This scenario is also frequent in most of the countries in Latin America (Fernández-Álvarez, 2017).

According to interviews conducted for the purposes of this chapter, most CBT therapists work in private practice, addressing several problems, including depressive disorders, anxiety disorders, personality disorders, as well as marital problems. Professionals working with children and adolescents, in addition to anxiety and depressive disorders, also address behavioral problems and train parents and families in behavioral management.

One of the most important health entities in the country, the Instituto de Previsión Social (n.d.-a, n.d.-b), offers CBT (among other approaches) for children, adolescents, adults, seniors, couples, and groups. Therapists working at the institute also help in other medical departments as paraprofessionals, including bariatric surgery, ablation and transplantation, hematology, burns, surgery, oncology, neurology, cardiology, urology, gynecology, and neonatology. It is worth mentioning that the statistics of the institute indicate that the majority of the consultations are for anxiety and depressive disorders, learning problems, behavior problems, and counseling for clinical inpatients.

## Cultural Adaptation of CBT in Paraguay

No specific research on Paraguayan cultural adaptations of CBT were found. However, studies held in other countries have found that Latinos tend to seek help when symptoms are already severe (Caballero et al., 2003), as well as being more likely to leave treatment before being discharged (US Department of Health and Human Services, 2001). These findings, when associated with common aspects of the Latin culture, such as family cohesion, religiosity, and traditionalism, suggest that it is critical to have adaptations that consider the needs of Paraguayans, especially for Guaraní speakers. The American Psychological Association (2017) has addressed the importance of considering multicultural aspects in the practice of psychotherapy, including the influence of the language and the context. The historical context presented in the introduction (especially the wars and dictatorial periods) is relevant for the understanding of the most important cultural aspects of the Paraguayan people (Quiñonez de Bernal, 2012), which obviously influence the way they think and behave (Caballero, 2005).

It is difficult to describe a unique Paraguayan culture. As Aguirre and Galeano (2013) mention, there is no "Paraguayan culture," but a "group of subcultures" that develop depending on the economy, the environment, the market and communications, as well as other relevant factors. According to Saro Vera (1994), in the need of describing the Paraguayan culture, it may be characterized by five components: (a) collectivism or communitarian culture, (b) the Guarani language and its distinctive mindset, (c) the folkloric culture of oral transmission, (d) the importance given to nature, and (e) Christianity, considered as an element of moral judgment. In other words, the Paraguayan culture can be defined as collectivistic, traditional, and religious. The population is attached to their traditions, including those related to food, verbal expression, natural medicine, and religious manifestations, this being valid for all socioeconomic levels.

Religion and collectivism should be given special attention, since the devoted Paraguayan population guides itself by social norms based on Christian principles and strong family ties (Vera, 1994). In consequence, the opinion of others (especially from immediate family members) is essential when making important decisions, such as when to get married, when to change jobs, and when to go to therapy. This results in a marked social dependence, with young adults still living with their parents, even if they have an income to be independent.

At a cognitive level, Paraguayans are more prone to concrete, immediate, and short-term thinking (Vera, 1994). The main cause lies in a defective educational system, with students' academic performance below the regional average (Sistema Regional de Evaluación y Desarrollo de Competencias Ciudadanas, 2009) and the parameters proposed by the National Reform of Education (UNESCO-IBE, 2010). In this scenario, the complications of a bilingual population inserted in a pure monolingual educational system in Spanish are evident (Ortíz Sandoval, 2012; Quiñónez de Bernal, 2012), especially for people whose cognitive structure in Guarani is substantially different. The Guarani language has a very peculiar cognitive structure. For example, it lacks time units and concrete distances. These complications limit the opportunities of cognitive development, particularly for Guarani speakers developing in a dominant Spanish-speaking environment.

On the other hand, as a consequence of the long dictatorships, the people of Paraguay have been characterized by silent and close-minded behaviors. This has created a tendency of "demanding in silence," or as Vera (1994) mentions, being people of "few words." Therefore, of course Paraguayans have the natural orientation to express rigid and demanding thoughts, but they rarely verbalize them in an open manner. Previous research on the matter revealed that the most common irrational beliefs in Paraguayans are catastrophic thinking and frustration intolerance (Coppari, 2010; Coppari et al., 2008). These irrationals beliefs are generally expressed in association with irritability, fatigue, sense of failure, and negativity (Coppari et al., 2008). Other characteristics that are very common in Paraguayans are shyness, passiveness, conformity, and lack of leadership (Vera, 1994). Therefore, the tendency to demand and complain will not be sided by actions of making changes, causing them to accommodate to situations even when they are considered unpleasant.

The dictator Rodríguez de Francia observed that Paraguayans had behaviors that differed from other populations, which made him think about the possibility of Paraguayans having a different body structure. This is known as the "theory of lost bone" (Vera, 2011), which attempts to explain why Paraguayans tend to lower their heads and refuse to talk in an energetic way to defend what they think and feel. It arises from the hypothesis of Rodriguez de Francia, who believed that the Paraguayans might have an extra cervical bone that prevented them from holding their head high (Renger, 1982, cited in Vera, 2011). Of course this was proven wrong, but it exemplifies how the culture and cognitive tendencies interact with behaviors and attitudes.

Concerning the wars, it should be highlighted that the gender imbalance also had a significant impact in the culture, considering that after the war against the Triple Alliance, Paraguay lost between 70 and 90% of their male population, depending on the source. It resulted in a “macho” culture, where men and women are still raised differently within the same family. Women are educated to be housewives and to accept the conditions imposed by their husbands, while men are encouraged to work outside the home and to take care of the finances at home, having greater freedom of action. As a consequence of the war, due to the uneven gender distribution, people were ordered to "repopulate" the country. At that time, it was acceptable that a man had multiple partners. However, the counterpart of this sociological stance was *machismo*, where the men overpower women, generating serious problems of domestic violence continuing until the present day. Even though this situation is changing with new generations, it is still a matter to be considered.

Regarding the positive cultural characteristics of Paraguayan people, kindness, warmth, and hospitality should be mentioned (Vera, 1994). Paraguayans are very open and receptive to foreigners and to people of different cultural backgrounds (Quiñónez de Bernal, 2012; Vera, 1994). Their simplicity, sense of humor, humbleness, and tendency to be sensitive should also be noted (Vera, 1994). In addition, a recent worldwide survey by Gallup (2018) revealed that Paraguay was the happiest country in the world, for the second year in a row. According to this survey, 85% of adult Paraguayans are prone to experience positive emotions.

Considering the cultural characteristics mentioned above, as well as the lack of knowledge about how evidence-based psychotherapies work, certain adaptations could benefit clients in order to increase adherence to treatment and to improve the effectiveness of CBT in Paraguay. One of the most important modifications needed refers to homework assignments. With the exception of some clients, it might not be advisable to give assignments in the first session, although the therapeutic conceptions (such as how CBT works) and the importance of the assignments should be explained (Lega et al., 1997). Since psychodynamic therapy remains dominant, it is very common that, after mentioning assignments, clients respond they “only want to talk” or that they “did not know therapy was how much work.” In addition, it should be considered that Paraguayans tend to catastrophize and be passive and intolerant to frustrations (Coppari et al., 2008, 2010), which leads to concerns regarding how difficult and how well they should perform on the assignments. With these aspects in mind, it might be better to explain the CBT model and the

importance of homework in the first session, introducing them gradually in the following sessions, considering that the first assignments should be relatively easy to accomplish. It is also very important to highlight the concepts of "human fallibility" and unconditional self-acceptance (Dryden et al., 2003), reinforcing to the client that she/he might make mistakes on the assignments, without decreasing her/his value as a person nor the effectiveness of the therapy.

Another relevant aspect to keep in mind is that psychotherapy is still considered taboo in Paraguay, even though this aspect is changing during the last decade, but mainly in urban areas and middle to high-income clients. For many, therapy can be the last option considered for improvement, probably because of the strong religious orientation and the importance given to herbal medicine. It is not uncommon to hear clients mention they do not "believe in psychotherapy" (as it was a matter of faith rather than science), but since they tried other options without success they might "take the chance" of trying it. Mental health services are mostly secondary to the assistance provided by priests and other religious leaders, physicians, shamans, homeopaths, and even fortunetellers. As a consequence, clients who actually seek attention might have chronic conditions as well as hopelessness. It will be necessary for psychotherapists to invest a considerable amount of time building a strong therapeutic alliance, providing psychoeducation about the benefits psychotherapy can offer and how the CBT approach works.

Remembering that Paraguayans tend to be concrete and short-term thinking, the practice of CBT should begin with a more behavioral approach and then gradually introduce more cognitive strategies. In Sensorium, our psychology center, several therapists in the staff observed that Socratic dialogue and classic CBT restructuring strategies do not work with some clients, at least not in the beginning of therapy. In these cases, it is recommended to use a more didactic style as well as self-disclosure by the therapist (Lega et al., 1997). With some clients it is also helpful to implement therapeutic strategies typically used with adolescents, such as those proposed by Ann Vernon (2002), because they are more concrete, didactic, and visual, but still effective for many adults.

As a result of the dictatorial periods mentioned above, where Paraguayans were forbidden to openly express their thoughts and ideas, there is a tendency to not talk about emotions. They will rarely express what they feel and think (Vera, 1994) to the point of having a very poor emotional vocabulary. In practice, we have observed that it is extremely useful to initiate therapy with emotional education, so they can identify, name, and rate their own feelings.

It should be mentioned that even for the monolingual clients in Spanish, some emotions are best expressed in Guaraní, a language with many expressive tools. In fact, there are emotions in Guarani that have no literal translation to Spanish, but still are very commonly mentioned by the Spanish-speaking clients. One example is the word "kaigue," used to express a mixed state of fatigue, apathy, and negative mood. Thus, it is important that psychotherapists working with Paraguayan clients learn some basic phrases and words in Guarani, so they can understand them better as well as show empathy.

These examples suggest that the cognitive structure of Paraguayans is distinctive, so, although the ideal would be to have a psychotherapy validated in the country, it is also possible to infer the benefits that CBT offers for the general population will be also efficient in Paraguay, especially in terms of short time and positive outcomes. Considering that several psychologists in the country do not work as psychotherapists and that most of those who do provide therapy do so in larger cities and in private settings, having a short and effective treatment adapted to Paraguay becomes even more relevant, especially for the public sector and the most disadvantaged, who rarely receive the attention they deserve.

## Research on CBT in Paraguay

It has been mentioned throughout this chapter that research resources are extremely limited in Paraguay, which is why there is a lack of data on research that applies CBT in specific populations. This is a panorama that is evident not only in Paraguay, but in several Latin American countries.

There is some research that has focused on understanding the cognitive tendencies of the Paraguayans. Previous studies based on the psychopathological model of CBT have found that Paraguayans are prone to demandingness, catastrophizing, and frustration intolerance (Airaldi, 2013, Coppari et al., 2008), and, considering that CBT has proven to be effective to address these issues, it is considered that Paraguayans would benefit greatly from a wider dissemination of the model in the country.

The interest in investigating the efficacy of CBT in different populations has only been observed in the last decade, but still mainly as a result of undergraduate and graduate studies. Some of the issues that have been investigated refer to the efficacy of CBT in cases of sexual abuse (Figueredo & Gamarra, 2018), electroencephalographic alterations of psychiatric patients (Laconich, 2016), and depression (Coppari, 2010). It should be mentioned that Dr. Julio Torales, a psychiatrist and professor at the National University of Asunción, is one of the most prolific authors in the country, making several publications, especially systematic reviews, related to CBT, including its application in trichotillomania (Torales & Di Martino Ortíz, 2016), skin-picking disorder (Torales, 2018), and disease anxiety disorder (Torales, 2017).

As mentioned by Coppari (2011), research in psychotherapy will improve the quality of life of Paraguayans, in terms of helping them to cope with conflicts, have a healthier lifestyle, and prevent substance abuse and sexually transmitted diseases, in addition to contributing to social problems of notorious relevance, including family violence, discrimination, and care for the environment. For these reasons, it is imperative to promote research in psychotherapy, and specifically on evidence-based psychotherapies such as CBT, to have cultural adaptations that respond to the needs of the country's clients.

## CBT with Special Populations

Even though there is no research on CBT with special populations in Paraguay, some guidelines can be given to psychotherapists working with immigrants and LGBT+ individuals in the country.

Paraguay has a large number of immigrant residents, almost twice than other Latin-American Countries (Organización de los Estados Americanos, 2014). According to the United Nations Population Fund (2003), around 12% of the Paraguayan population corresponds to immigrants (not including seasonal or temporary immigrants), most of them speaking a different language from the nationals' Spanish and Guarani. This scenario shows that psychotherapists working in the country (especially in border cities where the immigrants agglomerate) might need to broaden their cultural knowledge for a more global context. It is not uncommon to see clients from Brazil, Argentina, Taiwan, Lebanon, South Korea, as well as German-descents, known as "colonos," a fact that shows the broader cultural spectrum of clients. It is advised that psychotherapists working with immigrants know cultural aspects of their origin as well as their specific struggles adapting to the countries own culture. As an anecdotic report of this matter, Paraguayans are very prone to physical contact and kissing when meeting other people (including strangers), and, for example, Muslim Lebanese clients do not engage in physical contact with the opposite sex. This contrast can be particularly difficult for these immigrant groups when trying to socially adapt to groups outside their community. Another example of this matter is vegan Hindi clients having a limited social life, considering the Paraguayan tradition of eating barbecued red meat in almost all types of celebrations. Even though the abovementioned cases reflect isolated problems presented by clients in therapy, they show how simple and everyday matters can result in psychological disturbances for immigrant clients when their cultural background is not understood.

Regarding the LGBT+ community, it should be mentioned that, according to Coppari et al. (2014), psychology undergraduate students have a moderate tendency toward homophobia that tends to decrease (but not dissipate) during their years in the University. Considering that the law regarding the professional practice of psychology does not prohibit conversion therapies nor specifies the consequences in case of discrimination by the psychologist, the LGBT+ community is greatly unprotected regarding clinical practice. Unfortunately, there is a proliferation of religious-based psychotherapy, in spite of all the well-documented consequences conversion therapies have. More information regarding how to treat LGBT+ clients is needed, as well as how CBT can help them, not only for clients, but particularly for psychotherapists so they can better attend their specific needs.

## Conclusions

As it can be noticed, psychology in general is still developing in Paraguay, and as a consequence, psychotherapy and research are even less established, as in other developing countries. A negative effect of the current scenario is that clients do not usually receive evidence-based psychotherapy when needed and that there is a lack of knowledge about which cultural adaptations might work better for them. The bright side refers to a fertile field for psychologists to do research and develop clinical programs for general and special populations. Paraguayan psychologists can make history in the field if they work together in these endeavors, setting the basis for the future generations. It is expected that now, with a law regulating the practice of Psychology, soon we will be able to see the firsts steps to practice a better, science-based psychotherapy in the near future.

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# Chapter 25
# Cognitive Behavioral Therapy in Peru


**Natalia Ferrero, Martha Paredes, Valerie Hage, and Courtney Duhning**

## Country Overview

Peru is a country located in western South America. It borders in the north with Ecuador and Colombia, in the east with Brazil, in the southeast with Bolivia, in the South with Chile, and in the west with the Pacific Ocean. Its people are scattered throughout the extremely biodiverse country, ranging from the arid desert that extends the length of the pacific coastal region to the Andes mountain range, spanning vertically from north to far south, to the world's largest rainforest, the Amazon, in the east.

In 2018, the Peruvian Statistics Office (Instituto Nacional de Estadística e Informática [INEI]), who provides numerous demographical, economic, and geographical statistics, carried out the latest population census, which identified that Peru has a population of over 32 million people and an annual population growth of 1.7%. According to the population ranking of South America, in 2020, Peru is considered the fourth most populated country after Brazil, Colombia, and Argentina (Statistic Time, 2020; United Nations [UN], 2019) and the fifth most populated of all Latin America, after Brazil, Mexico, Colombia, and Argentina (UN, 2020).

Peru's largest city is its capital, Lima, which also has the largest population, with 41.2% being urban population (Ipsos, 2018). 58% of the population is found in the coast, 28.1% in the Andean highlands, and 13.9% in the rainforest (Andean Air Mail & Peruvian Times, 2020). Peruvian life expectancy is of 75 years (Ipsos, 2018).

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The official languages are Spanish and, in the areas where they are predominant, Quechua, Aymara, and all other aboriginal languages (Constitución Política del Perú, 2015). There are 47 languages that are spoken around the country, 20 of which have been given official alphabets, approved by the Peruvian Ministry of Education, entity responsible for determining the policies and direction of the educational system across Peru (Sullón et al., 2013). For this reason, Peru is considered a multilingual and multicultural country.

Since the turn of the century, the Peruvian economy has experienced different phases of economic development. Between 2002 and 2013, Peru was one of the fastest-growing countries in Latin America, with an annual average GDP (gross domestic product) growth rate of about 4% (The World Bank, 2019). After several years of inconsistent economic performance, the last 10 years of the Peruvian economy have been booming and could potentially more than triple its GDP (The World Bank, 2019). Even though in the past 4 years GDP growth rates declined due to lower metal prices which affected exports and a weaker domestic demand, the country still has one of the highest GDP growth rates in Latin America and worldwide (The World Bank, 2019).

Despite this rapid growth, there are indisputable indicators that position Peru as a country with significant poverty. The World Bank (2018) identified that poverty affected 20.5% of the country's population. Díaz Munguía et al. (2018) specifies that 66.7% of the population in poverty lives in the mountains, 21.1% in the rainforest and 12.2% on the coast.

If categorized by age, the incidence of poverty is higher in the child and adolescent population. The risk factors related to their lack of resources lead to malnutrition, school dropouts and lower levels of education, and lack of access to medical and health services. These circumstances certainly affect the opportunities children have to progress in the future, since the effects of poverty are difficult to overcome and can even be irreversible. Although the described deficiencies are not exclusive to the child and adolescent population, it is likely that they will not only be affected by it throughout their lives, but that they can be a determining factor in the perpetuation of the intergenerational transmission of poverty (INEI, 2018).

With the exclusion of Lima, mental health services are provided throughout the country by community mental health centers (Centros de Salud Mental Comunitaria [CSMCs]), which are exclusively outpatient specialized mental health institutions. These centers are the first level of care, and because of this, they are the articulating axis of mental health services. The CSMC's actions are closely linked to other health-care providers, medical support services, the nearest hospitals, as well as local social organizations and communities (Ministerio de Salud, 2018a). Their main goal is to progressively increase integration and provide more access to services for the promotion, prevention, treatment, psychosocial rehabilitation, and recovery of mental health of families within the community, all integrated into the health service networks, focusing on community mental health in the entire country during the period 2018–2021 (Ministerio de Salud, 2018a).

The Community Mental Health Care Model focuses on the attention of individuals, families, and communities and acts together with their lead and effective

participation, from planning to the assessment of the processes implemented for the promotion and protection of mental health, as well as for the health care of people, families, and communities with psychosocial problems and/or mental disorders, in each territory (Ministerio de Salud, 2018a).

The CSMCs focus on people with depression, anxiety, drug and alcohol abuse, and other psychosocial problems and mental disorders. In addition to this, CSMCs feel it is very important to aim their efforts in reducing the rates of different types of abuse, aggressive behavior, and violence, especially in couples and toward women, which is unfortunately highly prevalent and considered a very serious problem in our country (Ministerio de Salud, 2018b).

It has been verified that 30 out of every 100 people who go to a health center in Peru have a mental health disorder. Specifically, in 2017, 859,000 Peruvians were treated for various mental disorders: 20.7% presented with a depressive episode, 11.3% presented problems with violence, and 4% presented some psychosis (Diario Oficial El Peruano, 2018). The majority of these individuals were women and 7 out of 10 were teenagers. 40% of the people with psychiatric problems are recorded to live outside of Lima. Out of these cases, 80% of suicide cases are associated with depression, and 20% of children already have a mental health problem (Diario Oficial El Peruano, 2018).

The government has recently allocated 350 million soles for mental health for the year 2020, a 70 million soles increase compared to the budget assigned in 2019 (Diario Oficial El Peruano, 2019). This amount will allow the 151 community mental health centers (CSMC) to operate and to open 50 new ones for 2020, and it also ensures the provision of strategic medicines and other hospitalization services for them (Diario Oficial El Peruano, 2019).

This new budget will also be used to implement 10 new mental health units in regional hospitals and 40 protected homes that are intended to accommodate patients with severe mental disorders and who do not have family support (Ministerio de Economía y Finanzas, n.d.). In addition, it will allow the 395 nationwide health facilities to have a psychologist that will join the more than 1000 that have already done so (Ministerio de Economía y Finanzas, n.d.).

Recently, in May 2019, the Peruvian government enacted the New Mental Health Law (Law No. 30947) to guarantee access to services and the promotion, prevention, treatment, and rehabilitation of mental health as well as to guarantee conditions to ensure the full right to health and well-being of the individuals, the families, and the communities (Ministerio de Salud, 2019). This new law modifies the previous one by strengthening the first and second levels of care; guaranteeing the rights of people with mental health problems to universal and equitable access to interventions for the promotion and protection of health, prevention, treatment, recovery, and psychosocial rehabilitation; as well as establishing the community model as the new paradigm of mental health care in Peru, aligned with the World Health Organization`s (WHO) recommendations and scientific evidence (Ley de Salud Mental, 2020; Ministerio de Salud, 2019). This law has a comprehensive vision and a community-based approach to human rights, gender, and interculturality, at different levels of care (Ley de Salud Mental, 2020; Ministerio de Salud, 2019).

In March 2020, the regulation of the Mental Health Law established that the psychiatric and general hospitals must adapt to the community care model, through the progressive deactivation of long-term hospitalization services, as well as the eradication of practices that violate mental health service users' human rights (i.e., use of isolation rooms, electroconvulsive therapy, or pharmacological interventions without informed consent, among others) (La Ley, 2020; Ley de Salud Mental, 2020).

This regulation also demands that the mental health services of general hospitals should be organized, in the form of interdisciplinary teams that perform mental health care in psychiatric and mental health liaison services, including the care of people with mental health problems in their emergency services, hospitalization services, and day hospitals (La Ley, 2020; Ley de Salud Mental, 2020).

## History of Psychotherapy in the Country

The practice of psychotherapy in Peru was initially considered a medical discipline and a method of treatment exercised within the psychiatric practice (Alarcón, 1975 aforementioned by Benites, 2006). Psychotherapy practice was initiated early in the twentieth century and linked to figures such as Honorio Delgado, a recognized Peruvian psychiatrist, who was influenced by the Freudian doctrine and disseminated psychoanalysis in Peru through several publications and the creation of the Revista de Psicología Médica y Psicoterapia and Revista de Psiquiatría y Disciplinas Conexas (1918–1924), which was the first psychoanalytic journal in Peru and South America, with Honorio Delgado being one of its directors. Another important figure to mention is Walter Blumenfeld, a recognized German psychologist, who arrived in Peru in 1935 and founded the first experimental psychology laboratory in 1941 (Arias, 2014). Blumenfeld was a decisive influence in the development of psychology in our country and is considered, by many, as the founder of scientific psychology in Peru.

It was from the creation of the first section of psychology in 1955 in the Faculty of Letters and Human Sciences of the Universidad Nacional Mayor de San Marcos [UNMSM] in Lima, and later in 1963 the first psychology department in the same university, that psychologists slowly and still under psychiatric direction began to have a larger and more visible participation in the mental health field. At this stage, the theoretical orientation that prevailed within the training of psychologists was essentially psychoanalytic.

UNMSM and the Universidad Nacional Federico Villarreal [UNFV], both public universities located in Lima, were the pioneers in the implementation of the professional psychology career in Peru. Later, Pontificia Universidad Católica del Perú [PUCP] and the Universidad Peruana Cayetano Heredia [UPCH], both private universities, followed in their steps.

Today a larger amount of universities offer the psychology professional career in our country and among the most known are in Lima, such as Universidad de Lima [UL], Universidad San Martin de Porres [USMP], Universidad Femenina del

Sagrado Corazón [UNIFE], Universidad Ricardo Palma [URP], Universidad Inca Garcilaso de la Vega [UIGV], Universidad Peruana de Ciencias Aplicadas [UPC], and Universidad Científica del Sur [UCS]. Some of the universities in other Peruvian cities that offer the psychology professional career are Universidad Cesar Vallejo [UCV], Universidad Privada del Norte [UPN], Universidad Nacional de San Agustín [UNSA], Universidad Católica San Pablo [UCSP], Universidad Antonio Ruiz de Montoya [UARM], Universidad Nacional Hermilio Valdizán [UNHEVAL], and Universidad Continental, among others.

As referred by Emperatriz Torres PhD (personal communication, May 11, 2018), one of the pioneers in behavioral educational psychology in Peru, the UNMSM (UNMSM) in Lima, was, in the beginning of the 1970s, the first University to incorporate the B.F. Skinner's behavioral framework and theory. Gradually, university curricula and academic psychology programs from different universities began to include courses such as Applied Behavioral Analysis, Behavior Modification Techniques, and Learning Psychology (E. Torres, personal communication, May 11, 2018). And it is for this reason that the UNMSM along with its professors is considered the institution that began an approach that changed and revolutionized the psychotherapy of that time, which had mainly centered itself in psychoanalysis during those years. Later, in 1975 the Universidad Peruana Cayetano Heredia [UPCH] created the School of Psychology with a curriculum based mainly on the behavioral model (Salmavides, 2016).

Psychologists, who graduated from these universities under the theoretical psychoanalytic and behavioral influence, were organized into two large groups: professionals oriented to the application of psychology in the educational field and those oriented to the application of psychology in clinical settings. Emperatriz Torres, PhD (personal communication, May 11, 2018) mentions that educational psychologists were very influenced by Skinnerian theory, and so began various initiatives linked to the creation of School Tutoring Programs for children and adolescents with learning disabilities, special education centers, behavior modification institutes, and applied behavioral analysis centers, among others. Likewise, Maria Victoria Arévalo, PhD, one of the pioneers of cognitive and behavioral clinical psychology in our country, indicated that clinical psychologists found professional opportunities in the mental health services of local general hospitals, as well as in Mental Health hospitals (personal communication, June 6, 2018).

Special reference should be made to the Hospital Hermilio Valdizán (2018) because it was the first mental health hospital to implement the Departamento de Análisis y Modificación del Comportamiento [DAMOC] (Analysis and Behavioral Modification Department) in 1985. In 1975, the Peruvian psychiatrist Rafael Navarro Cueva, MD, and clinical psychologist María Victoria Arévalo Prieto, as well as other highlighted professionals that worked in this hospital, began to apply behavioral modification techniques with patients with diverse diagnoses. In 1978 the achievements of this group of professionals made possible the creation of the Servicio de Terapia de Modificación del Comportamiento [SETEMOC] (Behavioral Modification Therapy Service).

The continuous advance and development of the increasingly influential model of cognitive behavioral therapy helped the evolution from SETEMOC to a larger area that conforms a specialized department (DAMOC). Maria Victoria Arévalo points out that the DAMOC not only provided, by that time, patient service and care but also trained clinical psychology interns in clinical interviewing and behavioral modification and taught the different techniques derived from operant and classical conditioning (personal communication, June 6, 2018). Gradually, it began to incorporate cognitive behavioral techniques as well as the supervision and follow-up of cases by those professionals who were pioneers in the knowledge and management of these techniques (M.V. Arévalo, personal communication, June 6, 2018). Nowadays the psychotherapeutic intervention and the work of DAMOC are based on the cognitive behavioral psychotherapeutic model integrating not only the behavioral and cognitive techniques of the first and second generation of cognitive behavioral therapies but also the contributions of the third-generation therapies, especially dialectical behavioral therapy (DBT), acceptance and commitment therapy (ACT), and mindfulness-based interventions in their clinical practice over the span of recent years.

Similarly an institution called Centro de Rehabilitación de Ñaña (CRL) (Ñaña Rehabilitation Center) is an institution which uses the behavioral approach for the treatment of patients with substance use disorders. This institution is part of the Hermilio Valdizán Hospital (HHV) and the Peruvian Ministry of Health. The CRL was founded as the first therapeutic community in our country, initially utilizing behavioral therapy and the therapeutic community model (Hospital Hermilio Valdizán, 2018).

Bearing in mind the effectiveness of behavioral modification and treatments based on the cognitive behavioral model, it is that the different universities included courses on behavior modification and cognitive therapy techniques within their curricular grid which was received with great acceptance. In this way, not only the professionals who knew about this practical application but also the students began to incorporate this knowledge into their training, which favors the increased interest of professionals who subsequently receive training within the cognitive behavioral theoretical orientation. This interest was reaffirmed and increased in such a way that not only graduates but also those who were already practicing clinical psychology in their different professional spaces began to be interested in cognitive behavioral psychotherapeutic training programs.

In recent years there is no curriculum, at least in psychology, pre- or post degree, which does not have courses and laboratories in experimental analysis, behavior modification and cognitive behavioral therapy, and even third-generation therapies applied in different areas of psychology, especially in clinical psychology where great results have been demonstrated (Salmavides, 2016).

## Current Regulations in Psychotherapy

In Peru, the National Superintendence of Education (Superintendencia Nacional de Educación [SUNEDU], an entity related to the Ministry of Education in Peru, is the one that regulates pre- and post-graduate studies. According to the regulations that they have developed and that are considered law in our country (University Law), post-graduate studies are aimed at obtaining diplomas, second specialties, master's degrees, and doctorates. Specifically, postgraduate programs are short-term professional upgrading studies in specific areas, which are taught by university institutions duly accredited by law which require a minimum of 24 credits (Ley Universitaria, 2014).

Likewise, degrees and titles are obtained in accordance with the academic requirements that each accredited university establishes and which are regulated by the University Law. The degrees can be bachelor, professional degree, second specialty degree, master's degree, and doctor's degree (Ley Universitaria, 2014).

In the case of second professional specialty titles, the individual must first have a bachelor's degree or other equivalent professional degree and have approved studies of 2 academic semesters with a minimum content of 40 credits, as well as a thesis or an academic work approved. Currently, the Universidad Nacional Federico Villareal has a cognitive behavior therapy second specialty program (http://www.unfv.edu.pe/facultades/faps/oficinas-1/unidad-de-pos-grado/itemlist/category/150-malla-academica-segunda-especialidad).

All degrees are awarded by universities that have accreditation recognized by SUNEDU. The current vice dean of the National Board of the Peruvian School of Psychologists (Consejo Directivo Nacional del Colegio de Psicólogos del Perú), Miguel Vallejos, indicates that these titles are subsequently registered in the Peruvian School of Psychologists (Colegio de Psicólogos del Perú [CPSP]), which recognizes the title of second specialty and incorporates it into the National Specialty Registry (personal communication August 17, 2018).

Currently, the CPSP does not have a valid current internal regulation that frames the training or practice of the different schools of psychotherapy in our country. This means psychologists can legally conduct psychotherapy having only their psychological degrees. Psychotherapy training is usually given by private institutes or training centers which are directed by professors trained in different therapeutic schools of psychotherapy, usually from international organizations (M. Vallejos, personal communication August 17, 2018). Therefore, at the culmination of these programs, graduates do not have an accreditation of title recognized by the nation. Currently, proposals have been submitted to be evaluated for this purpose (M. Vallejos, personal communication August 17, 2018).

The graduates of these training centers have recognition from their own institution and/or with the support or endorsement of institutions to which they are affiliated outside of the country. Such is the case of the Institutes PSICOTREC and ITRE, whose Training Programs in Rational Emotive and Cognitive Behavior Therapy have the accreditation and support of the Albert Ellis Institute in New York.

## Professional and Cognitive Behavior Therapy Organizations

In Peru in the 1970s and 1980s, scientific associations were created to promote behavioral analysis and behavioral modification, such as the Scientific Core Association of Behavior (Asociación Núcleo Científico de la Conducta [NUCCI]), which later became the Peruvian Society for Behavioral Analysis and Modification (Sociedad Peruana de Análisis y Modificación del Comportamiento [SPAMC]), the Asociación Behavioral Analysis applied to Education (Asociación de Análisis Conductual aplicado a la Educación [ACAE]), and the Peruvian Society for Behavioral Modification and Therapy (Sociedad Peruana de Terapia y Modificación del Comportamiento [SEPTEMOC]), among others. All of them had temporary activity and gradually dissolved throughout the years (Benites, 2005).

Peru is part of the Latin American Association for Behavioral Analysis and Modification (Asociación Latinoamericana de Análisis y Modificación del Comportamiento y Terapia Cognitivo Conductual [ALAMOC]) founded in 1975, in the city of Bogotá, Colombia. This association is made up of Latin American professionals with cognitive behavioral orientation. This association also represents Latin America at the World Congress of Cognitive Behavioral Therapy [WCBCT]. Together with Peru, they are associate members with countries such as Argentina, Bolivia, Brazil, Colombia, Chile, El Salvador, Guatemala, Honduras, Mexico, Panama, Paraguay, the Dominican Republic, Uruguay, and Venezuela (ALAMOC, 2014).

ALAMOC aims to bring professionals interested in the dissemination, execution, research, evaluation, accreditation, and reflection on the science of cognition and behavior together, from an integral view of the human being and its relationship with the context. This association organizes congresses around Latin America, having carried out, from its foundation until the present time, 18 Latin American Congresses, the last of which was carried out in the city of Lima in November 2019.

Likewise, with the support of ALAMOC, congresses have been organized in different Peruvian cities such as Chiclayo and Cusco, aiding the dissemination of knowledge about cognitive behavioral therapy (CBT) outside the capital of Lima. ALAMOC has had an important influence in the diffusion of CBT in Peru, several of its presidents have been Peruvian professionals. It is important to mention that ALAMOC was one of the six World Congress Committee [WCC] organization members in behavioral and cognitive therapies, and in 2013, Lima hosted the 7th World Congress of Cognitive Behavioral Therapies. This was the first time a Latin American country hosted this important world congress, allowing CBT to enhance its presence in our region.

During the first quarter of 2020 in Lima, the Peruvian Association of Cognitive and Behavioral Therapies (Asociación Peruana de Terapia Cognitivo Conductuales) was forged by a group of the main representatives of the cognitive behavioral tradition in our country, and it has already been affiliated with the cognitive behavioral psychotherapies Latin American Confederation (Confederación Latinoamericana

de Psicoterapias Cognitivo Conductuales [ALAPCCO]), which is an entity that groups several associations of CBT in Latin America since 1996.

## Training Opportunities and Programs in CBT

There are limitations regarding the training on CBT for mental health professionals in the different regions of Peru, due to the fact that the main universities and professional trainings in mental health are basically offered in the city of Lima. It is for this purpose that we think training programs and courses in CBT are needed to be offered in different cities of our country for them to be accessible to mental health professionals allowing them to cover the needs of the less favored Peruvian population.

Since the 1980s, training and specialization programs in cognitive behavioral therapy have been emerging due to the prevailing need to train CBT therapists and contribute to mental health and the treatment of psychological disorders in the population.

As was mentioned, regular 2-year programs are developed for the most part in Lima and are mainly aimed at psychologists and psychiatrists. They are offered by the following institutions: the Peruvian Institute of Behavioral and Cognitive Therapy (Instituto Peruano de Terapia Conductual Cognitiva [IPETEC]), the Peruvian Institute of Cognitive Behavioral Therapy (Instituto Peruano de Psicoterapia Cognitivo Conductual [IPSICOC]), the Specialization Program in Cognitive Behavioral Therapy [PROMOTEC], the Rational Emotive Therapy Institute (Instituto de Terapia Racional Emotiva [ITRE]), the Center for Rational Emotive and Cognitive Behavioral Therapy (Centro de Terapia Racional Emotiva y Cognitiva Conductual [PSICOTREC]), and the CBT Specialization Program of the Universidad Nacional Federico Villarreal (UNFV).

IPETEC was founded in 1983 by the former psychiatrist Rafael Navarro Cueva and psychologist María Victoria Arévalo Prieto. Since 1984, they have offered a 2-year training program, exclusively for psychology and psychiatry graduates. Currently there are 23 graduated classes that represent approximately 400 specialists in cognitive behavioral therapy (M.V. Arévalo, personal communication, June 6, 2018).

Psychologist Edgar Rodríguez Vílchez and a group of cognitive behavioral psychotherapists interested in the training and dissemination of CBT in the country founded IPSICOC in 1986. Its training program is aimed toward psychologists, psychiatrists, and students in the last years of their education. The program is 2 years long and consists of four modules. It has 39 graduated classes and approximately 400 graduate students. IPSICOC is a member of ALAMOC and for the past 8 years has also offered a Specialization in Schema Therapy that lasts 1 year and has approximately 61 graduates (E. Rodriguez, personal communication, August 27, 2018; IPSICOC, 2020).

The training in cognitive behavioral therapy in PROMOTEC was founded in 1995 by psychologists Edwin Manrique Gálvez, Haydee Aguado Molina, and Raquel Silberman Pach. Their aim was of providing a structured program to acquire and/or strengthen therapeutic skills within the model of cognitive behavioral therapy. It is a 2-year program divided into four modules, which is also aimed at psychologists and psychiatrists; PROMOTEC has approximately 264 graduated students. (E. Manrique, personal communication, September 01, 2018).

ITRE was founded in 1987 by Pedro Reyes Mispireta, the current director. Initially their training was offered through short courses which in 1999 later evolved into a 2-year training program in rational emotive behavior therapy endorsed by the Albert Ellis Institute of New York. ITRE has approximately 500 professionals among psychologists and psychiatrists that have graduated from this program (P. Reyes personal communication, June 9, 2018).

PSICOTREC, on the other hand, was founded in 2001 by its current director, psychologist Natalia Ferrero Delgado. PSICOTREC initially offered short training workshops to psychologists and mental health professionals and with the endorsement of the Albert Ellis Institute of New York and in 2005 started the Training Program in Rational Emotive and Cognitive Behavior Therapy. Its training program is offered to psychologists and psychiatrists exclusively and is divided into five semesters with a total duration of 2 years. PSICOTREC has approximately 500 graduates in 18 graduated classes. In conjunction with the Institute of Rational Emotive Therapy (ITRE), both institutes are REBT and CBT training centers, affiliated with the institute of the creator and founder of rational emotive behavior therapy, the Albert Ellis Institute in New York City (N. Ferrero, personal communication, May 10, 2018).

At Universidad Nacional Federico Villarreal (UNFV) , the Cognitive Behavioral Therapy Specialty Program was created in 2006 by a group of psychologists from the Ministry of Health of Peru (Ministerio de Salud del Perú) and the Social Health Insurance (Seguro Social de Salud [ESSALUD]). This program lasts four semesters and is offered over the course of 2 years, and the students graduate as specialists in CBT. Initially they enrolled a group of 50 students approximately every year, but since 2012, they have opened enrollment to the training program twice a year, having approximately 50 students per class (F. Roca, personal communication, August 8, 2018).

Additionally, all of the institutions that offer training in CBT regularly provide specific courses and workshops on CBT topics of interest to health professionals such as CBT for children, adolescents and their parents, couples and sexuality, crisis intervention, and grief, among others.

Currently, there is interest in creating links between the different training schools of the cognitive behavioral therapy tradition, since it is recognized that generating associations would favor and strengthen this psychotherapeutic orientation in our country as well as open spaces for reflection, dissemination, research, organization of scientific events, and congresses, among other initiatives that are of great significance and interest in the training of students and professionals in psychology and related disciplines.

## Populations Most Frequently Worked with Using CBT in Peru

According to the National Institute of Statistics and Informatics [INEI] in 2017, the economically active population (EAP) in the country reaches around 5 million people, and only 27% of this group finished school. Of this total, 10.49% did not complete primary education, 10.53% completed primary education, 16.11% did not complete secondary education, and 27.55% completed their school. This means that around 65% of the EAP have completed school studies but do not have university or higher education studies (INEI, 2017a, b).

Although these data did not confirm that this population does not have any analytical skills or critical thinking abilities that facilitate the comprehension of cognitive behavioral therapy, they do show this proportion of limited educational level in our total population and suggest that a basic behavioral intervention approach and a more concrete level of cognitive restructuring and practical solutions could be better taken advantage of. Due to the fact that the majority of the Peruvian population with college and/or university studies are found in urban areas, it makes access to cognitive behavioral therapy more viable.

## Adaptation of CBT in Peru

There were no identified publications related to adaptations of cognitive behavioral therapy in Peru. However, considering that Peru has several geographically different regions (coastal, mountains, and rainforest), adaptations by region should be contemplated because each has its own characteristics, customs, traditions, habits, beliefs, and even language.

As mentioned in the previous section, limited educational opportunities in different contexts demand that psychotherapists make adjustments in their interventions and even other health professionals, such as nurses, doctors, or social workers, to offer assistance within this theoretical approach.

The essential adaptations that are presumed to be carried out within the different cultures in Peru would be aligned with those proposed by Bernal and collaborators in 1995, who described eight overlapping cultural dimensions and characteristics of the treatment population that should be incorporated into research results. These dimensions of psychotherapy include concepts, language, people, content, metaphors, objectives, methods, and context (Bernal et al., 1995).

## Research on CBT in the Country

The different national and private universities have documented investigations where the application of cognitive behavioral therapy in universities (students), clinical (hospitals or health centers), or single case studies are described. These

investigations are framed within the thesis to obtain their professional degree or master's degree in clinical psychology. While it is true that there are still limited studies examining the impact or influence of cognitive behavioral psychotherapeutic intervention, it is estimated that, given current regulations requiring universities to conduct research to achieve the title of professional psychologist, these studies will increase significantly in the following years. At present, students can earn their psychological degree by completing their credits. Doing research is not mandatory for licensure.

Several theses were submitted to obtain licensure in psychology that address CBT, such as Kantor (2011), who defended a "Validation of the abbreviated version of the Personal Style of the Therapist Questionnaire in therapists of Metropolitan Lima." This thesis evaluates the psychometric properties of the abbreviated version of the self-descriptive questionnaire PTS-Q that addresses the personal style of 126 accredited therapists comprised of 48 psychoanalytic therapists, 30 psychoanalysts, and 48 cognitive therapists. In addition to these, single case study theses have been also defended to obtain this degree, such as "Clinical case study: Rational emotive therapy in a social phobia case" (Jordan, 2017).

In 2016, Brocca and Grimaldo published a paper: "Emotional Schemas in a group of patients with depression in a hospital of the city of Lima." In this paper, the Leahy Emotional Schemas Scale (LESS), that has 50 items, was taken in a sample of 80 patients diagnosed with depression in a mental health hospital in order to identify emotional schemas that depressed patients have about their own emotions.

In 2018, Aguirre and colleagues published a paper titled: "Emotional Schemas and emotional dependency in metropolitan Lima university psychology students." In this study the relationship between emotional patterns and emotional dependency in Lima university students was investigated using the Leahy Emotional Outlines Scale.

In 2019, during the International Congress of REBT in Romania, results of three quantitative studies were presented during the symposium "The practice and training of REBT across cultures." One of them identified the different names given to the same emotions according to the REBT conceptualization of emotions in several Latin American countries, including Peru. The aim of this study was to identify a list of semantically homogenous words of negative emotions in Spanish and Portuguese which might help Latin American therapists to be aware of how their clients refer to their emotions (Ferrero et al., 2019a). The second study identified the most common errors and omissions committed during primary and advanced training supervision sessions in REBT (Ferrero et al., 2019b). Finally, the third research study assessed the strategies and styles of disputing used most during supervision sessions as well as additional clinical resources therapists preferred to use in their practice (Ferrero et al., 2019c). In these three research studies, data was obtained from Peruvian psychotherapists with mostly primary and advanced trainings in REBT.

## CBT with Special Populations

Approximately, in the course of the past 20 years, the intervention of cognitive behavioral therapy in Peru has been introduced or applied to special populations such as patients with chronic diseases, terminal illnesses, physical health diseases, neurocognitive illnesses, and learning and developmental disorders; victims of domestic and/or sexual violence; populations affected by emergencies, crises, and natural disasters; people with substance use disorders, eating disorders, personality disorders, and sexual dysfunctions; and populations with particular problems such as older adults and the specific needs of the LGBT+ population, among others.

In many of these cases, professional societies have been created to bring together specialists from different psychotherapeutic schools that meet the needs of these specific groups, among which, it is estimated that a majority are psychologists with training in cognitive behavioral therapy. The Peruvian National Association of Psycho Oncology (Asociación Nacional de Psicooncología del Perú [ANPPe]), the Peruvian Society of Suicidology (Sociedad Peruana de Suicidología [SPS]), and Autism Project Association (Asociación Proyecto Autismo [ASPAU]) are some that are currently active in our country.

Peru is one of the largest and most diverse countries in Latin America. Given its multilingual and multicultural particularities, we have experienced different phases of economic development since the turn of the century, and despite our rapid growth we still have limitations in providing education and quality health services to our population.

Recently the government has increased the budget for mental health. This is a big win, not only for those individuals that need mental health assistance and live in different regions of the country but also for mental health professionals as it will bring with it job and training opportunities.

A CBT presence has grown among mental health professionals in our country, and for this reason, specialized training in CBT in the different regions is increasingly being required. It will be highly recommended that this training be delivered by certified trained CBT psychotherapists that will hopefully engage in the cultural adaptation of the model to our reality and requirements, including scientific research related to CBT in Peru, which is one of our largest opportunities and challenges.

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# Chapter 26
# Cognitive Behavioral Therapy in Romania


**Paula I. Stroian and Daniel O. David**

## Overview of the Country

Situated at the crossroads between Central, Eastern, and Southern Europe, Romania has an estimated number of 19,638,000 inhabitants (INS, 2017), making it the 7th most populous member state of the European Union (Eurostat, 2018). Its official language is Romanian, a Romance language. The capital city, Bucharest, situated in the southeast, numbers approximately 2.1 million inhabitants (INS, 2016).

The modern Romanian state was formed in 1859, through the union of the Principalities of Moldavia and Wallachia. At the end of World War I, in 1918, the union of regions of Transylvania, Banat, Bessarabia, and Bukovina with the Romanian state followed. Bessarabia and other territories were later lost to the Soviet Union in 1944, and they roughly correspond to the present Republic of Moldova.

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Romania became a socialist republic following World War II. The 1989 Revolution brought the fall of communism in Romania and led to the country's transition toward democracy. In 2007, Romania became a member state of the European Union. Today, the country has the world's 47th largest economy by nominal GDP and has one of the fastest-growing economies in the European Union (Central Intelligence Agency, 2018). Further steps are needed to bring institutional change in the country, as, after almost 30 years of democratization, Romania is one of the countries in the European Union in the category of "semi-consolidated democracies," along with Bulgaria (Freedom House, 2010).

## A Short History of Psychotherapy in Romania

The history of psychotherapy in Romania is closely related to the cultural and sociopolitical status of psychology as a science in the country. Time-wise, the history of psychology as a science in Romania began promisingly, as early as the end of the nineteenth century. A positivist approach to the study of psychology was established then by three of Wilhelm Wundt's PhD students, who founded experimental psychology laboratories in the three historical university centers in the Romanian space: Eduard Gruber (at the University of Iași, in 1893), Constantin Rădulescu-Motru (at the University of Bucharest, 1897), and Florian Ștefănescu-Goangă (University of Cluj, 1921/1922) (Bejat, 1982). Their research, mainly psychophysiological, focused on the empirical testing of positivist philosophical principles and on the identification of psychological variables in physical, biological, and medical phenomena (Tinker, 1932). The first attempt in Iasi was, however, short-lived, and the psychology movement was restarted here much later. The development in Bucharest was more systematic, but, here, psychology was mixed with philosophy. The development in Cluj-Napoca was systematic and specifically focused on psychology and an experimental/evidence-based ground.

In terms of psychotherapeutic practice, Romania was one of the first countries to assimilate the psychoanalytical theory, which was particularly popular among Romanian doctors in the interwar period (Zamfirescu, 2012). Some of the most notable works on psychoanalysis by published Romanian scholars in this interval are neurologist Gheorghe Marinescu´s article "Introduction to Psychoanalysis," published in 1923 in the French journal "Revue generale de sciences pures et apliquees," Ion Popescu-Sibiu's PhD thesis in medicine titled "Freud's doctrine" (1927), and the study "The sexual instinct," published by Iosif Westfried and Mina Minovici in 1927, with a foreword by Sigmund Freud (Zamfirescu, 2012). The most notable Romanian neurologists practicing psychoanalysis at that time were Constantin Vlad and Ion Popescu-Sibiu (Zamfirescu, 2012).

Before the instauration of the communist regime, Romanian psychology was aligned with international research standards. Indeed, Romanian psychologists had international publications, and Romania was a candidate for hosting the 12th International Congress of Psychology in 1940, which was canceled due to the onset

of World War II (Bejat, 1972). After the instauration of communism in 1948, however, Romania was left mostly unable to keep up with developments in the field, as the public discourse and policy measures strongly discouraged scientific contact with the West. The Western model was presented as dangerous for the "new man" portrayed by the communist ideology (David & Stefan, 2017). Many Romanian psychologists were dismissed from their university positions, and some of them were even imprisoned, under the accusation of conspiring against the newly formed communist regime. For instance, Nicolae Mărgineanu – vice-president of the "Friends of America" society at the time and a beneficiary of a scholarship by the Rockefeller Foundation – was charged with treason due to his affiliation with Western institutions (see Mărgineanu et al., 2017, Mărgineanu's memoir, for an account of the communist repression of psychologists in Romania). Furthermore, the citation of foreign publications was banned in 1952 (Mărgineanu et al., 2017), followed by the ban of the academic study of psychology, in 1977, and the ban of scientific research in the field, in 1982 (Kiss, 2013).

In parallel came the ostracization of psychotherapeutic approaches, considered to be incompatible with the communist view of human liberation. For instance, while psychoanalysis had received important recognition on a national level in the pre-communist years – for instance, in 1932, Ion Popescu-Sibiu had received the prize of the Romanian Academy for his work "Freud's doctrine" (Zamfirescu, 2012) – communist propaganda would strictly condemn psychoanalytical theory, seeing it as a threat to the new ideology (Petrin, 2017). The notion of man as a "set of social relations," having infinite plasticity and potential for cultural modeling, was presented in opposition to psychoanalytic theory, which portrays man as driven by individual instinctual forces. As such, psychoanalysis was perceived as a doctrine of the bourgeoisie, and its practice was even banned after the 1952 meeting of the Romanian Academy (Zamfirescu, 2012).

Moreover, Western behaviorism was presented as equally dangerous. As an iteration of the Soviet "antibourgeois" ideology, Romanian psychologist Mihai Ralea, counselor of communist leader Gheorghe Gheorghiu-Dej, states, in his programmatic book "The anti-human and anti-scientific character of bourgeois American psychology" (1954), that "[behaviorism] satisfies the need of capitalists seeking to brutalize, enslave and transform workers into automatic, blind, 'auxiliary' tools of the assembly lines, into moving mannequins, working, accepting orders without knowing what they are doing" (p. 66) and that "almost all behaviorists have started off by using their famous labyrinths with rats and have easily moved from that to identifying man as a rat" (p. 68).

Ralea's manifesto presents behaviorist ideas simplistically and in a distorted manner, describing, for instance, the behaviorist definition of language as nothing more than a "laryngo-muscular association" (Ralea, 1954, p. 68), whereas thought was merely "movement of the larynx" (p. 70) and emotions "a reaction of the secretion function" (p. 70), according to Ralea's account of behaviorist ideas. The early dissemination of such a simplistic (and often erroneous) view of behaviorism may be the reason why the mainstream understanding of the model in Romanian academia has been fragmentary even after the fall of communism (David, 2012). The

only notable exception to the general reprobation of American behaviorism in communist Romania was professor Ioan Radu who, in his work "Educational Psychology" (1974), offers a rigorous presentation of the principles of operant conditioning and their implications for educational psychology.

As an alternative to "brutalizing" Western models, the Pavlovian model of mental illness was, similarly to the public discourse in the USSR, perceived as the only viable way to conceptualize mental health illness (Zajicek, 2009). A Romanian psychiatry textbook from 1956 praises the Pavlovian model, adding that "Romanian psychiatry has to creatively develop the firm materialist orientations of Soviet psychiatry, by closely observing the Soviet model in both content and organization, on the footsteps of Pavlovian psychiatry" (Parhon, 1956, as cited in Dobos, 2015, p. 97).

In line with the newly adopted conceptualization of mental functioning, psychology was soon deemed to be "just a branch of physiology, an expression of the processes of excitation and inhibition and of their interaction that take place in the cells of our brain" (Parhon, 1951, as cited in Dobos, 2015, p. 95). Practicing psychologists, working alongside psychiatrists in hospitals as mere assistants, were made to adopt the classical conditioning model of mental illness (Stevens, 1998). Pavlovian principles were, moreover, implemented in the structural and physical organization of public institutions such as factories and hospitals, in order to enhance productivity and social integration (Stevens, 1998). Principles of classical conditioning were believed to be applicable to all types of mental disorder, the most common diagnosis being that of "asthenic neurosis" (see Dobos, 2015, for a discussion of the Pavlovian treatment of asthenic neurosis in communist Romania). Furthermore, classical conditioning was used as a repression tool against opposers and dissidents. Their opposition to the regime was attributed to "madness," and, as such, they had to be "reeducated" in psychiatric and detention facilities, often using aversion therapy principles (Mărgineanu et al., 2017).

The fall of communism in 1989 saw Romanian psychotherapy in need to become realigned with international standards in mental health treatment and research (Stevens, 1998). Psychology departments in the country's main university centers were reopened in 1990. In the same year, the National Institute of Psychology, which had been disestablished in 1982, was reopened as part of the Ministry of Education and was shortly reintegrated into the Romanian Academy (Romanian Association of Psychologists, n.d.).

Western schools of psychotherapy soon began to find increasing numbers of adepts in the country. In particular, cognitive-behavioral therapy had a notable academic and practice history in Romania throughout the years following the fall of communism, albeit more informal at first. The Romanian "grandparents" of cognitive-behavioral therapy, the first to approach the field in a more thorough way and disseminate its principles to the public, are considered to be on a clinical level (e.g., David et al., 1998; Holdevici, 2005, 2009; Joja & Goldstein, 1998; Joja, 1998, 2004). On an academic level, the first cognitive-behavioral therapy courses were held in Cluj-Napoca and Bucharest (David, 2012; Miclea, 1997). Although there was interest for the field, contributions were not yet systematic enough to lead to significant recognition nationally and internationally (David et al., 2002). Some

academics and practitioners with a CBT affiliation had contact with Western institutions conducting research providing training and research. For instance, psychologist Irina Holdevici had pursued CBT training in Germany in the 1980s (Kiss, 2013), and Daniel David pursued part of his doctoral studies, as well as a postdoctoral program in the United States, at SUNY at Binghamton (cognitive science/clinical psychology), Mount Sinai School of Medicine (Bio-Behavioral and Integrative Medicine), New York, and Albert Ellis Institute (Clinical Psychology and Psychotherapy), New York.

Probably the first monographic work presenting the field of cognitive and behavioral psychotherapies in Romania, "Cognitive-behavioral psychotherapy and hypnotherapy" (1998), was coordinated by Daniel David and was based on the seminars that Daniel David was giving at Babes-Bolyai University in Cluj-Napoca as part of the course "Cognitive and Behavioral Modification." The volume sold more than 3000 copies, and, although overtaken in the meantime by newer developments in the field, it helped introduce and structure the study of CBT in Romania at that time (David, 2012).

In 2007, a clinical psychology and psychotherapy department with a cognitive-behavioral focus was established at Babes-Bolyai University, aiming to integrate evidence-based practice and the scientist-practitioner paradigm into its academic activity (Department of Clinical Psychology and Psychotherapy, n.d.). The department is the first academic unit of its kind in the country, having gained recognition on an international level through its inclusion in the MERIL (Mapping of the European Research Infrastructure Landscape) platform, a catalogue of research infrastructures of excellence (MERIL, 2018). Moreover, the department was ranked first among Romanian university programs by the Ministry of Education and Research, for its scientific input in the interval 2006–2010 (Ministry of Education and Research, 2001).

The department delivers the first CBT-oriented master programs in Romania, one in clinical psychology, psychological counseling, and psychotherapy and the other in "Psychological Techniques for Behavioral Control and Human Potential Development," the latter being addressed to future clinicians/psychotherapists practicing in other fields with clinical implications (e.g., medical, educational, or organizational). Both masters programs are structured according to the Bologna system and are professionally accredited by the Romanian Agency for Quality Assurance in Higher Education (ARACIS), as well as by the College of Psychologists in Romania (Department of Clinical Psychology and Psychotherapy, n.d.). In 2011, the masters program received recognition from Babes-Bolyai University as a program of excellence (David, 2013).

It is difficult to estimate how many psychotherapy schools are currently operating in Romania, especially since official statistics are lacking at this moment (mainly due to the state professional association, the College of Psychologists in Romania, presently undergoing structural transformation). It must be mentioned at this point that there is a tendency toward "insularity" in this professional field in Romania: the fact that there are four institutions presently providing CBT training in a country of 22 million is an example in this respect (David, 2012). Additionally, professional

schools and training programs not only operate in isolation from one another, but many of them also tend to be disconnected from the empirical evolution of the field. This is somewhat explainable, given the sociopolitical history of the country – by discouraging research and practice in the field, the communist regime also forced professionals to develop a "do it yourself" approach to the study and practice of psychotherapy.

The psychotherapy schools recognized by the College of Psychologists in Romania are the following: cognitive-behavioral psychotherapy (e.g., rational-emotional behavioral psychotherapy, cognitive psychotherapy, behavioral psychotherapy), dynamic psychotherapy (e.g., psychoanalytic psychotherapy, analytical psychotherapy, short-term dynamic therapies), Ericksonian psychotherapy (e.g., Ericksonian psychotherapy, Ericksonian hypnosis), short-term psychotherapy (e.g., short-focus therapy on the solution, competence and resource orientation, constructivist-collaborative and narrative approaches), and humanistic-existential-experiential, systemic, and transpersonal psychotherapy (e.g., gestalt therapy, logotherapy, psychodrama, experiential psychotherapy, transactional analysis) (College of Psychologists in Romania, n.d.).

## Regulations Regarding Psychotherapy Provision: Current Professional Associations

After the fall of communism, the Romanian Association of Psychologists (APR) was reorganized in line with the newest state regulations. The conceptual and methodological eclecticism defining the activity of psychologists in the first years after communism called for a discussion regarding the status of the profession: at the 2001 meeting of APR, the need for convergence in terms of the professional identity of Romanian psychologists was discussed, seeing that, in the years after the fall of communism, the association had not managed to reinforce a unified perspective upon professional practice (Kiss, 2013). Several years later, in 2004, the College of Psychologists in Romania (CPR) was formed, aiming to provide a more coherent regulatory framework for Romanian psychologists' professional practice, including that of psychotherapists (Kiss, 2013).

Currently, with regard to psychotherapy provision, College of Psychologists in Romania enables and testifies the right to practice for professionals who have a bachelor's degree in psychology (obtained by accredited higher education institutions) and have undergone training via one of the certified programs provided on a national scale. The accreditation procedure in psychotherapy follows the international norms in the field. The first level of practice is that of a "practitioner in psychotherapy/psychotherapist under supervision," involving the following prerequisites: 1800 h (courses, seminars, practice plus individual study) in the following fields, clinical assessment and diagnosis, clinical psychology, counseling and psychotherapy, psychiatry and/or psychopathology, psychology of health and/

or psychosomatics, and developmental psychology. The second professional level, that of "psychotherapy specialist," requires the previous "practitioner in psychotherapy" level, plus professional training through an accredited professional association, a minimum of 100 hours of self-knowledge and personal development, 300–600 hours of supervised clinical practice within medical institutions and individual offices or in governmental and non-governmental institutions carrying out psychotherapy/counseling activities and 150 hours of clinical practice supervision, held by an accredited professional association. The third professional level is that of "principal psychotherapist," and it requires the psychotherapy specialist level, plus training as a supervisor (via certified institutions) and high performance in the academic field, as proven by publishing research and holding specialty courses (College of Psychologists in Romania, n.d.).

## *Cognitive-Behavioral Therapy Organizations*

In 2000, the Romanian Association of Cognitive and Behavioral Psychotherapies (APCCR) was founded in Cluj-Napoca, aiming to provide training and practice opportunities in cognitive-behavioral psychotherapy and to align professional activity in the field with international standards and evidence-based paradigm. APCCR is the largest CBT organization in Romania, having Albert Ellis and Aaron T. Beck as honorary presidents. Also, APCCR offered the first training program in CBT in Romania, fully recognized both in the United States (e.g., by the Albert Ellis Institute/Academy of Cognitive Therapy) and Europe (e.g., by EABCT). Activity in APCCR was based on the research and educational activity already existing at Babes-Bolyai University. The association is a member of the European Association of Behavioral and Cognitive Therapies and has a training center recognized by the Academy of Cognitive Therapy, USA, and Albert Ellis Institute, USA (APCCR, n.d.). APCCR collaborates with the Institute for Advanced Psychotherapy and Applied Mental Health at Babes-Bolyai University, as well as with the university clinic (PsyTech). In 2017, APCCR was the host of the 9th International Congress of Cognitive Psychotherapy. Held in Cluj-Napoca, the Congress reunited world experts in the fields of clinical psychology and evidence-based counseling and psychotherapy, with an emphasis on cognitive and behavioral psychotherapies (APCCR, n.d.).

Three other accredited cognitive-behavioral therapy organizations exist in Romania, namely, the Association of Cognitive-Behavioral Psychotherapy and Hypnotherapy (AHPCC), the Association of Psychopharmacology and Cognitive Science (APFSC), and the Romanian Association for Behavioral and Cognitive Therapy (ARTCC). The Association of Hypnotherapy and Cognitive Behavioral Psychotherapy (AHPCC) in Bucharest was founded in 2006 as a professional association within the University of Bucharest and aims to support, develop, and promote psychotherapy as a science and as a profession (AHPCC, n.d.). The Association of Psychopharmacology and Cognitive Sciences (APFSC) is another Bucharest-based training institution accredited by the College of Psychologists in Romania for

complementary and continuous cognitive-behavioral training (APFSC, 2018). The Romanian Association of Behavioral and Cognitive Therapy (ARTCC), also based in Bucharest, is accredited by the Romanian Psychologists' College and is a member of the European Behavioral and Cognitive Therapy Association (ARTCC, n.d.).

## Training Opportunities in CBT in Romania

Currently, in Romania, training in CBT is offered by the four aforementioned associations, which operate according to the guidelines provided by the College of Psychologists in Romania. Of these four institutions, APCCR provides complex training in behavioral therapy, cognitive-behavioral modifications, cognitive therapy, acceptance and commitment therapy, mindfulness-based cognitive therapy, dialectic behavioral therapy, metacognitive therapy, schema therapy, multimodal therapy, appraisal therapy, constructivist cognitive therapy, problem solving therapy, cognitive-affective behavior therapy, and choice therapy. The association provides both initial and continuous training; initial training can be carried out as part of one of the two masters programs offered by the Department of Clinical Psychology and Psychotherapy at Babes-Bolyai University in Cluj-Napoca (APCCR, n.d.). AHPCC offers initial and continuous training in cognitive behavior psychotherapy and hypnotherapy and can deliver training as part of the Cognitive Behavior Psychotherapies Masters program offered at Titu Maiorescu University in Bucharest (AHPCC, n.d.). As for APFSC, the association provides complementary CBT training services to specialists in the fields of clinical psychology, psychotherapy, psychopharmacology, psycho-oncology, biological psychiatry, and other medical fields (APFSC, 2018). The training services offered by ARTCC are mainly addressed to psychiatrists and psychiatry residents, but psychologists can benefit from the association's services as well (ARTCC, n.d.).

## Use and Adaptation of CBT in Romania

Most CBT practitioners in Romania work in individual offices or in public institutions; currently there are 2462 registered CBT therapists and counselors in the Romanian Psychologists' College register (CPR, n.d.). As far as CBT clinics are concerned, it must be said this area is still in its infancy in Romania. Only several such clinics exist, and few of them have an explicit cognitive-behavioral focus. One notable example is the PsyTech clinic at Babes-Bolyai University in Cluj-Napoca Founded in 2007. PsyTech is the first university psychology clinic in Romania, offering affordable psychological assessment and interventions to the community. To date, the clinic has provided mental health services to over 1000 patients with a broad spectrum of psychopathology. Classic psychological treatment offered at the clinic is doubled by virtual reality-based and robot-enhanced therapies. The clinic

has been the first to introduce this type of service to the public in the country. PsyTech has two external clinical sites: an evidence-based psychological assessment and intervention unit for children and adolescents, at Iuliu Haţieganu University of Medicine and Pharmacy, and a clinical psychology and psychotherapy unit for seniors at Theodora Seniors Center in Cluj-Napoca (Clinica Universitară De Psihologie Babes-Bolyai PsyTech, 2018).

Cognitrom Ltd. has developed a multiuser platform (DEPRETER) that functions as an online clinic for the scientific treatment of depression. The platform offers a wide range of services, namely, assessment, monitoring, therapy modules and programs, videochat-based therapy, asynchronous communication, add-on treatment applications, and dedicated discussion forums (DEPRETER, n.d.) (see also Ciuca, 2013, for Cognitrom Ltd.'s program in anxiety disorders).

## Populations Most Frequently Worked with Using CBT

Although there are no official data regarding the most common problems treated with CBT, current empirical evidence of the use of CBT in the country can offer a general perspective upon the directions of treatment. Thus, randomized clinical trials testing CBT have been performed for depression (e.g., David et al., 2008; Sava et al., 2009), anxiety (e.g., Ciuca et al., 2016, 2017; Tulbure et al., 2015), affect, and quality of life in cancer patients (Schnur et al., 2009; Vasile et al., 2008), children's externalization problems (David et al., 2014a; Gavita et al., 2012), and weight management (Chirila et al., 2017; Podina et al., 2018). There is also increased interest for cognitive-behavioral coaching (e.g., Ratiu et al., 2017).

## Research on CBT in Romania

The most prominent research unit with a focus on cognitive-behavioral therapy is based at Babes-Bolyai University in Cluj-Napoca. The International Institute for Advanced Studies of Psychotherapy and Applied Mental Health was founded in 2003/2004 at UBB, in collaboration with the Albert Ellis Institute in the United States. The institute is the most representative in the field on a global level.

Several international theoretical contributions to the CBT model on behalf of the institute can be mentioned. First, the binary model of distress, which is based on Albert Ellis's original classification of negative emotions (i.e., functional versus dysfunctional), was tested within the institute (David et al., 2004b, 2005b). Second, the concept of mental contamination in cognitive restructuring, integrating two separate research lines – mental/psychological contamination and cognitive restructuring – has also been articulated and tested experimentally by the research team at the institute (David et al., 2005a). Another theoretical contribution is the extended cognitive ABC model of psychopathology, which incorporates clinical cognitive

science concepts (such as the unconscious processing of information) into the classic cognitive ABC model of psychopathology (David & Szentagotai, 2006; David et al., 2010). Finally, a new system for psychotherapy classification was proposed by David and Montgomery (2011), which was used by a large group of international psychologists and psychiatrists to evaluate the evidence-based status of various psychological treatments for key mental disorders (David et al., 2018b).

On an interventional level, new cognitive restructuring and behavioral modification techniques have been proposed by the research team at the institute, namely, the rational anticipation technique, the global restructuring technique, and the incompatible information technique. These techniques have been tested experimentally (David et al., 2005a) and later taught to students and incorporated into psychological services (David, 2012).

Moreover, the research group at the institute has developed a rational emotive behavioral therapy intervention protocol for major depressive disorder (David, 2007; David et al., 2004a), which was tested in several clinical trials (David et al., 2008; Sava et al., 2009) and integrated into training programs in cognitive and behavioral psychotherapies both in the country and in the United States.

Another contribution on behalf of the Institute is the REBT-based PsyPills application, which is meant to promote psychological health by "delivering" rational messages to users, based on the problem they are currently being confronted with and the thoughts and emotions they are experiencing (David & David, 2013).

Journal of Evidence-Based Psychotherapies (formerly Journal of Cognitive and Behavioral Psychotherapies), the Institute's peer-reviewed journal, publishes original quality contributions from the field of clinical psychology and psychotherapy and includes top researchers around the world on its editorial board. The journal has gained recognition both at a national (category A by the National Council for Higher Education Research) and international level, being abstracted in PsycInfo and SCOPUS, featured full text in EBSCO and ProQuest, and indexed by Thomson ISI/Web of Science-SSCI (JEBP, 2018).

## CBT with Special Populations

In what concerns the use of CBT with special population categories in Romania, several noteworthy examples can be mentioned. First, CBT has been used with Romanian foster children with externalization problems (Gavita et al., 2012). Second, interventions based on the comic book character RETMAN, developed by the International Institute for Advanced Psychology and Applied Mental Health at Babes-Bolyai University in Cluj-Napoca, have been successfully used with children and adolescents (e.g., Cristea et al., 2016; David et al., 2014b, 2018a; Gavita & Calin, 2013). The first RETMAN concept was developed at Albert Ellis Institute, USA, in the 1970s and 1980s (Merrifield & Merrifield, 1979), and the name is based on the acronym for rational emotive therapy. Because of the high cost back then, the project was abandoned after the publication of a comic book magazine. In 2008, the

project was resumed at Babes-Bolyai University; the concept was integrated with modern technology, and new applications have been developed, including comic books, therapeutic stories, cartoons, robotherapy, and a therapeutic videogame. RETMAN-based interventions are currently being used in the child and adolescent psychiatry clinic at the University of Medicine and Pharmacy in Cluj-Napoca, at the Babes-Bolyai University clinic PsyTech, as well as in kindergartens and private psychotherapy practice (RETMAN, n.d.). Third, and most recently, the International Institute for the Advanced Studies of Psychotherapy and Applied Mental Health at Babes-Bolyai University, Cluj-Napoca, has been involved in a joint research project aiming to develop a new generation of autonomous social robots to be integrated in treatment protocols for autism spectrum disorders (*DREAM* project). The project is financed by the European Commission, and the activities carried out at the Institute are co-financed by the Romanian Executive Agency for Higher Education, Research, Development, and Innovation Funding (UEFISCDI). The Romanian team has been involved in the coordination of the clinical component of the research project (International Institute for the Advanced Studies of Psychotherapy and Applied Mental Health, n.d.-a, n.d.-b).

## Conclusion

To conclude, the evolution of cognitive-behavioral therapy in Romania is promising, both in terms of research and practice. After the fall of the communist regime, and particularly in the past decade, psychotherapeutic practice and research in Romania have become better synchronized with international trends in cognitive-behavioral therapy. However, steps are still needed to ensure that Romanian CBT research and practice are attuned to the latest developments in the field and that the scientist-practitioner paradigm is equally assimilated across research and training centers, as disparities are still present.

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# Chapter 27
# Cognitive Behavioral Therapy in Russia


**Snezhana Zamalieva and Alexandra Yaltonskaya**

## The Russian Federation Country Overview

The Russian Federation is the largest country in Eurasia. It is also the largest country in the world by area, covering more than one-eighth of the Earth's inhabited land area, and the ninth most populous, with over 144 million people (Rogatchevski & Steinholt, 2017). Russia's capital, Moscow, is one of the largest cities in the world (Central Intelligence Agency, n.d.). It is also home to major urban centers such as Saint Petersburg, Novosibirsk, Yekaterinburg, Chelyabinsk, Nizhny Novgorod, Ufa, and Kazan. There are eleven time zones in the Russian Federation. It has a wide range of environments and landforms.

According to the Constitution, Russia is a semi-presidential republic (Central Intelligence Agency, n.d.). The president is the head of state and the prime minister is the head of government. The president is elected by popular vote for a 6-year term (eligible for a second term, but not for a third consecutive term). The ministries of the government are comprised of the prime minister and his deputies, ministers, and selected other individuals; all are appointed by the president on the recommendation of the prime minister (Central Intelligence Agency, n.d.).

Economically, Russia is considered to be an upper-middle income mixed economy with enormous natural resources, particularly oil and natural gas. It has the 12th largest economy in the world by nominal GDP and the sixth largest by purchasing power parity (PPP) (Central Intelligence Agency, n.d.). The country has the world's largest natural gas reserves, the eighth largest oil reserves, and the second

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largest coal reserves. Russia is the world's leading natural gas exporter and second largest natural gas producer, while also the largest oil exporter and the largest oil producer (Central Intelligence Agency, n.d.). Russia is the third largest electricity producer in the world and the fifth largest renewable energy producer, the latter because of the well-developed hydroelectricity production in the country.

Russia is quite diverse with over 160 different ethnic groups and indigenous peoples in Russia. The country's vast cultural diversity spans ethnic Russians with their Slavic Orthodox traditions, Tatars and Bashkirs with their Turkic Muslim culture, Buddhist nomadic Buryats and Kalmyks, Shamanistic peoples of the Extreme North and Siberia, highlanders of the Northern Caucasus, and Finno-Ugric peoples of the Russian North West and Volga Region (Braden, 2020; Bulayeva, 2006; Hartley, 2014; Holland, 2014; Imamutdinova, 2017).

Russian philosophy is considered to be unique, and its uniqueness is based on the originality of the philosophical ideas, concepts, and issues characteristic of the many phenomena of Russian culture. The key issues of Russian philosophy were those of human spirituality, faith, life and its meaning, death, freedom, responsibility, good and evil, Russia's fate, etc. Russian religious philosophy provides individual spiritual anchorage by giving attention to the world of spirit. Russian religious and philosophical anthropology had developed the idea of searching the meaning of life long before ordinary people could see the timely character of such studies. These patterns of focus may be seen within the development of psychology and psychotherapy within the country.

## History of Psychotherapy in Russia

Psychotherapy, like any other branch of medicine, has its own history – as a science and practice of medicine. The history of psychotherapy in Russia can be broken down into two large (basic) periods. The first is pre-scientific, covering millennia, and the second, only the last two centuries are considered to be the scientific period of psychotherapy. The history of Russian psychotherapy is included as an integral part in the development of world psychotherapy. Description of the history of psychotherapy in Russia is based on two main criteria – the internal logic of the development of science and the impact of external socioeconomic, cultural factors (the historical background) on the development of psychotherapy as an aspect of psychiatry and, in a broad sense, on medicine, psychology, pedagogy, sociology, and philosophy.

For the beginning of psychotherapy in Russia, we start with the end of the nineteenth century, when the term "psychotherapy" appeared in the world practice of treatment of nervous diseases and came into use. The first period, when Russia was the origins and development of the practice of psychological assistance, free from political pressure and based on the entire previous experience of the development of the domestic and global scientific, cultural, and spiritual thoughts started in the 1870s. Over the next three decades, psychotherapy has been part of the psychiatry, and the neuropathology, determined in the areas of application, acquired its own

name; institutions specializing in the provision of psychotherapeutic assistance began to appear, the number of specialized publications and publications increased, and in particular, the journal *Psychotherapy* was first published in 1910.

In Russia, the study of hypnosis was examined by many prominent scientists of the time, and in the 1870s, the enhanced scientific development of hypnosis as a therapeutic method emerged. This, in turn, is a great influence on the clarification of the etiological role of psychogenic factors in the development of neuroses. It is our opinion that hypnosis was the beginning of all scientific psychotherapy, in all its variety of methods.

In Russia, interest in psychoanalysis was mediated by clinical testing of Freud's hypotheses and had both his supporters and critics. The internal logic of the development of Russian psychotherapy was consistent with the theoretical studies of such leading world scientists as academicians Bekhterev and Pavlov. Experimental study of higher nervous activity in Pavlov's laboratories, selection of types of nervous activity (physiological equivalent of temperament), and interrelations between the first and the second signal systems led to theoretical justification of experimental neuroses, which Pavlov transferred to the clinic of nervous diseases. This was the methodological basis of pathophysiological theories of neurosis and psychotherapy and was called Pavlovskaya psychotherapy.

As the first psychoanalytic movement spread globally, after the revolution of 1917, there was a rise of psychoanalysis in the Soviet Union with receipt of state support in the 1920s. In 1922, the Russian psychoanalytic society was formed in Moscow. In the 1930s, Birman developed the deep analytical and dialectical psychotherapy, assigning a leading role to remedy perverse targeted socio-reflex installation of neurotic personality by socio-reflexology.

In the 1930s–1940s, pathogenetic psychotherapy was developed in Leningrad, the theoretical basis of which was the psychology of relations. Myasishcheva (1893–1973) a pupil of Bekhterev, Lazursky, Basova, and Myasishchev developed theoretical ideas about the relationship of the individual and the environment of his teachers and developed the concept of psychology of the individual as a system of individual relations to reality, in contrast to the usual understanding, considering the individual as a system of functions. On the basis of psychology of relations, in 1939 Myasishchev formulated the clinical and pathogenetic concept of neuroses. Here, the main pathogenic link in the emergence of neurotic disorders are contradictions in the trends and possibilities of the individual with the requirements and opportunities provided by the environment and perceived by the individual as insoluble. Theoretical principles of V. N. Myasishchev was developed by his associates, disciples, and followers of E. S. Averbuch, E. K. Yakovleva, T. Y. Chilibeck, R. A. Shchepetkin, and A. J. Strumica. These were the origins of the Leningrad (St. Petersburg) school of personality-oriented psychotherapy. Another important figure was S. I., Kanstoroom (1890–1950) who developed an original approach, called activating psychotherapy. The purpose of this approach was restructuring inadequately experiencing and reacting psyche not only and not so much by verbal appeal to the intellect and emotions of the patient, to his perception of the world and worldview, but through the change and correction of his relationship.

In the history of the country, these years (late 1960s–mid-1980s of the twentieth century) are the era of Khrushchev's thaw and Brezhnev's political stagnation. For the development of psychology and psychotherapeutic practice, it became a time of revival and loosening of the dogmatism of Pavlovsky ideas.

In the mid-1960s, the rise of interest in psychology was reflected in the opening of the psychological faculties at Moscow State University and some other universities in the country. At the base of the Institute of Psychology in the system of Academy of Sciences (1971), the introduction in the universities the specialization in medical psychology, called the Moscow psychoanalytic society. In 1990, Belkin founded the Russian psychoanalytic Association.

In the late 1980s Gestalt therapy, psychodrama (1996), neuro-linguistic programming (1989), existentially humanistic psychotherapy (1993, the first Russian-American conference, which marked the beginning of a long-term educational program), systemic family psychotherapy (1998, the emergence of a society of family consultants and psychotherapists), cognitive-behavioral therapy, and classical and modern psychoanalysis came to Russia.

Today, psychotherapy has a rapid development, as the demand for effective methods of psychotherapy, and not only in the health-care system, has increased significantly. Today there is an increase in the quality of psychotherapeutic assistance offered in Russia. More intensive use of psychotherapy also puts pressure on the scientific arm of psychology to conduct research to evaluate the effectiveness of psychotherapeutic methods.

## Regulation of Work of Psychologist and Psychotherapist

Russian legislation stipulates that psychotherapy can only be conducted by medical doctors who have received additional specializations in psychiatry and psychotherapy ("Mental Health in Russia," 2021). Every 5 years specialists are required to reapply for their specialization certification through participating in continuous professional education. Psychotherapy can only be officially practiced in official medical settings or by private licensed therapists. Psychologists can practice psychological counseling after receiving a university degree in psychology or clinical psychology. No licensing is necessary for practicing psychological counseling. Additional training in certain psychotherapeutic modalities (i.e., CBT, family therapy) is strongly encouraged but is not required. A list of the current law regulating the work of psychologists and psychotherapists is available in the link http://www.psy.msu.ru/science/public/psy_prof/lows.html ("List of Normative," n.d.).

## Beginning of CBT in Russia

The first presentation of cognitive-behavioral therapy (CBT) to the Russian professional community took place in 1996 when two leading specialists from the Moscow Research Institute of Psychiatry, Professor Alla Kholmogorova and Doctor Natalia Garanian, prepared a special edition of the Moscow Psychotherapeutic Journal dedicated especially to CBT. Doctor Aaron Beck kindly agreed to write the forward this remarkable edition as well as giving his permission to publish a translation of two chapters from his well-known book *Cognitive Therapy and Emotional Disorders*. The chapters described the main principles and basic techniques of CBT as well as its practical application for the treatment of depression and were translated by Dr. Garanian and for the first time presented to a Russian professional audience. Further. the issue included several reviews of international literature on CBT as well as an interview with a leading Russian therapists where they discussed their views on future of CBT in Russia and possibility of its integration into local psychotherapeutic practice (Beck, 1996). Interestingly, some specialists strongly believed that CBT will find its place in Russian psychotherapy, but some were skeptical about its future.

Since 1996, the interest in cognitive-behavioral therapy continued to grow, and in 1998 Professor Kholmogorova and Doctor Garanian started training at the Beck Institute in Philadelphia, USA. By 1998, the first regular training program for Russian mental health providers was established by these specialists in Moscow.

The first chapter dedicated to cognitive-behavioral therapy in the Russian language was published in 2000 in the Handbook of Modern Approaches in Psychotherapy (Kholmogorova & Garanian, 2000). Ten years later in 2011, the first manual on CBT for depression and anxiety became available for Russian mental health providers (Kholmogorova & Garanian, 2011). Both of these publications represented significant millstones in popularizing CBT among Russian specialists.

In 2001, the second special edition of the Moscow Psychotherapeutic Journal dedicated to cognitive therapy was published. At that time, it already included articles with results of scientific work by Russian psychologists and cognitive therapists in the area of psychological treatment of s, as well as psychological work with perfectionism (Kholmogorova, 2001a; Garanian et al., 2001). Moreover, in this issue Prof. Kholmogorova presented her unique work where she compares the theoretical framework of Beck's Cognitive Psychotherapy, L.S. Vygotsky's Cultural Historical Psychology, and other Russian "schools" of psychology (Kholmogorova, 2001b). This article by Prof. Kholmogorova became recently available for English speaking readers when it was published at Revue Internationale Du CRIRES: Innover Dans La Tradition De Vygotsky (Kholmogorova, 2017). Since 2001 publications dedicated to CBT became more common and started to appear in major Russian scientific journals. During the last decade, several major publications presented discussed developments on CBT in Russia, and the process of integration of Russian therapists and researchers into the international community was made in the English language (Kholmogorova & Garanian, 2010; Kholmogorova et al., 2012; Kholmogorova & Volikova, 2015).

## Regulation of Work of Psychologist and Psychotherapist

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## Professional and Cognitive-Behavioral Therapy Organizations

Currently, there are three active CBT associations in Russia. All three associations provide training programs and are involved in research and the popularization of CBT in Russia.

### *Association of Cognitive-Behavioral Psychotherapy (Saint-Petersburg)*

The association of cognitive-behavioral psychotherapy was established in 1999 in St. Petersburg. The current leaders of the Association are Dr. Dmitry Kovpak, Dr. Andrey Kamenyukin, Dr. Yulia Yerukhimovich, Dr. Alexandr Fedorov, Dr. Snezhana Zamalieva, and other specialists. The honorary members are Dr. Aaron Back, Dr. John Viterito, and Dr. Robert Leahy. It has more than 750 members and 16 branches in the regions of Russia, as well as abroad, and unites professionals in the field of mental health: psychiatrists, psychotherapists, and psychologists. Individual members of the Association were trained at the Beck Institute in Philadelphia (USA), the Ellis Institute in New York (USA), the Oxford Center CPT (Great Britain), Center for Mindfulness (Massachusetts Medical School), and other international centers for teaching cognitive and behavioral therapy.

The Association conducts training programs of various levels – basic, advanced, and supervisory, each of which includes more than 200 hours of theory, practice, and supervision. Those educational programs have been conducted since 1999 in more than 23 cities of Russia, Belarus, Estonia, Ukraine, and other countries. In 2012–2013, the Association, together with the Positive Wave Foundation,

conducted work on the prevention of AIDS and the correction of psycho-emotional disorders in HIV-infected citizens in Russia and Estonia within the framework of the EU-Russia cross-border cooperation project. In November 2018, the annual International Suicide Survival Day took place in Russia.

## *Association of Cognitive-Behavioral Therapists (Moscow)*

This association was established in 2014 through the initiative of clinical psychologist, director of the Center of Cognitive Therapy in Moscow, Doctor Yakov Kochetkov (current president of Association), and a group of young and active cognitive therapists. The main goal of the Association is to provide CBT training that matches international standards. In 2016, the Association became a full member of European Association of Behavioral and Cognitive Therapies (EABCT) and initiated an international education program for Russian specialists. This program includes regular training with famous CBT therapists in Moscow (Dr. Stefan Hofmann, Dr. Jurgen Margraf, Dr. Tomas Kalpakoglou, Dr. David Clark, Dr. Helen Macdonald and other outstanding specialists). Association members receive international supervision on a regular basis as well.

Membership in the Association is at two levels: a) simple, available for all mental health providers that have received at least basic training in CBT, and b) accredited members, available for CBT therapists who received training in CBT in accordance with European standards and have passed the qualification exam ("Training, Supervision," n.d.). The Association includes several regional branches located in different parts of Russian Federation (Voronezh, Vladivostok, Orenburg, Perm, Ufa, Saint-Petersburg, Nizhny Novgorod, and others). Regional branches provide training programs for local specialists in line with international standards. Moreover, the Association includes several sections that provide training in developing special branches of cognitive-behavioral therapy: a) Section of Schema Therapy (chair: Dr. Aleksandra Yaltonskaya); b) Section of Dialectical-Behavioral Therapy (chair: Dr. Dmitrii Pushkarev); c) Section of Sexology (chair: Dr. Amina Nazaralieva); d) Section of Metacognitive Therapy (chair: Dr. Denis Moskovchenko); e) Section of Acceptance and Commitment Therapy (chair: Nikita Chernov); and f) Section of CBT for Psychosis (chair: Dr. Alexandr Erichev). Biannually the Association organizes all Russian conference with active international participation on CBT.

## *Society of Cognitive Therapists and Counselors (Moscow)*

The Society was established in 2012 by Prof. Kholmogorova and Dr. Garanian, the first Russians certified by the Academy of Cognitive Therapy (USA) CBT therapists ("Kholmogorova Alla Borisovna," n.d.; "Garanian Natalia Georgievna," n.d.). The main goals of the Society are to provide high-quality training for specialists,

conduct research, support therapists, and spread knowledge about CBT in their local communities. The Association provides a regular two-year program for cognitive-behavioral therapy for affective and personality disorders, as well as regular group supervision. The association closely collaborates with Faculty of Clinical Psychology at the Moscow State University of Psychology and Education that allows active involvement into research in the area of CBT. On top of that the association conducts activities to analyze, develop, and monitor ethical aspects of CBT therapists working in Russia.

Web-site: http://cognit-therapy.ru/

## CBT with Specific Clinical Populations

Patients with all types of mental disorders or psychological difficulties can receive CBT in different regions of Russia. Different approaches connected to CBT such as DBT, schema therapy, mindfulness, acceptance, and commitment therapy are also available for patients. These treatments are available mostly in Moscow, Saint Petersburg, and few other large Russian cities. During the last 3–5 years, the number of specialists trained in CBT has significantly increased, and more and more people from different regions of the country can receive evidence-based psychological help. This happened mostly due to intensive educational activity of abovementioned associations. Unfortunately, there is practically no insurance coverage for CBT treatment in Russia, which means that patients must financially cover the treatment by themselves.

### *Dialectical Behavioral Therapy (DBT) in Russia*

Several DBT teams offer their help in Moscow and Saint Petersburg for patients with high suicide risks, borderline-personality disorder, addiction, and eating disorders. This training in DBT for professionals has been available since 2015 by Drs. Dmitrii Pushkarev and Amina Nazaralieva at the Mental Health Center with the support of Linehan Institute (USA) ("Ambassadors," n.d.).

### *Schema Therapy in Russia*

Patients with different types of personality disorders can receive schema therapy in Moscow, Saint Petersburg, and Voronezh. The training of specialists in this area is available by the Schema Therapy Institute of Saint Petersburg which was established by Dr. Paul Kasyannik and his team and at the Schema Therapy Institute of Moscow established by Dr. Aleksandra Yaltonskaya. Dr. Joan Farrell, and Ida Shaw

from the Schema Therapy Institute of the Midwest (USA) and International Society of Schema Therapy (ISST) made significant contributions to the establishment of these training programs in Russia.

### *Acceptance and Commitment Therapy (ACT) in Russia*

ACT and other types of contextual behavioral therapies are available for patients suffering depression, anxiety disorders, psychosis, and other disorders. The Center of Contextual Behavioral Therapy organized by Nikita Chernov and Nikolai Pavlov provides training and practical help in this area.

### *Mindfulness-Based Interventions in Russia*

Mindfulness programs are available for patients suffering from anxiety disorders and depression and for those who are experiencing a high level of distress. Special programs are also developed for organizations to train the employees how to manage stress and develop emotional intelligence. The Mindfulness Studio #1 was developed by Dr.Snezhana Zamalieva as an online platform and offline studio as well.

## Research on CBT in Russia

Current scientific activity in the area of psychotherapy in general and in cognitive-behavioral therapy in particular is limited in Russia ("Mental Health in Russia," 2021). However, there are several research groups that concentrate their efforts of studying cognitive and behavioral aspects of certain disorders and the application of different forms of CBT to its treatment. The pioneers in this area are the group headed by Prof. Kholmogorova and Dr. Garanian. Their scientific work is dedicated to affective disorders, anxiety disorders, and psychosomatic disorders and their psychotherapeutic treatment. The researchers developed a multifactorial model of affective disorders that includes macro-social, familial, individual, and interpersonal components. When problems arise related to macro-social, familial, individual, and interpersonal issues, this can lead to the development of depression and/or anxiety. Treatment can then be targeted to address the particular level of the problem (Kholmogorova & Garanian, 1998a; Kholmogorova, 2011b). The research group shows that integrative psychotherapy is particularly effective for the treatment of chronic affective disorders; this includes a combination of CBT and systemic family therapy (Kholmogorova & Garanian, 1998b; Garanian & Kholmogorova, 2013). Other groups of researchers led by Prof. Natalia Sirota and

Prof. Vladimir Yaltonsky from Faculty of Clinical Psychology at the Moscow State University of Medicine and Dentistry, named after A.I. Evdokimov, concentrate their scientific efforts on understanding psychological aspects including factors of cognitive vulnerability and coping behavior among people with substance abuse problems and chronic somatic illnesses (i.e., cancer survivors, cystic fibrosis, etc.). The research group develops and assesses the effectiveness of short-term cognitive-behavioral interventions for the abovementioned population of patients. Doctor Denis Moskovchenko conducts research of effectiveness of cognitive-behavioral interventions for cancer patients in different stages of treatment (Buizman et al., 2007; Sirota et al., 2016).

The first research into the effectiveness of group cognitive-behavioral therapy for the treatment of depression among a Russian inpatient group was conducted by Dr. Alexandra Yaltonskaya. The research showed that brief CBT applied in a group format in combination with treatment as usual (mostly pharmacological) for inpatients with non-psychotic depression can significantly improve the long-term prognosis for patients and reduce their chances of relapses during a 1-year follow-up. The application of CBT in a group format significantly increases patient access to this evidence-based psychological treatment. This fact is particular important for Russia when taking into account the presence of a universal health care system that covers predominantly psychopharmacological treatment for all forms of mental disorders (Yaltonskaya, 2013).

The research group headed by Prof. Kholomogorova from the Federal Research Center of Psychiatry and Addiction named after V.P. Serbsky (Moscow) and the group chaired by Dr. Aleksandr Erichev from the Scientific Psychoneurologic Institute named after V.M. Bekhterev (Saint-Petersburg) independently developed and assessed effectiveness of protocols of cognitive-behavioral therapy for psychotic disorders among a Russian population (Kholmogorova, 2011a; Turkington, 2007).

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# Chapter 28
# Cognitive Behavioral Therapy in South Africa


**Lena S. Andersen, Jaco Rossouw, and Ashraf Kagee**

## Overview of South Africa

South Africa has a population of 59.6 million (Statistics South Africa, 2020), with just over half living in urban areas (Statistics South Africa, 2017). South Africa has 11 official languages: Zulu, Xhosa, English, Afrikaans, Ndbele, Northern Sotho, Sotho, SiSwati, Tsonga, Tswana, and Venda. There are large disparities in income within South Africa. An estimated 40% of people live below the poverty line, earning less than the national lower-bound poverty line of ZAR 758 per person per month (US$63.05) (Statistics South Africa, 2018). As a result of centuries of colonialism and several decades of legalized racism, the racial and class fault lines still roughly coincide. Thus, most White South Africans are affluent, and most Black South Africans live in relative poverty.

South Africa has both a private and public health system. The public health system provides services to most citizens (46 million; Statistics South Africa, 2016), while those who have health insurance or can afford to pay out of pocket are cared for in the private health system.

South Africa was first colonized by the Dutch in 1652 and then by the British in 1795. In 1961 the Union of South Africa, a self-governing colony of the British Empire, left the Commonwealth and became the South Africa Republic. In 1948 the National Party came to power and began to implement apartheid policy and legislation (Nattrass, 2017). Apartheid was a legal political system of forced racial segregation in which White South Africans enjoyed full legal rights, including the right to vote, high-quality education, and health care. Black, "colored" (an apartheid era term used to refer to those of mixed-race origin), and those of Indian origin were not

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allowed the franchise (i.e., the right to vote) and received inferior social, educational, and health services. In the apartheid era, White South Africans had access to optimal health care, while their Black counterparts did not. For Black South Africans, health care was severely under-resourced, poorly staffed, and significantly oversubscribed.

South Africa held its first democratic non-racial elections in 1994 after 46 years of apartheid. After 1994, the non-racial post-apartheid government desegregated the health-care system and sought to create equal standards of care for all race groups. While significant gains have been made in this regard, the quality of care in public hospitals and community clinics remains sub-optimal and uneven compared to the quality of care in the private health-care sector.

Currently, in the public health system, health services are provided within communities via primary health-care clinics. When more specialized psychological and psychiatric care is required, referrals to secondary- and tertiary-level hospitals are made. Primary health-care clinics are staffed primarily by nurses with the support of limited medical practitioners (Petersen et al., 2016). Psychology posts are scarce in the public health system (Lund et al., 2010). Consequently, most psychologists work in private practice. There are currently 13,000 psychology practitioners (such as psychologists, registered counselors, and psychometrists) registered with the Board of Psychology (PsySSA, 2017) and 8600 psychologists (HPCSA, 2018a).

## Access to Mental Health Services in the Public and Private Health Systems

It is estimated that approximately 30% of the South African population experience a psychiatric disorder in their lifetime (Herman et al., 2009). Yet, only 25 percent of people who met diagnostic criteria for a psychiatric disorder in the South African Stress and Health study had received treatment in the past year (Seedat et al., 2008). Needless to say, a significant mental health treatment gap exists in South Africa.

In 2010, the latest year for which data are available, there were 207 psychiatrists and 364 psychologists in the employment of the National Department of Health. This amounts to 0.28 psychiatrists and 0.32 psychologists per 100 000 in the public health system (Lund et al., 2010). Given the limited number of psychologist posts available within public health care and posts not being filled due to budgetary constraints, most psychologists find employment in the private sector, and thus their services are only affordable to those who have health insurance or who can pay out of pocket. It has been estimated that only 16% of the South African population have private health insurance (Council for Medical Schemes, 2016). Yet, according to the National Income Dynamics Study (Southern Africa Labour and Development Research Unit, 2014), in a survey of 28,000 households, 41.5% of participants reported visiting a private health-care practitioner at their last visit. Thus, the

proportion of South Africans who can afford private psychologist care lies somewhere between 16% and 41.5%.

Most of the South African population seeks services in the public health system, which is severely under-staffed (WHO-AIMS Report on Mental Health System in South Africa, 2007). Limited mental health care is available at primary health clinics, and it is mainly focused on the provision of psychotropic medication. Access to mental health care is further complicated as most public health psychologists work in tertiary hospitals and urban centralized psychiatric hospitals, which require referral from a primary health clinic for mental health services. Because of these circumstances, many South Africans experience difficulties in accessing mental health treatment, including cognitive-behavioral therapy (CBT).

## History of Psychotherapy in South Africa

South Africa has a proud history of playing a significant role in the earlier days of behavioral therapy, particularly in the contributions from the renowned South African behaviorists. Three prominent South Africans, namely, Joseph Wolpe, Stanley Rachman, and Arnold Lazarus, have played an important role in the development of cognitive-behavioral therapy.

Wolpe (1915–1997), a major influence in behavior therapy, was a South African psychiatrist. After studying medicine at the University of the Witwatersrand, he was awarded a Ford Fellowship and spent a year at the Centre for Behavioral Sciences at Stanford University. After working in South Africa, he held positions at the University of Virginia and Temple University. Originally a practitioner of psychoanalysis, Wolpe's work with traumatized South African soldiers led him to question psychoanalytic principles. His work on reciprocal inhibition and systematic desensitization has had a major impact on behavior therapy. Wolpe is also known for developing the Subjective Anxiety Scale and the Fear Survey Schedule, two measures that have extensively used in research on behavior therapy. He also developed the Subjective Units of Disturbance Scale (SUDS) to assess psychological distress. Wolpe has been ranked as the 53rd most cited psychologist of the twentieth century (Haggbloom et al., 2002).

Lazarus (1932–2013), a South African born clinical psychologist, was known for developing multimodal therapy (MMT). MMT assumes that because people operate in multiple modalities, therefore psychological treatment should address each of these. Multimodal assessment and treatment addresses these modalities of personality, namely, behavior, affect, sensation, imagery, cognition, interpersonal relationships, and drugs/biology (Lazarus, 2004). In terms of the MMT conceptualization, each individual is affected in different ways and in different amounts by each dimension of personality, and thus therapy should be uniquely tailored for each individual. Classical and operant conditioning are foundational concepts in the MMT approach (Town Topics, http://www.towntopics.com/wordpress/2013/10/09/obituaries-10-9-13/).

Rachman (b. 1934) is a psychologist and is Professor Emeritus at the University of British Columbia in Canada. He is well-known for his research in the field of obsessive-compulsive disorders and related anxiety disorders (British Psychological Society, 2012). He served as Editor in Chief of Behavior Research and Therapy until his retirement from active scholarship. His most recent work has been in proposing new cognitive models of obsessions and compulsive checking and a revised conceptualization of the fear of contamination, key aspects of OCD.

After these prominent behaviorists left South Africa for North America, many clinical and counseling psychology training programs in South Africa became and continue to be more heavily influenced by psychodynamic and humanistic approaches, while only a few have retained behavior therapy as part of the training curriculum. Many training programs have an eclectic approach to psychotherapy (Kagee & Lund, 2012), of which behavior therapy constitutes a small component.

Currently evidence-based practice, including CBT, is sometimes met with skepticism and/or resistance among South African psychologists. This is exemplified by the equivocal approach to evidence-based practice (EBP) taken by psychology training programs, of which CBT is an example. In a qualitative study of the 18 training programs on EBP in South Africa, two training directors indicated that they were opposed to EBP, four directors were in favor, and seven were ambivalent about where their programs stood regarding EBP (Kagee & Lund, 2012). Major reasons for opposition or equivocality included disapproval of a positivist epistemological paradigm that they believed dominates the evidence-based movement; an ontological opposition to imposing universalized knowledge on South African patients; misunderstandings of EBP being based on case studies as an example of scientific evidence; the perceived limited utility of CBT as being effective for personality disorders; concerns about the absence of evidence for community prevention programs; and concerns about a potential mismatch between EBP and African cultural practices that could be psychologically helpful to individuals (Kagee & Lund, 2012). While Kagee and Lund (2012) did not specifically research training of CBT, the mixed sentiments regarding EBP among training directors in their study suggests skepticism about empirically supported treatments in general, of which CBT is an example.

To our knowledge, the only study on the practice of CBT in South Africa was a survey of a random sample of 400 of the then 1463 psychologists registered with the Professional Board for Psychology (Moller & van Tonder, 1999). At the time, 20% of the sample indicated they had received training in CBT, and 23% stated that they used it in their practice. Yet, only 11% of the study participants stated that 50% of their work could be described as CBT, and only 6% stated that 80% and more of their professional time was spent practicing CBT. While nearly 20 years have passed since the Moller and Von Tonder study, we know of no other published surveys of psychologists that have been conducted subsequently. Our sense is that although a strong opposition still exists among many psychologists in South Africa toward CBT and EBP, there is a growing recognition of the need for evidence-based practice and a greater interest in training in CBT and EBP.

Psychotherapy as a professional practice in South Africa emerged mainly under the rubric of clinical and counseling psychology. As academic disciplines and fields of practice, clinical and counseling psychology was heavily affected by apartheid. The first organized psychology body, the South African Psychological Association (SAPA), was founded in 1948. In its official documents, there were no restrictions on Black psychologists joining the organization. However, when the first Black person joined in 1962, several psychologists objected to his admission to the organization and resigned from SAPA. They founded the Whites-only Psychological Institute of the Republic of South Africa (PIRSA) (Nicholas, 1990).

In 1974, the Medical Dental and Supplementary Services Act was enacted which made registration of psychologists' compulsory. SAPA and PIRSA merged in 1983 to form the Psychological Association of South Africa, whose membership was open to all races. Nonetheless, by 1989 less than 10% of South African psychologists were Black (Nicholas, 1990). In 1994, the Psychological Society of South Africa was formed, and later that year the first democratic national elections were held, heralding the end of apartheid. In 2017, more than 20 years after the end of apartheid, 41% of clinical psychologists were Black (PsySSA, 2017). Even though increasing numbers of Black psychologists are being trained, in part due to efforts by University training programs to attract Black candidates, the profession still has a White majority. We suspect this is in part an ongoing legacy of apartheid that takes several forms: (1) there are more White students who meet the rigorous academic criteria for admission to masters programs as they are advantaged by excellent schools in historically White areas compared to less functional schools found in many Black townships; (2) most Black students are financially disadvantaged and do not have the luxury to wait 7 years post-matric (i.e., high school) to qualify as a psychologist and begin earning an income; and (3) many Black students have several family members as dependents due to the high unemployment rate in South Africa and may prefer shorter academic programs that lead to qualifications with which they can generate an income.

## Current Regulations Regarding the Provision of Mental Health Counseling and Psychotherapy

Unlike the term "psychologist," the term "psychotherapist" is not a regulated term in South Africa. Thus anyone, regardless of skill level or training, may call him or herself a psychotherapist. Professionals who practice psychotherapy or who claim to do so may have training in counseling, social work, or psychology. Some may even have no clinical training at all. Psychologists in South Africa on the other hand are professionals who hold at least a master's degree in clinical or counseling psychology and have completed a 1-year clinical internship accredited by the Health Professions Council of South Africa (HPCSA, 2007).

The scope of practice of psychologists is defined in the Health Professions Act, which was endorsed in 2010 (Health Professions Act, 2010). The Act states that the scope of practice for clinical psychologists regarding psychotherapy includes "applying evidence-based psychological interventions to people with psychological and psychiatric conditions" (Health Professions Act, 2010). The scope of practice for counseling psychologists includes "applying psychological interventions to patients with developmental challenges and performing therapeutic counseling interventions" (Health Professions Act, 1974). The reason for the difference between the two registration categories in emphasis on evidence-based interventions in the language of the Act is unclear and is presumed to have its roots in a perceived need to separate the two registration categories. Nonetheless, evidence-based psychological interventions, of which CBT is a prime example, are endorsed in the Act, at least in terms of the practice of clinical psychologists (Health Professions Act, 1974).

## Professional and CBT Organizations

The Professional Board for Psychology is constituted in terms of the regulations relating to its constitution (HPCSA, 2007). It registers the following professions under its auspices: psychologists, intern psychologists, student psychologists (i.e., in training), registered counselors, psychometrists, student psychometrists, psychotechnicians, and student registered counselors. The five categories of registration in psychology are clinical, counseling, educational, industrial, and research psychology (HPCSA, 2007). Practitioners of CBT are usually clinical and counseling psychologists as training in this modality forms part of the curriculum for these programs.

The Professional Board for Psychology is mandated in terms of the Health Professions Act of 1974 to set the minimum standards of education and training for registration to ensure that the interests of the public are protected. This body is considered the Standard Generating Body (SGB) for psychology. Eighteen universities in South Africa are accredited to provide masters level training (1 or 2-year academic, practical, and thesis program). This is followed by an internship (1-year) at an accredited treatment facility (such as a public health hospital). Completion of these requirements and successful completion of a Board of Psychology examination culminate in registration with the Professional Board (Kagee & Lund, 2012). The National Board Examination for Psychology is presented under the auspices of the Professional Board to determine whether a practitioner possesses adequate professional knowledge, skills, and competencies to practice the profession. Continuing education credits of 60 units per 2-year period is required in order to maintain registration as a psychologist (HPCSA, 2018b).

The Professional Board for Psychology is the regulatory body that oversees training programs at universities in South Africa. Members of the Board conduct oversight visits to programs every 5 years. During these visits, they examine the content of the curricula, interview staff and students to determine the merits and

limitations of the programs, and determine whether programs retain their registration with the Professional Board. In this way, the quality of practical training and academic rigor of programs are maintained. Currently no formal body that sets training standards oversees training and licenses the practice of CBT exists in South Africa.

## Training Opportunities in CBT

An unpublished survey carried out by Drake and colleagues in 2009 of 12 South African universities found that 11 universities offered some theoretical training in CBT during their masters program, although the training was limited (19 h on average). Access to CBT-specific supervision during masters training was variable, with only four of the universities surveyed providing regular CBT supervision (30 h in total) during their masters training. Only seven of the universities had staff members who had been practicing CBT for more than 5 years.

The provision of CBT training workshops to mental health professionals has increased in recent years. The Centre for Cognitive-Behavior Therapy based in Cape Town (www.cognitive-behaviour-therapy.co.za) has been presenting internationally certified training in rational emotive behavior therapy (REBT) in association with the Albert Ellis Institute since 2011. The Schema Therapy Institute of South Africa also provides internationally accredited training that can lead to an international certification in schema therapy (http://www.schematherapysouthafrica.co.za). Mindfulness-based training, which includes training in mindfulness-based CBT, is offered by the Institute for Mindfulness South Africa in association with Stellenbosch University (https://mindfulness.org.za). Other training workshops in CBT are offered in South Africa, but they do not lead to international certification. The Psychological Society of South Africa organizes a yearly congress with limited opportunities for training in CBT. We are of the opinion that psychologists seek training opportunities in CBT internationally by attending training programs in the USA and Europe and/or accessing training through Internet-based programs.

## CBT with Specific Clinical Populations

There is little evidence to suggest the availability of evidence-based psychotherapy treatments, including CBT, for clinical populations within the public health system in South Africa (Lund et al., 2010). To our knowledge, the only cognitive-behavioral intervention that has been systematically integrated into the public health system is the matrix model of outpatient treatment for substance abuse (Gouse et al., 2016). The matrix model is a cognitive-behavioral treatment that was developed and empirically validated in the USA for stimulant abuse. It is a 16-week outpatient

program that includes individual, group, and family sessions (Shoptaw et al., 1994). The first substance abuse treatment program based on the matrix model in South Africa was launched in conjunction with the Provincial Department of Health in a community health clinic in Cape Town in 2008. This center was accredited as a matrix model center of excellence in 2010. There are currently multiple matrix substance abuse treatment centers located throughout Cape Town providing treatment for a range of substance abuse disorders including tik (methamphetamine), alcohol, Mandrax (methaqualone), cannabis, and heroin (Gouse et al., 2016). We are not aware of any other CBT programs or services that are formally available in the public health system in South Africa.

## Adaptation of CBT in South Africa

The use of evidence-based treatments (EBTs), including CBT, to treat mental disorders in low- and middle-income countries (LMICs) is controversial (Murray et al., 2013). Some clinical researchers support the use of EBTs in LMICs. They argue that since many of the constructs of psychiatric disorders in LMICs, including South Africa, appear similar and consistent with DSM-V criteria, it seems probable that the core components, i.e., the change agents in evidence-based treatments that have been found effective in high-income countries, could be effective in LMICs. This has been supported by some promising outcomes of randomized controlled trials of EBTs in LMICs (Patel et al., 2011). However, given cultural and contextual differences, misgivings can exist of the direct importation of "Western" developed psychotherapies (Patel, 2000; Wessels, 2009). Cultural factors, such as individualistic versus collectivist orientations, and health systems factors, such as the availability of mental health resources, differ and could impact on the applicability, acceptability, and sustainability of EBTs (Patel, 2000). An approach taken by many of those who have been conducting research on the application of EBTs in LMICs to date has therefore been to adapt the EBT to the specific culture and context in which the EBT is to be applied without compromising the core components responsible for change (Murray et al., 2013; Patel et al., 2011).

Cultural adaptation has been defined as, "the systematic modification of an evidence-based treatment or intervention protocol to consider language, culture, and context in such a way that it is compatible with the client's cultural patterns, meaning, and values" (Bernal et al., 2009; p. 362). Several frameworks for culturally adapting psychotherapies have been developed and tested (Hwang, 2009). They identify several key steps including (1) selecting a "best fit" treatment through formative research, (2) culturally adapting the treatment in consultation with local community members, stakeholders and experts, (3) piloting the culturally adapted treatment, and (4) further modifying and finalizing the treatment based on lessons learned in the pilot. Similar systematic approaches of cross-culturally adapting and testing evidence-based treatments, i.e., CBT and IPT, have been carried out

successfully in Uganda (Verdeli et al., 2004), Pakistan (Rahman et al., 2008), and India (Patel et al., 2010).

In South Africa, in recent years, a few randomized controlled trials of CBT for the treatment of common mental disorders in primary care have been underway. For example, Andersen and colleagues followed a similar cultural adaptation process to modify CBT for the treatment of depression in people living with HIV (PLWH) in South Africa. In the formative phase, a small case series ($n$=6) of CBT was conducted to ascertain the applicability and acceptability of CBT in this context. A master's level psychologist administered a standard 14-session CBT treatment program in English (Andersen, 2009). Qualitative interviews were also conducted with people living with HIV (PLWH) who met criteria for major depressive disorder about their experiences and manifestations of depression (Andersen et al., 2015). Based on the information obtained in the formative research, CBT was deemed cross-culturally applicable. From the lessons learned and in consultation with local and international health providers and stakeholders, cultural adaptations were made to the CBT treatment. These modifications included translating the treatment into isiXhosa (one of the eleven official languages of South Africa), using comprehensible language and culturally appropriate examples and metaphors, and including psycho-education on the process of therapy, as talk therapy is culturally unfamiliar for some patients.

Due to the cultural context and the existent health system constraints, additional modifications are necessary when adapting a treatment program to the South African context. Given the shortage of mental health professionals in public health care in South Africa, task shifting to a more available cadre of health worker is often recommended as a sustainable solution in resource constrained settings (Petersen et al., 2011). In the current study, nurses were chosen as the treatment interventionists as this cadre of professional exists in all primary care sites where the treatment would ultimately be delivered.

A further implementation consideration when adapting an evidence-based treatment program to the South African context is the length of treatment. Standard CBT treatments implemented in high-income countries usually consist of 12–16 sessions. Due to resource constraints and the structural barriers faced by patients in South Africa, the implementation of 12–16 sessions is unfeasible in this context. The treatment length in the current study was therefore reduced to 8 sessions by removing the cognitive restructuring module. Andersen and colleagues considered that the time needed to train and supervise non-specialists in administering cognitive restructuring techniques might compromise the long-term feasibility of implementing this treatment in primary care. The finding in a non-inferiority trial that behavioral activation can be as effective as the full CBT package in treating depression further supported this decision (Richards et al., 2016).

A small pilot study of the culturally adapted, shortened, task-shifted CBT treatment (Ziphamandla) was then conducted. Two nurses administered between six and eight sessions of CBT to 14 isiXhosa speaking participants. All 14 participants reported improvements in their depressive symptoms and improvements in their quality of life and functioning posttreatment (Andersen et al., 2016). Exit interviews

conducted with participants 3 months after treatment completion supported the patient-perceived applicability and acceptability of the treatment. Given the promising outcomes, the next step is a large-scale, randomized controlled trial of the culturally adapted, task-shifted CBT treatment for adherence and depression in PLWH. This study is currently underway.

This South African-based research, as well as other studies, such as the one conducted by Rahman et al. (2008) in Pakistan, suggests that CBT can successfully be adapted to different cultural contexts when a rigorous, systematic approach to cultural adaptation is used. This approach has promising implications in South Africa where mental health treatment needs far outweigh available resources.

## Research on CBT in South Africa

There is currently a paucity of high-quality research on EBP, including CBT, in South Africa. An early review by Young (2009) identified mostly case studies (10) with only five randomized clinical trials (RCT) having been conducted on CBT between 1979 and 2009. The RCTs and case studies examined a variety of conditions and disorders. Of the five RCTs, one focused on reducing pain in rheumatoid arthritis patients, one on reducing Type A behavior patterns in salesmen; one on reducing anxiety, depression, and anger in adult survivors of childhood sexual abuse; one on behavioral seizure management in epileptic patients; and one on treating social phobia. Four of the five RCTs reported various degrees of success of the intervention. For example, an RCT that focused on reducing pain among rheumatoid arthritis patients reported no improvements. There were notable limitations in the studies described, including small sample sizes, the treatment not being administered in participants' first language, no blinding procedures, and little or no information on the treatment adaptation process.

Between 2000 and 2015, a 15-year period, only 16 randomized controlled trials of treatment effectiveness of psychotherapy was conducted in South Africa on depression, substance abuse, and anxiety in adults (Kaminer et al., 2017). Most of the studies occurred from 2010 onward indicating an increase in recent years of RCTs. Of these 16 RCTs, 8 of them contained some elements of CBT. Of these eight RCTs, two were group treatments for depression, four were individual treatments for substance abuse, one was a group treatment for substance abuse, and one was a group treatment for social anxiety. Although there were some promising findings of the effectiveness of these treatments, many limitations in the studies were evident. These included non-reporting of effect sizes, small sample sizes, outcome measures consisting solely of symptom severity measures, and little or no information on the treatment selection and adaptation process.

Since 2015, two RCTs of CBT have been underway in South Africa, both applied to special populations. One tested individual CBT for PTSD in adolescents and one tested individual CBT for adherence and depression among people living with HIV. Both of these studies will be described later in the chapter.

## CBT among Special Populations

### *CBT with persons living with HIV*

HIV/AIDS is a major health burden in South Africa. Over 7 million people in South Africa are estimated to be living with HIV/AIDS (PLWH), more than in any other country in the world (UNAIDS, 2016). Given the realities that PLWH in South Africa face, including chronic management of their condition, potential side effects of antiretroviral therapy (ART), and high levels of stigma, discrimination, and social isolation, it is not surprising that elevated rates of common mental disorders (CMD) have been documented in this population. In a study conducted by Freeman et al. (2008), 44% of a nationwide sample met criteria for a mental disorder, with depression being the most common. These rates of common mental disorders in PLWH are higher than in the general population (Herman et al., 2009). Yet despite South Africa's extensive HIV treatment program, i.e., the biggest ART program in the world (UNAIDS, 2016), mental health services have yet to be integrated into primary HIV care.

A few CBT studies have been undertaken with people living with HIV in South Africa. These studies have focused on the treatment of depression in adults (Ziphamandla), in the prevention of mother-to-child transmission (PMTCT), and in supporting HIV-infected adolescents.

Mamekhaya (Respect for Women) is a cognitive-behavioral intervention administered by mentor mothers to pregnant women newly diagnosed with HIV to assist with the management of the prevention of mother-to-child transmission of HIV (PMTCT) program (Futterman et al., 2010). In 2016, mother-to-child HIV transmission accounted for an estimated 12,000 new infections in babies (UNAIDS, 2016). To prevent women living with HIV from passing on the virus to their babies during pregnancy, childbirth, and breastfeeding, effective PMTCT programs have been successfully implemented in South Africa. However, PMTCT program success is dependent on multiple treatment compliant behaviors by the mother, including optimal ART adherence during pregnancy, optimal ART administration to the baby after birth, exclusive breast or formula feeding for 6 months after birth, and having the baby tested for HIV. The purpose of the Mamekhaya program is to aid in the management of these treatment compliant behaviors. The program consists of eight cognitive-behavioral group sessions focusing on the provision of education and support for healthy living, feeling happy and strong, partnering and preventing transmission, and parenting. The program was implemented and tested in a primary clinic in a peri-urban community outside Cape Town, and outcomes were compared to a control site, a neighboring clinic serving the same community. Mothers living with HIV in both conditions demonstrated high treatment compliant behaviors, including ART adherence for self and baby, exclusive breastfeeding, and having the baby tested for HIV. Also, participants reported greater improvements in their affect and demonstrated better HIV/AIDS-related knowledge than participants at the control site (Futterman et al., 2010).

Hlanganani (Coming Together) is a cognitive behavioral support group developed to assist adolescents newly diagnosed with HIV (Snyder et al., 2014). The support group model was adapted from the Mamekhaya project described above. The sessions focus on coping and support, HIV health, and HIV prevention and are administered by lay facilitators across three sessions. In the pilot study, adolescent participants who attended all three support group sessions ($n$=65) were more likely to attend their first ART visit and demonstrated improved attitudes toward HIV as a manageable disease compared to the comparison condition. Participants also described the intervention as applicable, acceptable, and beneficial.

The outcomes of these studies suggest that CBT could be an appropriate approach to managing health behaviors and treating mental health in HIV in the South African context. Not only were the study outcomes promising, but CBT was described as applicable and beneficial by study participants. Furthermore, those administering the interventions in these studies were all non-mental health professionals (i.e., nurses, mentor mothers, lay facilitators). The findings support the feasibility of task-shifting the provision of treatment to non-professionals, which has important implications in this resource-constrained setting.

## *CBT with Adolescents*

Within South Africa no population-based studies on the prevalence of psychiatric disorders among adolescents and children are available. The prevalence rates of mental disorders among children and adolescents in South Africa is estimated to be 17% (Kleintjes et al., 2006) and is among some of the highest in the world. Of all mental disorders, anxiety disorders are the most common among children and adolescents in South Africa (Rosenstein & Seedat, 2011). The occurrence of trauma is particularly high with exposure rates upward of 50% and PTSD prevalence rates as high as 6–22% (Kaminer & Eagle, 2010). Yet, little research has been conducted on child and adolescent mental health. Clinical trials on the effectiveness of psychotherapeutic interventions for the treatment of anxiety disorders in children and adolescents in South Africa are particularly sparse. In recent years, research on the effectiveness of trauma-focused CBT treatments for PTSD (PE-A and TF-CBT) in adolescents has been a welcome addition in South Africa.

Rossouw et al. (2016) conducted a small ($n$=11) pilot and feasibility study comparing prolonged exposure treatment for adolescents (13-18) diagnosed with PTSD (PE-A) with an active non-trauma-focused control group who received supportive counseling (SC). Treatment was administered by nurses in a school setting. Prolonged exposure consisting of psychoeducation, imaginal exposure (exposure to trauma memories and debriefing discussion that target change in trauma-related cognitions), and in vivo exposure (exposure to external triggers) in this small sample led to an improvement in PTSD symptoms with a very strong effect size ($d$=4.06) resulting in subclinical levels of PTSD symptoms posttreatment. These

improvements were maintained at 1-year follow-up ($d$=4.04). Cohen's d was used as a measure for effect sizes (a large effect > 0.8).

In the larger parent RCT ($n$=63) of the school-based, nurse-administered treatment of PTSD, PE-A was compared with SC (Rossouw et al., 2018). PE-A led to an improvement in PTSD symptoms posttreatment ($d$=3.81) with improvement being maintained 6-months posttreatment (d=4.38), resulting in subclinical levels of PTSD symptoms severity. PE-A also led to a reduction in depression symptoms to subclinical levels at posttreatment ($d$=3.18) and was maintained at 6-month follow-up ($d$=3.03). Finally, PE-A also led to an improvement in global functioning at posttreatment ($d$=2.71) with improvement being maintained at 6-month follow-up $d$=2.18).

A nested qualitative study of the stakeholders participating in the first year of the three-year active treatment phase of the main study was also conducted. The adolescent participants and nurse providers were interviewed about their perceptions of the psychotherapeutic interventions (PE-A and SC) (van de Water et al., 2018), and the nurse treatment providers and school coordinators were interviewed about the impediments and catalysts to task-shifting the treatments in a school setting (van de Water et al., 2017). The adolescent participants, who were mostly previously psychosocial treatment naïve, described both treatments as beneficial. The treatment providers (nurses) also reported that they perceived both treatments as applicable and they perceived both treatments as resulting in symptom improvement. The school coordinators spoke positively about their experiences of the treatment being provided at their school. This suggests that CBT as a treatment for PTSD in adolescents can feasibly be implemented in South Africa.

CBT has also been applied to assist with bereavement in adolescent girls in South Africa. Abangane (Friends) is a culturally adapted, group-based CBT treatment, administered by social workers, for bereavement using locally relevant stories, games, and metaphors. A RCT of the adapted treatment in 13–17-year-old girls ($n$=453) found that the CBT group had significantly lower scores for primary outcomes compared to the control condition posttreatment, including reductions in complicated grief (d=0.14), intrusive grief (d=0.21), and depression (d=0.21) (Thurman et al., 2017). Although the results seem promising, the effect sizes are low and could be accounted for by the large sample size. Replication studies are needed to ascertain the extent to which this culturally adapted group CBT treatment can assist with bereavement in adolescents in the South African context.

It appears that CBT can be successfully implemented with an adolescent population in South Africa. Not only does CBT have the potential to successfully treat PTSD and assist with bereavement in adolescents in South Africa, but also the treatment is perceived as acceptable and applicable to those administering and those receiving the treatment. Furthermore, it seems that nurse-administered CBT can be feasibly implemented in a school setting. These findings have promising implications for the future rollout of CBT for adolescents in South Africa.

## Conclusion

This chapter rests on the assumption that evidence-based psychological practice is an epistemologically and clinically correct approach in the world in general and in resource-constrained settings in particular. In the context of limited public funds to provide services to users of mental health care, it is necessary that those funds that are available are used effectively and efficiently, in such a way that patients may gain from treatment in a time-limited manner. CBT offers such an opportunity, given its considerable evidence base in treating a range of disorders, its time-limited approach, and the relative ease with which clinicians may be trained.

Promising findings are emerging suggesting that CBT can be effective in treating common mental disorders in South Africa and other low- and middle-income countries when adapted to the specific culture and context. Further research, particularly replication and implementation studies, are needed to strengthen the South African evidence base to inform local policy development. Furthermore, psychologists working in public health in South Africa need to be proficient in the application of CBT and EBP in treating common mental disorders. Universities training psychologists and psychiatrists need to commit to appropriate levels of training in CBT and EBP, and the Health Professions Council of South Africa (HPCSA) needs to ensure that training programs provide the necessary standards of training in these approaches. To aid in its growth, it may be helpful to establish an association for CBT in South Africa to develop training standards and provide certification. The association could also take the lead in ensuring the necessary collaboration between research and training programs at academic institutions, national and provincial health departments, and the HPCSA. This collaboration is critical if we are to improve access to effective mental health treatment in South Africa.

It is likely that ideological and theoretical objections to CBT will continue in South Africa, especially from the psychoanalytic and post-modern quarters, as has been the case in the past. Our concerns, however, are not ideological or theoretical. The clinical, ethical, and public health imperative is to address the considerable unmet need for psychological treatment in South African communities where common mental disorders are prevalent and where individuals are unable to afford psychological treatment. We believe that CBT has an important role to play in addressing this treatment gap.

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# Chapter 29
# Cognitive Behavioral Therapy in Spain


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## Country of Spain

Spain is a European country located in the Iberian peninsula, which borders with Portugal and the Atlantic Ocean on the west, with France on the north and with the Mediterranean Sea on the south and the east. The capital is Madrid, which is also the place where the Spanish Royal family lives and the base of the Spanish Government is located. Since 1982, Spain is a full member of the European Union. Over the last years, the population of Spain has stabilized around 46 million, of which approximately 10% are immigrants.

Spain has a rich and varied cultural heritage: Romans, Moors, and Phoenicians all lived and prospered in this territory in the past, strongly influencing the culture. With such a deep history behind the Iberian Peninsula, each region of Spain could easily be considered an independent country.

There is no doubt that the sixteenth century was Spain's "Golden Age," a period where Spain rapidly became Europe's most powerful country, with a huge empire: the world's first superpower with seemingly unlimited horizons. But the burden of the empire was too much and by the end of the seventeenth century, Spain started losing territories and powers. Eventually, at the end of the nineteenth century, Spain lost all its colonies.

During the twentieth century, after the Civil War between Monarchians and republicans, the general and dictator Francisco Franco (1892–1975) ruled over Spain from 1939 until his death. During this period, the general Franco persecuted political opponents, repressed the culture and language of Spain's Basque and

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Catalan regions, censured the media, and otherwise exerted absolute control over the country. Some of these restrictions gradually eased as Franco got older, and upon his death the country transitioned to democracy.

It is noteworthy to mention that the Spanish Civil War and the subsequent dictatorship had a negative impact on the development of Spanish culture, science, and technology. As for scientific psychology, the discipline was limited by the philosophical orthodoxy to the extent that it was considered a mere branch of philosophy. The only form of accepted psychotherapy was psychoanalysis. It is only during the 1970s and 1980s, largely due to progressist views, that behaviorism started to gain social interest, and by the end of the 1980s, the term cognitive-behavioral psychotherapy came to be accepted.

Despite Franco's dictatorial efforts to suppress any form of cultural and ideological differences, Spain is a country rich in diversity, in which different cultures and languages try to coexist. Presently, Spain is a constitutional monarchy, with a hereditary monarch and a parliament with two chambers: the House of Representatives and the Senate. The country is divided into 17 autonomous communities (regions), and all of them have their own directly elected authorities. In Catalonia, the Basque Country, and Galicia, the regional languages have official status alongside the national Spanish language, which is called Castilian. Noticeably, thought and political and economic conflicts still exist in Catalonia and Basque Country against the central government. Part of these populations is still striving to separate themselves from Spain and create different nations.

In consideration of religion, it is important to note that Spain is a secular country, but the Spanish Constitution guarantees freedom of religion. While 67% of the population is declared Catholic, only 20% of them attend church rituals on a regular basis, and this percentage is constantly diminishing. Curiously, approximately 20% of the population identify as Atheists or Agnostics (i.e., irreligious). This percentage is higher in urban areas where people tend to have higher educational attainment and increased income levels. It is probably because of the secularization process that started after Franco's regime period that psychotherapy is now broadly accepted within the Spanish population to treat mental diseases or improve their well-being.

## History of Cognitive Behavioral Psychotherapy in Spain

Cognitive behavioral therapy (CBT) is a type of psychotherapy that has its origin in the scientific investigation of the way thought and inferences affect emotions and behavior. Given that psychoanalysis was the first kind of psychotherapy, it would be convenient to describe its development in Spain first and describing the history of experimental psychology and CBT later.

Generally speaking, psychoanalysis is considered the first type of modern psychotherapy, i.e., a helping relationship between a person trained to treat mental disorders and a person with emotional and behavioral problems. Even though the publication of Freud's first ideas on psychoanalysis appeared very early in Spain

(1893), it did not attract a lot of scientific attention at that time. This was probably due to the fact that Spanish psychiatrists were strongly following the French psychiatry school, which considered mental diseases due to physiological defect of the nervous system that alienates the person from a normal functioning. In addition, the ideas proposed by psychoanalysis that mental malfunctioning causes emotional and behavioral problems were at odds with the dominant morality in a predominantly rural, Catholic country, where emotional and behavioral malfunctioning was explained in terms of immoral beliefs and sins. It was only in 1909 when the first extensive and documented writing on psychoanalysis by the psychiatrist Gayarre appeared in a Spanish clinical journal. However, in his publication, this author manifested a clear mistrust and criticized psychoanalysis based more on ethical and ideological aspects than on its theoretical contents (Mir, 2010). Likely, this could partially be explained by Ramony Cajal's discovery of that time about neurons as the basic unit of the nervous system (Carpintero, 2004). The discovery of this Spanish researcher strongly reinforced an organicist view of mental health. It was not until the second decade of the twentieth century that Spanish physicians began to accept psychoanalytic ideas (Glick, 1981). Clearly, the First World War and the outbreak of the civil war in Spain did not help to develop psychoanalysis in this country (Carpintero, 1984, 2004).

Scientific psychology is viewed as an important variable in the development of CBT in Spain. Psychology has a short history as an experimental science in Spain, but there have been several individuals who have had a profound influence and warrant recognition to the development of the field of psychology and more specifically psychotherapy and CBT. At the beginning of the sixteenth century, the humanist Juan Luis Vives (1492–1540) defended the idea of grounding knowledge of human functioning on experience rather than on metaphysical theories. Some centuries later, Simarro and Turró tried to introduce the experimental approach to study mental functioning in Spain. Simarro (1851–1921) founded the first laboratory of experimental psychology in Madrid (1902), although unfortunately there was no continuity after his death. In 1922 a laboratory of experimental psychology was also founded in Barcelona with the participation of the biologist Turró, a researcher who tried to study human behavior in scientific terms. Turró strongly believed that behavioral phenomena were subjected to the same laws as other phenomena of nature, and therefore, once we knew the variables that regulated them, their modification and control would be possible. He was aware of and influenced by the work of Pavlov studies and the theories of Bain and Spencer (Yela, 1987). In 1921, two other researchers, Mira and Lopez, praised the work of Watson, who tried to explain human behavior in a rigorous scientific way. In 1936, Mira and Lopez were to coordinate at the XII International Congress of Psychology that was to be held in Madrid but was canceled because of the start of the civil war. During the war, they went into exile (Carpintero, 1984, 2004).

The civil war (1936–1939) meant a serious crisis for the cultural and scientific institutions of Spain because it created a huge gap both in psychological research and in the training of psychologists between Spain and other countries (Carpintero, 1984). The end of the civil war brought with it disorganization and

underdevelopment of all the advances that had taken place in the field of mental health in the prior decades. Most of the leading scholars in this scientific field had to go into exile or were removed from their posts. For example, the Ministry of Health was abolished, and the organization and operation of health care became dependent on the premier of the government. Cultural and scientific activities returned to international isolation and political and religious control prevailed for many years (Marset, 1983).

Years after the civil war, psychology studies were resumed with a notable delay. Compared with other surrounding countries, Spanish practice and investigation in psychology have suffered from an unfortunate lack of continuity, mainly for political and cultural reasons. The first department of experimental psychology, and the first school of psychology were created at the Complutense University of Madrid in 1948 and 1953, respectively. In 1966, a professional school of psychology was also funded at the University of Barcelona. The degree in psychology was offered as a specialization within the faculty of philosophy and letters at the universities of Madrid and Barcelona in 1968 (Carpintero, 2004).

It was during the 1970s that behaviorism and psychoanalysis started to consolidate in Spain as forms of "psychotherapy" (Cruz, 1984). Since psychoanalysis was considered a nonscientific "psychotherapy," behavioral therapy was renamed as behavioral modification therapy. The first degree in psychology conferred, as a specialty in philosophy and letters, dates from 1973. In 1975, the implementation of behavioral modification as therapy in Spain became established. However, at the end of the 1960s, US behaviorism started to be criticized for not examining mental processes and the cognitive therapy movement began to spread (Neisser, 1967). It is interesting to remember, though, that Spanish behaviorism was strongly influenced by Eysenck's behavioral model (1992) and Wholpe's behavioral techniques (Wolpe & Lazarus, 1966) so that Spanish behavioral therapists have always been reluctant to give crucial importance to cognition over behavior. Noticeably, Bayes (1983) has pointed out that the behavioral crisis reached Spain only at the end of the 1970s, during the scientific meeting held in Madrid in 1979 on "current problems of scientific psychology."

Despite the aforementioned behaviorism crisis, the Spanish Association of Behavior Therapy (AETCO) was created in 1981 followed by the SCRITC, the Catalan Society of Research and Behavioral Therapy, in 1983 (Cruz, 1984). In 1984, the first national symposium on the importance of cognitive-behavioral therapies in infant-juvenile psychopathology was held in Malaga (Cruz, 1984). In this period, the contribution of Spanish researchers in CBT started to become evident. The crisis of behavioral psychology began to be noticed in Spain only at the end of the 1980s. Subsequently, with the emergence of cognitive theory, Spanish behaviorists became more indulgent and accepted the terms psychotherapy or cognitive-behavioral therapy (CBT). In 1989, the AETCO ceased its official activity, and the AEPC (Spanish Association of Behavioral Psychotherapy), which is currently located in Granada, was created (Cruz, 1984). In 1992, the FEAP (Spanish Federation of Associations of Psychotherapists) recognized the ASEPCO (Spanish Association of Cognitive Psychotherapies), an association located in Barcelona that

brought together senior and trainee psychotherapists with a cognitive-constructivist orientation.

All in all, Spanish CBT, especially AEPC associations have progressively gained importance to the point of organizing the "30th European Congress of Behavioral & Cognitive Therapies" in Granada 2000 (Cruz, 1984).

## The Profile of the Psychotherapist in Spain

At present, the profile of psychology professionals in Spain is unusual. In fact, in Spain, there is no official register of psychologists working in the clinical field, and there is no single training path to be a psychologist. Furthermore, the figure of the general health psychologist (described below) is still recent.

Having the knowledge to describe the profile of psychotherapists in Spain would provide information on the number of psychologists, whether they work in the public or private sphere, the problems they usually deal with, the psychological orientation or model of intervention they follow, and to what degree is research applied toward clinical practice.

There have been a few studies of the professional characteristics of psychologists in Spain over the past few decades that highlight some important findings as they relate to practice. In their study of 606 psychologists, Díaz and Quintanilla (1992) described the professional as typically a female (67.8%) with an average age of 35 years, with a cognitive-behavioral orientation and 9 years of clinical experience. They also reported that clinical psychology was the second-highest area of dedication in psychology behind education. Santolaya et al. (2002) surveyed 6700 psychologists, while the gender and age breakdown was similar to the Díaz and Quintanilla study, clinical psychology was now the main area of dedication (68.36%); and among the clinicians, the majority reported that they were working in a private setting with a preferably cognitive-behavioral orientation (49.08%).

The Psychotherapy Division of the General Council of Psychology (COP) was created in 2014 for unifying, at a national level, the professional field of psychotherapy. They developed the "Survey on Psychotherapy in Spain" (Labrador & Berdullas, 2017) to analyze the profile of the psychotherapist. According to this survey, the profiles of the majority of psychologists were a 52-year-old woman with a master's degree. As there is no regulated path to access the title of psychologist specialist in psychotherapy, training as a psychotherapist was found to be quite varied. One third had completed a master's degree, another third had gone through a 2-year private training program, and the other third had not had regular or regulated training. In training as psychotherapists, the majority (85.7%) reported to have taken clinical case treatments under supervised training.

The summary of respondents training in psychotherapy led the authors to conclude that the overall profile was that of a psychologist with 6 years of training and who had been supervised in more than 25 cases by other experts. Most psychologists have more than 20 years of experience (52%), are self-employed (88.5%) and

combine it with a public or private institution. Regarding the continuous training of the psychotherapist, 90.8% have received training in psychotherapy in the last 7 years which typically involves 150 hours a year, and many reported this training be done through a face-to-face mode (45.3%). Many also reported that they received additional training through attendance at courses (90.8%) and conferences (88.2%). In consideration of the number of cases treated per year, 45% of respondents indicated that they typically worked with fewer than 50 cases. The difference in the number of cases attended is related to whether or not you work in a public institution. In terms of length of treatment, the average duration of treatments is usually 23 sessions for 10.8 months. Regarding the effectiveness of treatment, regardless of clinical orientation, respondents indicated that 38% of the cases have completely improved and 29% have a significant improvement of 75% with only 14% not improving or stopping treatment. The average cost of treatment per session is 62 euros, and the average of the entire treatment is 805 euros.

When asked to identify which clinical approaches were used, 66.8% of respondents indicated that they used a CBT model in their treatment. This was followed by a systemic (42.4%), humanistic (39.8%), and psychodynamic model (34.9%). Respondents were able to indicate more than one clinical approach, but it is notable that CBT is endorsed as an approach used by over 2/3 of the respondents. Regarding the treatment modality, 97.2% used individual therapy, 64.2% used family therapy, and 41.5% group therapy. The majority of psychologists (85%) work with adults, and 5.2% report doing with children and adolescents also. This group of children and adolescents is treated mainly by psychologists who work in children's schools and hospitals.

In terms of the main disorders reported to be treated by respondents, more than 70% of cases are anxiety disorders (GAD, panic attack/agoraphobia, OCD, PTSD or stress, social anxiety, and specific phobia), mood disorders (depressive disorders, other mood disorders), adaptive disorders, and personality disorders. The majority of psychologists (80.9%) follow the guidelines and intervention protocols based on empirical evidence and consider that the practice of psychotherapy must follow the criteria of effectiveness, and efficiency (79.3%).

Despite the fact that most psychologists teach courses (90.2%), only 5% write scientific or dissemination articles, books, or treatment guides. Perhaps it is the weakest point of the practice of psychotherapy in Spain.

## Current Regulations Regarding Psychotherapy Provision in Spain

Psychology as a behavioral science has the objective of improving the health (physical, mental, and social well-being), safety (in traffic, justice, prisons, etc.), and /or performance of people (educational, job, sports, etc.) and needs to be regulated and authorized by the government to guarantee good practice.

There are many laws and regulations (general law of public health) that regulate the professional practice of psychotherapy such as:

- Law 43/1979, of December 31, on the creation of the official college of psychologists.
- Law 44/2003, of November 21, on the organization of health professions.
- Law 5/2011, of March 29, of the social economy. Section 2 of the sixth additional provision.
- Law 33/2011, of October 4, general of public health. Seventh additional provision on the regulation of psychology in the health field (modified by the final provision eight of Law 3/2014 on the defense of users).
- Royal Decree 183/2008, of February 8, which determines and classifies the specialties in health sciences and the relevant aspects of the specialized health training system.

Psychology in Spain is configured in four professional categories (Infocop, 2014) as explained below. The first is not a health professional (e.g., the psychologist who works in organizations and companies); the other three are health professional (and they can be qualified, general health, and specialist):

1. Psychologist: Graduated in psychology (bachelor by the university). It is the most basic level that qualifies as a psychologist by the government but has no recognition as a health professional. This title reflects that the individual has developed all the psychological competences in the social, business, sports, and education field except those that involve intervening in the health field. That is, they cannot provide intervention or psychotherapy.
2. Psychologist Qualified with Health Training: Graduated in psychology with a specific training in clinical and health psychology or has a clinical postgraduate training of 400 hours (of which at least 100 are practical). They can practice psychology in the health field as a counselor, except in the national health system (e.g., they cannot work in public hospitals).
3. General Health Psychologist: Graduated in psychology with the official master's degree in general health psychology. They can develop their professional activity on their own or on other institutions in the health sector by conducting research, evaluations, or psychological interventions whenever specialized care is not required. Here with this title, one can practice psychology in the health field, except in the national health system. The general health psychologist is comparable to the training of psychologists in Europe established with the European Certificate of Psychology EuroPsy (http://www.europsy.cop.es) issued by the European Federation of Psychologists' Associations (http: //www.efpa.eu), which implies a university preparation of 5 years plus 1 year of supervised practice and which offers a generalist level of preparation, without specialization. It is established by the government that the general health psychologist has the training of a degree in psychology (4 years), plus the master or degree in general health psychology (year and a half of training, of which half a year must be

supervised practice). So, the general health psychologist has a total university education of 5 years, plus half a year of practice.

4. Psychologist Specialized in Clinical Psychology: Graduated in psychology with the official title of psychologist specialist in clinical psychology. You can practice psychology in all health sectors such as public or private hospitals. The official title of specialist psychologist in clinical psychology is obtained through specialized health training through the residency system in hospitals (PIR), which is convened annually by the Ministry of Health. A little more than a hundred places per year are offered by the government (https://www.boe.es/boe/dias/2018/09/14/pdfs/BOE-A-2018-12537.pdf), a selection exam is required, and those who obtain the positions, after completing a period of 4 years of supervised professional practice and passing the evaluations, obtain the official title of psychologist specialist in psychology clinic, issued by the Ministry of Education. Foreign psychologists who come to practice in Spain can obtain the homologation of these degrees by the procedures that are officially established by the Ministry of Health (http://www.mecd.gob.es/alemania/reconocimiento-titulos/para-extranjeros.html).

Degrees in psychology, as well as the official master's degree in general health psychology, are offered by Spanish Universities.

In addition, in order to practice psychotherapy in Spain, one must be a member of an official association of psychologists. In Spain, there are 23 associations that can be found on the website of the General Council of Associations (https://www.cop.es).

In Spain, psychologists who wish to train as psychotherapists will first have to finish the degree or master's in general health psychology, which is taught exclusively by Spanish universities and whose main objective is to prepare students as professionals in general health psychology. It is necessary to have this degree or master's in general health psychology to work as psychotherapist in a public and private area. It is an applied, advanced, and specialized training in conceptual, procedural, technical, and attitudinal knowledge that allows professionals to develop in the field of the general health psychology and also includes clinical practice.

The master's degree in general health psychology programs usually have a duration of 90 ECTS credits (European Credit Transfer System). The requirements for the verification of the official university master's degree in general health psychology is established by the Order ECD/1070/2013 (https://boe.es/buscar/doc.php?id=BOE-A-2013-6412), indicating the minimum conditions that must be fulfilled by the study plans to be taught by the universities, and its contents are structured in two academic courses distributed in modules as follows:

I. Basic module: the scientific and professional foundations of health psychology
II. Specific module:

- Evaluation and diagnosis in health psychology
- Intervention in health psychology
- Training in basic skills of the general health psychologist

III. Module of external practices
IV. Master's end work module

Once they have obtained this qualification of basic theoretical-practical competences, psychologists can train and specialize in different types of therapies (cognitive-behavioral, psychoanalytical, humanistic, gestalt, etc.) or clinical applications (sexual disorders, couple therapy, therapy with children and adolescents, addiction therapy, etc.).

## Professional and Cognitive Behavior Therapy Organizations in Spain

Psychologists usually are working in a private setting with a preferably cognitive-behavioral orientation (Labrador, & Berdullas; 2017; Santolaya et al., 2002).

The training in CBT is not exclusive of the universities, and they are able to complete these through a number of associations or public and private centers approved by an official association of psychologists or the General Council of Psychology (COP).

The *Spanish Federation of Associations of Psychotherapists* (FEAP, http://www.feap.es) is a nongovernmental organization, created according to the legal framework of Article 22 of the Spanish Constitution, the Law of Associations of December 24 (1964), being a private legal entity of public and social interest, nonprofit, which brings together the scientific-professional associations of psychotherapists in Spain.

The association and organizations to promote knowledge and training of cognitive-behavioral therapy (CBT) among psychology professionals have been proliferating over the years since the late 1980s to the present. Nowadays, the main Spanish associations in cognitive-behavioral therapy are the following.

- **Spanish Association of Rational Emotive Behavior Therapy (AETREC)**

The *Spanish Association of Rational Emotive Behavior Therapy* (AETREC, http://www.aetrec.org), recognized by the government, has been established without profit and with the aim of disseminating, researching, developing, and applying the theory and practice of rational emotive behavior therapy (REBT) in different areas of health, education, and labor relations. Among the founding members are Dr. Leonor Lega, Francesc Sorribes, Montserrat Calvo, and José Luis Trujillo from the Institut RET in Barcelona (http://www.institutret.com), the official Spanish training center associated at the Albert Ellis Institute in New York (http://albertellis.org).

Its main aims are to promote research, studies, and training in rational emotive behavioral therapy (REBT), disseminate knowledge of REBT approaches in psychotherapy, and contribute to the training and updating of professionals in rational emotive behavior therapy. Since 2010, AETREC has provided training and

organized the first and only master's degree in REBT and CBT, with international certifications provided by the Albert Ellis Institute, specialization courses, workshops, and supervision of clinical cases.

- **Spanish Association of Cognitive Psychotherapies (ASEPCO)**

The *Spanish Association of Cognitive Psychotherapies* (ASEPCO, http://www.terapiacognitiva.net) brings together psychotherapy professionals and psychologists in training cognitive-constructivist orientation. Cognitive psychotherapies have enjoyed since their inception a broad scientific and social recognition, at the same time that they have been evolving from strictly rational positions towards more constructivist positions. These psychotherapies are represented by the works of Aaron Beck, Albert Ellis, Michael Mahoney, Donald Meichenbaum, Leslie Greenberg, Bob Neimeyer, and Vittorio Guidano.

Among the most outstanding activities of ASEPCO is the formation, conferences, and publications, aimed at research and study of the theoretical and technical modalities of cognitive therapies.

- **Spanish Association of Cognitive Behavioral Clinical Psychology (AEPCCC)**

The *Spanish Association of Cognitive Behavioral Clinical Psychology* (AEPCCC, https://sociedadeuropeadepsicologia.com), registered in the *European Society of Psychology*, was created by professionals of psychology with the objective to become a professional resource of the psychological field which has a greater presence in the main Spanish cities. In terms of training, the AEPCCC organizes different master's degrees and other specialist degrees, courses, conferences, and other scientific acts related to clinical psychology that are aimed at psychology students and active clinicians.

- **Spanish Association of Behavioral Psychology (AEPC)**

The *Spanish Association of Behavioral Psychology* (AEPC, http://www.aepc.es), founded in 1989, is a nonprofit scientific association and aims (among others) to promote the development of knowledge and education in the area of cognitive behavioral psychology and the relationship with national and international homologous societies and organizations and organize meetings of a scientific nature.

From its beginnings until today, it has organized and held more than 80 activities and meetings of a scientific and educational nature in which important international figures have participated such as Wolpe, Eysenck, Barlow, Kazdin, Hayes, and Mahoney. The AEPC is a fully consolidated scientific association, and it organized the "30th European Congress of Behavioral and Cognitive Therapies" in Granada (September 2000). Nowadays, AEPC offers a wide variety of specialized training courses, postgraduate training, and degree programs in CBT.

## Training Opportunities in CBT

There are a number of main centers or associations of psychology in Spain that offer specialized training in cognitive-behavioral therapies. The organizations described below are not to be considered to be the sole ones and an exhaustive list but rather highlight some of the training opportunities available in Spain in CBT.

- **Master's degree Program in Rational Emotive Behavior Therapy (Institut RET, Institute of Rational Emotive Behavior Therapy) – Barcelona**

The Master in Rational Emotive Behavioral Therapy (http://www.institutret.com/formacion), directed by Francesc Sorribes, provides specialized psychological training in the theory and practice of rational emotive behavior therapy (REBT) developed by Dr. Albert Ellis (Ellis, 1962), while also integrating the contribution of other cognitive-behavioral approaches to the model. The program follows the guidelines indicated by the Albert Ellis Institute of New York. The modality of training can be face-to-face and online. The students see clients and they get supervision.

The duration of the program is 2 years in length and consists of 348 training hours structured in two academic courses distributed in modules as follows:

Module 1: Theoretical-practical introduction – 40 hours
Module 2: Clinical conceptualization – 40 hours
Module 3: Clinical applications I – 94 hours
Module 4: Clinical applications II – 124 hours
Module 5: Clinical applications in children and adolescents – 24/50 hours
Module 6: Special clinical applications

Certification: Master's in Rational Emotive Behavior Therapy is issued by the Institute of RET and recognized as of interest for the profession of psychology by the Official Association of Psychologists of Spain (COPC) and by the Spanish Association of Rational Emotive Behavior Therapy (AETREC).

- **Master's degree in Contextual Therapies (MICPSY, Madrid Institute of Contextual Psychology) – Madrid**

The Master's degree in Contextual Therapy (https://micpsy.com), directed by Carmen Luciano, offers specialized training mainly in the therapy of acceptance and commitment (ACT; Hayes et al., 1999), as well as analytical-functional psychotherapy (FAP) and mindfulness techniques. The duration of the program is 12 months with approximately 600 hours organized in presencial (face-to-face) and online modules.

Certification: Master's degree in Contextual Therapies issued by MICPSY.

- **Master's Cognitive-Social Therapy (UB, University of Barcelona) – Barcelona**

The Master's degree in Cognitive-Social Therapy (http://www.ub.edu/tpia_cognitivosocial/mtcsc/mtcsc.htm), directed by Dr. Guillem Feixas and Dr. Manuel

Villegas, established in 1990 offers training in psychotherapy from a cognitive-constructivist and systemic perspective, aimed at developing basic knowledge and therapeutic skills in the areas of individual, group, family, and couple intervention, to work in the field of psychotherapy. The master's degree follows the guidelines indicated by the European Association for Psychotherapy (EAP), the Spanish Federation of Psychotherapist Associations (FEAP), and the Spanish Association of Cognitive Psychotherapies (ASEPCO). The duration of the program is 3 years, with a total of 90 ECTS credits (European Credit Transfer System) organized in 10 modules. The modality is face-to-face.

Certification: Master's Degree in Social Cognitive Therapy issued by the University of Barcelona.

- **Master's Degree in Cognitive Behavioral Psychotherapy (ISEP, Institute of Psychological Studies) – Barcelona, Madrid, and Valencia**

The Master's Degree in Cognitive Behavioral Psychotherapy (https://www.isep.es/curso/master-en-psicoterapia-cognitivo-conductual/), directed by Raimon Gaja, aims to enable students to learn the appropriate technical and personal skills that all psychologists need to develop an effective and responsible professional psychotherapeutic practice under a cognitive-behavioral approach. The duration of the program is 16 months with a total of 60 ECTS credits (European Credit Transfer System) organized in 13 modules. The modality can be face-to-face and/or online.

Qualification: Master in Cognitive Behavioral Psychotherapy issued by ISEP and recognized as of technical-professional interest by the Ibero-American Federation of Psychological Associations and Societies (FIAP) and by the Official Association of Psychologists of the Valencian Community.

- **Master of Clinical Practice (AEPCCC, Spanish Association of Cognitive Behavioral Clinical Psychology) – Barcelona, Madrid, Valencia, Seville, Granada, Malaga, Murcia, Oviedo, Palma de Mallorca, Salamanca, Santiago de Compostela, San Sebastian**

The main objective of this Master of Clinical Practice (https://sociedadeuropeadepsicologia.com/formacion/master-de-practica-clinica) is to prepare the psychologists who seek to specialize in the cognitive-behavioral treatment of the main disorders that are usually treated. The duration of the program is 60 ECTS credits (European Credit Transfer System) organized in 13 modules. The modality can be face-to-face and/or online.

Certification: Master's in Clinical Practice issued by the AEPCCC.

- **International Master's in Clinical Psychology (AEPC, Spanish Association of Behavioral Psychology) – Granada**

The International Master's in Clinical Psychology (http://www.aepc.es/web2/) was created in 1993 by the Spanish Association of Behavioral Psychology (AEPC) and is organized by the Institute of Clinical Psychology and Health (ISPCS). The training program aims to train psychologists in evaluation, treatment, prevention, and promotion of health, as well as training in the field of research and teaching.

The duration of the program is 600 hours, 90 ECTS credits (European Credit Transfer System). The modality is semi-face-to-face.

Certification: Master's in Clinical Psychology issued by ISPCS and recognized by the AEPC.

- **Master's in Clinical Psychology (CETECOVA, Behavior Therapy Center) – Valencia**

The Master's in Clinical Psychology of the Behavioral Therapy Center (http://www.cetecova.com/master-en-psicologia-clinica-en-valencia-nueva-edicion-31-promocion) is a postgraduate training course whose objective is for students to learn the technical and personal skills that every psychologist needs to perform a professional clinical practice. The teachers are recognized cognitive-behavioral therapists, with great experience and clinical practice. The duration of the program is 660 teaching hours. The modality is face-to-face.

Certification: Master's in Clinical Psychology issued by CETECOVA and recognized as of scientific-professional interest by the Official Association of Psychologists of the Valencian Community.

## Adaptation of CBT in Spain

Although, in Spain during the 1980s, behavioral therapy (BT) was found to be effective for the treatment of anxiety-related disorders (Marks, 1986; Foa, 1992; Becoña & Gutierrez-Moyano, 1987), the role of cognitive processes began to be seriously considered for the treatment of mood-related disorders (Bragado Carrasco, 1987; Perez & García Montes, 2001; Vallejo, 1995). It is during the 1990s that psychotherapists started to combine BT with cognitive treatments. Indeed, both therapies, behavioral and cognitive, have proved to be the most successful and have been scientifically supported with studies of anxiety disorders, phobias, obsessive, sexual, and mood disorders (Bados et al., 2002; Barraca, 2005; Becoña et al., 2004; Echeburúa, 1998; Echeburúa & Corral, 2001; Guimón, 2004; Perez et al., 2003). However, in many studies it has been argued that the effectiveness of these therapies is due more to their behavioral components than to the cognitive ones (Mayor & Labrador, 1984; Pelechano, 2007). Thus, for example, Albert Ellis, pioneer of cognitive restructuring and cognitive therapy, decided to add the word "behavioral" to rational emotive therapy. In this way, "cognitive therapy" must always be referenced as cognitive behavioral therapy in Spain (Salaberría et al., 1996).

The BT never disappeared from Spain due to the great influence in Spain of the English behavioral approach of Hans Eysenck and Isaac Marks (Frías & Pascual, 2003). Likely, this is one of the reasons why, while the BT applications of Skinner's work, were introduced by Dr. Ramón Bayés, the psychotherapy based on behavioral engineering was directly introduced by Hans Eysenck (gradual exposure and the prevention of response) and the systematic desensitization directly by Wolpe. They were very successful in the early treatment of anxiety disorders. As we previously

said, in Spain, the practice of psychotherapy has mainly followed the English model, especially in public and scientific health, while private health psychotherapy has always been more heterogeneous, i.e., different approaches and models (Becoña, 1999). Given the strong influence of the English BT model, it's reasonable to say that CBT Spain adaptation emphasizes very much the behavioral aspect of it. Actually, in Spain, Levinshon and Rehm's protocols to treat depression have been largely employed (Perez & García Montes, 2001), and, at present, the behavioral activation therapy is considered one of the preferential therapies for this disorder in our country. These examples show the importance of the behavioral approach in CBT therapies in Spain.

Finally, it should be noticed that in Spain, Beck's cognitive therapy has been developed mainly in colleges or universities and hospital centers of the national health system, probably because their studies were published in international scientific journals. In contrast, rational emotive behavior therapy (Ellis) has been more developed in private practice, thanks to the spread of his published self-help books (Becoña, 1999).

## Research on CBT

In Spain, CBT has been scientifically proven to be the most effective therapy in the treatment of adults (Pascual et al., 2004). Research in CBT is carried out mainly in public universities. Most of the results of these studies are replications and are mainly disseminated in journals written in Spanish. The University of Barcelona is one of the primary CBT research centers of Spain. Current CBT topics under investigation at the University of Barcelona are the treatment of depression, anxiety, and traumatic disorders (Bados, 2010; Bados et al., 2012), eating disorders, and the efficacy of CBT in the treatment of mental disorders (Ferrer Garcia et al., 2015; García-Grau et al., 2010). For instance, Bados et al. (2007) found that the CBT dropout rate in Spain is like the rate in other countries. Moreover, they also found that there are patients who leave therapy earlier because they believe they are doing well, not only because they do not feel an improvement.

It is also worth mentioning the creation at the University of Barcelona in 2010 of the Experimental Virtual Environment (EVE): this is a virtual reality laboratory created by Professor Mel Slater, aiming at studying cognitive processes in a virtual reality context. In addition, the research group "Applications of New Technologies in Clinical Psychology," at the University of Barcelona and guided by Professor José Gutiérrez Maldonado, makes use of virtual reality to create virtual environments with the purpose of applying them to the treatment of different psychological issues and for the training of professional skills, such as psychological interviews (Maister et al., 2015). In a study on aggressive behavior, Seinfeld et al. (2018) found that changing aggressive people's perspective with immersive virtual reality can improve their empathy skill and, consequently, reduce their aggressive attitude. In another interesting study, Hansler et al. (2017) found that making persons

experiencing a different virtual race (e.g., black or Arab) can change their attitudes toward that different race.

Another interesting Spanish research group dealing with CBT and the application of new technologies is led by Professor Cristina Botella of the Jaume I University of Castellón. Since the 1990s, the Laboratory of Psychology and Technology (Labpsitec) has been studying the incorporation of the new Information and Communication Technologies (ICTs) to the clinical and social fields in order to improve human well-being as well as life quality (Opris et al., 2012). Across several studies, Botella's research group shows that virtual reality exposure therapy (VRET) is effective in the treatment of specific phobias as well as in the treatment of anxiety disorders.

At the University of La Laguna in Tenerife, Professor Wenceslao Peñate deals with topics such as depression, anxiety, and phobias and has also conducted the validation of different diagnostic tools in psychology from a CBT perspective (e.g., the Schwarzer and Jerusalem's General Self-Efficacy Scale). At the University of Santiago de Compostela, the Research Group on Mental Health and Psychopathology (GRISAMP) has created XUNTO, a psychological and psychiatric care private center, which is considered an important mental health center in Galicia. Interestingly, GRISAMP has also developed a cognitive-behavioral program based on mindfulness to treat depression.

Since 2005, the Complutense University of Madrid houses the research group named "Psychological Treatment of Stress Related disorders." Some areas of interest of this group are posttraumatic stress disorder caused by domestic violence, essential hypertension and the relationship between personality and hypertension, and, finally, the psychological treatment of addictions.

Finally, it is worth mentioning the research activities of the private center of rational emotive behavioral therapy, Institut RET, of Barcelona. It is a center affiliated with the Albert Ellis Institute of New York. In this center, CBT investigations have been occasionally carried out in collaboration with other Spanish institutions as well as with the New York Institute (e.g., Bertacco et al., 2008, 2011; Sorribes et al., 2010; Trujillo et al., 2010). For instance, in a correlational study, Bertacco et al. (2008) found that high demandingness attitude and low self-esteem were strongly positively related with both drugs abuse and sex drive.

## CBT with Special Populations in Spain

Beyond the initial interventions that focused on clinical work with anxiety disorders and phobias, obsessive disorder, and depression, CBT has been applied to many other types of populations in Spain.

To begin with, CBT is being used in Spain to treat severe mental disorders. Specifically, it is used for the rehabilitation of schizophrenia and also in the intervention of acute psychosis (Labrador et al., 2000). As for the treatment of obsessive-compulsive disorder (OCD), the behavioral model of exposure with response

prevention is still used, and significant contributions were made to adapt it for the childhood by Josep Toro (Labrador et al., 2000). In the treatment of personality disorders, Beck's cognitive therapy model and the REBT model of Ellis have been used, except for the borderline personality disorder in which the dialectic-behavioral therapy of Marsha Linehan has been used more (Becoña et al., 2004). As for addiction disorders and other more complex disorders, the interventions used in Spain have often been combined (Becoña & Gutierrez Moyano, 1987), such as stimulus control, problem-solving, and cognitive restructuring for coping with craving symptoms. To work on addicts who are in a pre-contemplative stage (Prochaska & DiClemente, 1983), motivational interview is the choice in Spain. However, for those patients who are in stages of preparation or action (Prochaska & DiClemente, 1983), REBT is probably the treatment of choice.

CBT, mainly based on the protocols developed by Christopher Fairburn and Janet Treasure, has been established as the therapy of choice in Spain for the treatment of eating disorders (Becoña et al., 2004).

In clinical work with disorders often seen in children, behavioral contingency therapy has been the therapy of choice, although in recent years, a cognitive model of REBT developed by Ann Vernon and others has been used.

Another important area of CBT application is the treatment of medical and physical problems. More specifically, CBT is frequently used to improve "behavioral habits" related to certain causes of health diseases, such as high blood pressure, myopia, HIV, cardiovascular problems, obesity, cancer, people in a palliative state, neuropsychological rehabilitation, diabetes, chronic pain, etc. (Echeburúa, 2008). These interventions are known in Spain as "psychology of health," "psychotherapy of health," or "behavioral medicine."

Another area of intervention of psychotherapy that has emerged in Spain is the intervention in emergencies and catastrophes situations; in particular after the attacks in New York, London, Paris, Madrid, and Barcelona. However, given that there is still not a strong unified conceptual framework to psychologically work within this area, it is believed that more research on the application of CBT is warranted.

One of the areas in which CBT has been proven to be effective has been in the area of mental health and immigration (Echeburúa et al., 2005). After the Olympics Games in Barcelona 1992, our country has been the destination of many immigrants from many countries. Exile and uncertainty, loss, and adaptation are contributing factors for depression and anxiety, and CBT in Spain has been the therapy of choice, due to the simplicity of its application.

Finally, it should also be noticed that when dealing with posttraumatic stress disorders (PTSD), most of the Spanish psychotherapists use eye movement desensitization and reprocessing (EMDR) of Francine Shapiro (Becoña et al., 2004). Importantly, this technique combines, to some degree, both cognitive restructuring with imaginal exposure.

## Conclusion

Spain was one of the first European countries where Sigmund Freud's innovative ideas on psychotherapy were translated. Nonetheless, their divulgation was stopped mainly by the outbreak of civil war and the dominant national-catholic ideology (Duro, 1993; Mir, 2010). It is only during the 1970s, i.e., at the end of Franco's dictatorship, that psychology and psychotherapy dissemination resumed. In 1975, Spain organized the fifth Annual Congress of the European Association of Behavior Therapy (EABT) and in 1977 Bartolomé et al. published *The Practice of Behavior Therapy*, which is considered the first book on behavioral therapy written by Spanish authors (Cruz, 1984). Afterward, the behavioral model has been consolidated so quickly that by 1986 most of the Spanish clinical psychologists were classified within the behavioral model (Avila, 1989).

An important aspect of the Spanish healthcare system is that it changes greatly across different regions because Spanish regions are independent in the way they implement the general guidelines of the central government. Therefore, there are regions where specialized services, such as psychotherapy, are only delivered by private institutions, and others where psychotherapy is delivered within the public healthcare network. Besides these regional differences, it should be remembered that, in order to practice psychotherapy, all Spanish professionals must be members of the official association of psychologists. Furthermore, they must either achieve a formation named PIR to work in the public system or, since 2011, qualify as a general health psychologist (GHP) by taking a 2-year official master's degree in health psychology that enables practice in the private field.

Most of the Spanish psychotherapists have a CBT orientation. Application of the CBT in Spain is more influenced by English than by American psychology, and therefore it is more behaviorally than cognitively oriented. Moreover, it is important to remember that, in general, Spanish universities do not offer any specific CBT training, which is offered by a combination of public and private institutions. These institutions organize courses, conferences, and congresses. Today, there is a wide range of different training programs in CBT such as rational emotive behavioral therapy or acceptance and commitment therapy. All in all, despite the initial delay in the dissemination of modern psychotherapy, Spain must be considered a country where CBT is flourishing.

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# Chapter 30
# Cognitive Behavioral Therapy in Switzerland

**Yasser Khazaal, Eleni Kalogeropolou, Jerôme Favrod, Ueli Kramer, and Françoise Jermann**

## Overview of Switzerland

Switzerland, the Swiss Confederation, is a federal state in Europe with four main languages: German, French, Italian, and Romansh. Its population in 2017 was more than 8 million (FSO, 2017). As one of the rare direct democracies in the world, it was formed from the union of 26 cantons, which enjoy a high level of autonomy from the federal government (FDA, 2017), including the management and organization of their own health care services.

## History of Psychotherapy in Switzerland

Switzerland is among the countries with the highest density of psychotherapists worldwide (Hofmann, 2017). Different specialists, such as psychiatrists and psychologists, are frequently involved in psychotherapy. Other professional healthcare providers (e.g., nurses), although not registered psychotherapists, also contribute to the field by incorporating psychotherapeutic components into their practices. Such involvement, however, mostly depends on individual and local initiatives.

In Switzerland, basic health insurance is mandatory for everyone, with social welfare frequently providing the insurance costs for those who cannot afford to pay. Basic insurance to some extent covers psychotherapeutic treatments delivered by psychiatrists or psychologists, in accordance with specific rules. Much debate is currently taking place regarding enhancing accessibility to psychotherapy and,

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more specifically, to psychotherapeutic interventions organized and delivered by psychologists.

For over 50 years, Swiss specialists in psychiatry have comprised psychiatrists and psychotherapists. During their residency, future psychiatrists undergo specific psychotherapy training in one of three areas: cognitive and behavior therapy, systemic therapy, or psychodynamic therapy. Probably facilitated by Swiss openness to diversity, these three main approaches are well developed. For instance, one institute in Lausanne University is in charge of promoting teaching and research that involves all three approaches. Since the 1990s, however, cognitive behavior therapy has been growing in Switzerland (Despland & Berney, 2012), with a particularly dynamic research field.

## Professional and Cognitive Behavioral Therapy Organizations in Switzerland

There are three cognitive and behavioral therapy associations in Switzerland (Table 1): the Swiss Association for Cognitive Psychotherapy, the Swiss Society of Cognitive and Behavioral Therapy, and the Switzerland Working Group on the modification of behavior.

***APSCO*** The Swiss Association for Cognitive Psychotherapy (in French: Association Suisse de Psychotherapie Cognitive [ASPCO]), created in 1994 at Yverdon-les-Bains, brought together psychiatrists and psychologists who wanted to improve their knowledge and share their experiences with cognitive and behavioral therapy. The initial goals of the association were to promote cognitive behavioral therapy (CBT), encourage the study and creation of links between different aspects of CBT, stimulate interaction between professionals, develop national and international contacts, and offer continuous training possibilities.

In 1996, ASPCO created a CBT training course consisting of clinical workshops conducted by experienced local or international psychiatrists and psychologists. Since 2003, this course has been part of the continuous training program of Geneva University and offers two types of training: the *Diploma of Cognitive and Behavioral*

**Table 1** Cognitive and behavioral therapy associations in Switzerland

| |
|---|
| Association Suisse de Psychotherapie Cognitive - Swiss Association for Cognitive Psychotherapy<br>Official address: Rue du Conseil-Général 12, 1205 Genève. www.aspco.ch |
| Arbeitsgemeinschaft Verhaltensmodifikation Schweiz (AVM-CH)Official address: c/o Stiftung (AK15), Bürozentrum, Collègegasse 8, Postfach 4164<br>CH- 2500 Biel/Bienne. www.avm-ch.ch |
| Schweizerische Gesellschaft für kognitive Verhaltenstherapie Société Suisse de Thérapie Comportementale et Cognitive<br>Official address: Weihergasse 7, 3005 Bern, Switzerland. www.sgvt-sstcc.ch |

*Therapy*, psychotherapist training for psychiatrists and psychologists, and the *Certificate of Cognitive and Behavioral Strategies*. The latter, designed for other health professionals (e.g., nurses, social workers, educators), is not psychotherapy training but provides CBT tools to help professionals work better with their clients in health care relationships. From 1996 until present, eight students have completed their training. In 2005, ASPCO also started a *supervisor training* course, and 4 supervisors have completed their training. Furthermore, ASPCO encourages CBT research activities by organizing scientific meetings and congresses and by awarding prizes for the work of CBT trainees.

Other activities by ASPCO include the following:

- Workshops: ASPCO organizes five to six workshops per year with local and international speakers in order to promote new developments and provide continuous training.
- Congresses: ASPCO participates in organizing different congresses (e.g. 7th International Congress on Constructivism in Psychotherapy, Geneva 2000; EABCT 42nd Annual Congress, Geneva 2012; 1er Colloque Francophone de Pratiques en TCC, Lyon 2015; 2ème Colloque Francophone de Pratiques en TCC, Geneva 2018).
- Annual Swiss Romandie Meeting of CBT: For the last 6 years, ASPCO has organized an annual meeting of CBT in Swiss Romandie.
- Scientific coffee meeting: ASPCO organizes this annual event in order to promote exchanges between researchers and clinicians and encourage collaborations and progress on CBT.
- Website: The website keeps members updated about the association's activities and provides CBT material (e.g., videos, psychotherapy sheets, book recommendations)
- Newsletter: The newsletter keeps members updated about association activities and future projects.
- Psychotherapy groups: Groups are organized to provide clinical psychotherapy experiences required for students.
- Supervision: Group supervision is provided to members on a weekly basis.
- Trained CBT therapists: ASPCO provides the public with a list of these therapists.
- Promotion of international and national contacts: ASPCO is a member of the European Association for Behavioral and Cognitive Therapies (EABCT), the Société Suisse de Psychiatrie et Psychothérapie (SSPP), and the Fédération Suisse des Psychologues (FSP).

## *Swiss Society of Cognitive and Behavioral Therapy*

This association (in French: Société Suisse de Thérapie Comportementale et Cognitive: SSTCC) was founded in April 1978 and took on its current form as an umbrella association of CBT in Switzerland in 2002. It works to bring together all

who are interested in CBT in Switzerland and collaborates with local university institutions for psychology and psychiatry.

The goals of the SSTCC are to propose psychotherapy interventions, protect the professional interests of psychologists and psychiatrists, facilitate collaboration and exchange of clinical theoretical experiences on an international and national level, promote continuous training toward the title of a psychotherapist, organize training courses and seminars, and encourage public relationships. Furthermore, SSTCC provides the public with a list of trained CBT psychotherapists.

### *Switzerland Working Group on the Modification of Behavior*

This group (in German: Arbeitsgemeinschaft Verhaltensmodifikation Schweiz: AVM-CH) is a nonprofit association of behavioral therapists based in Biel. The association's aims are to provide training in behavioral therapy and medicine, promote behavioral psychotherapy in different aspects of health care (prevention, treatment, rehabilitation, research, public relations), and collaborate with institutions and organizations with similar goals. AVM organizes training events, collaborates with SSTCC, and promotes international congresses on CBT. Furthermore, it provides the public with practical information on CBT, offers help in finding a local behavioral therapist, and publishes reviews of books and films.

## The Field of CBT Research in Switzerland

Different research groups are actively involved in CBT research in Switzerland. The present chapter illustrates only some such developments. Before describing these works in more detail, we refer the reader to other important areas of research launched in Switzerland, particularly in several fields such as integrating emotion-focused components into a CBT (Babl et al., 2016), couple relationship education (Zemp et al., 2017), anxiety disorders (Borgeat et al., 2009; Berger et al., 2017; Fluckiger et al., 2016), gaming (Khazaal et al., 2013), and Internet and smartphone app interventions adapted from CBT (Klein et al., 2018; Schaub et al., 2015; Monney et al., 2015; Khazaal et al., 2018).

## CBT with Specific Clinical Populations

### *CBT for Patients with Schizophrenia*

Social skills training started to be used in the 1980s and disseminated in the 1990s. The University of California, Los Angeles, skills training programs (Liberman & Eckman, 1989), such as the medication management program, symptoms self-management, basic conversation skills training, friendship and dating, and interpersonal problem-solving skills, were translated into German and French and made available to clinicians to promote the dissemination of these methods (Favrod et al., 2009; Roder et al., 2009; Schaub et al., 2009; Tempier & Favrod, 2002; Favrod et al., 1996). At the same time, the team of Hans Brenner in Bern developed a structured intervention program called integrated psychological therapy that prescribes steps to remediate cognitive and behavioral dysfunctions that are characteristic of the psychopathology of schizophrenia (Brenner et al., 1992; Roder et al., 2006; Pomini et al., 1998).

Cognitive behavioral therapy for psychosis (CBTp) was initially used in the 1990s and disseminated in the 2000s. A game called Michael's game was useful for stimulating the use of CBTp in routine clinical practice (Khazaal et al., 2006, 2011). A collaborative group game, Michael's game consists of 80 cards, wherein each card corresponds to a situation that the central character, named Michael, has experienced. Michael asks himself questions about the encountered situations, jumping to conclusions that lead to a delusional interpretation of the situation. The objective of the group of patients is to answer Michael's questions or to discuss the validity of his interpretations and help Michael find an alternative interpretation of the situation. Each card contains questions that guide the participants through progressive stages in order to formulate alternative hypotheses to Michael's. Participants also have to identify the behavioral and emotional consequences of the different alternatives generated. Some cards guide the participants to build behavioral experiments to test the hypothesis. The game is supervised by two caregivers, nurses, social workers, psychologists, or peer practitioners. The results of a randomized controlled study (Khazaal et al., 2015) that compared Michael's game with treatment as usual showed that at 3 months, a positive treatment effect was observed on the conviction subscale of the 21-item Peters et al. Delusions Inventory (PDI-21). At the 6-month follow-up, a sustained effect was observed for the conviction subscale. Further effects were also observed at the 6-month follow-up on the PDI-21 distress and preoccupation subscales, as well as on the measure of belief flexibility of the Maudsley Assessment of Delusions Schedule.

### *Metacognitive Training Program*

The metacognitive training (MCT) program, developed by Moritz et al. (Moritz & Woodward, 2007), is a new way of approaching the psychological treatment of psychotic symptoms. The principal goal of MCT is to make patients aware of and to reduce cognitive biases. Cognitive biases are preferences or response tendencies in the processing of information that operate as triggers for delusional experience. From a cognitive experimental viewpoint, metacognition refers to the general capacity to think about thinking, which generally includes awareness of one's own mental processes, the fallibility of one's own thought, the ability to infer emotions from others' faces and prosody, and the cognitive understanding of the ideas, beliefs, and intentions of other people. The MCT program trains participants to become aware of, and to take into account in their everyday life functioning, cognitive bias associated with psychosis, such as attributional biases, jumping to conclusions, incorrigibility, theory of mind, overconfidence in memory errors, and negative cognitive schemata. The program consists of two cycles of eight modules. Each module is administered during a 1-hour session to a group of 3 to 10 patients. The program is composed of a manual and slides. MCT is currently available in more than 30 languages and can be downloaded freely via the following web address: http://www.uke.de/mct. A randomized controlled study (Favrod et al., 2014) involving participants with schizophrenia-related disorders in Switzerland showed that between-group differences in post- and pre-test values were significant at a medium effect size in favor of MCT for the delusion scale of the psychotic symptom rating scales and the positive scale of the positive and negative syndrome scale, both at post-test and 6-month follow-up. Selected participants for this study showed only a partial response to antipsychotic medication. The results indicate that MCT has a surplus and sustained antipsychotic effect for patients with schizophrenia-related disorders.

### *Positive Emotion Program for Schizophrenia*

Recent literature has distinguished the negative symptoms of schizophrenia associated with a diminished capacity to experience (apathy, anhedonia) from those associated with a limited capacity for expression (emotional blunting, alogia). The apathy–anhedonia syndrome tends to be associated with a poorer prognosis than do the symptoms related to diminished expression, suggesting that it is the more severe facet of the psychopathology (Strauss et al., 2013). The Positive Emotions Program for Schizophrenia (PEPS) was developed to improve the diminished expression syndrome in schizophrenia (Nguyen et al., 2016). The program teaches skills to help overcome defeatist thinking and to increase the anticipation and maintenance of positive emotions. PEPS involves eight 1-hour group sessions, administered by using visual and audio materials as part of a PowerPoint presentation of slides projected onto a screen. A pilot study was conducted with participants who met the

ICD-10 criteria for schizophrenia or schizoaffective disorders (Favrod et al., 2014). Thirty-one participants completed the program; those who dropped out did not differ significantly from completers. Participation in the program was accompanied by statistically significant reductions in the total scores for avolition–apathy and anhedonia–asociality on the scale for the assessment of negative symptoms, with moderate effect sizes. Furthermore, there was a statistically significant reduction of depression on the Calgary depression scale for schizophrenia, with a large effect size. Emotional blunting and alogia remained stable during the intervention, suggesting a specific effect on the diminished capacity to experience syndrome. The original program in French can be downloaded freely on the Internet at www.seretablir.net/peps/. It was designed to be easy to use and applicable to in-group sessions so as to meet the needs of community care psychiatry. The first results of a randomized controlled study indicate that PEPS is effective in reducing the apathy-avolition and anhedonia-asociality composite scores on the scale for the assessment of negative symptoms for participants with schizophrenia-related disorders (Favrod et al., 2018).

## Mindfulness for Mood Disorders

For more than 20 years, mindfulness has appeared in the field of CBT. Mindfulness corresponds to paying attention to the moment with a particular attitude, namely, with curiosity and without judgment. In the field of CBT, some researchers have incorporated mindfulness elements into their approaches, such as Marsha Linhean in dialectical behavior therapy (Lau & McMain, 2005), while others, such as Zindel Segal, Mark Williams, and John Teasdale, have developed mindfulness-based cognitive therapy (MBCT) (Farb et al., 2018) for the prevention of depressive relapse that is largely based on mindfulness. MBCT is a program that combines mindfulness meditation with elements of cognitive and behavioral therapy.

Concerning depressive relapse, a crucial point for someone who has had depressive episodes in the past, unlike those who have never experienced this condition, occurs when the individual experiences a transient drop in mood, which can happen at any time. At this moment, the patterns (associations between mood-emotion-negative thoughts) that were present during the past depressive episode might be reactivated automatically. This phenomenon is less likely to happen if the person has never had a depressive episode in the past (differential activation hypothesis) (Teasdale, 1998). In the context of depressive relapse prevention, mindfulness offers the opportunity to become aware very early of the first signs of this reactivation. When this is observed, cognitive and behavioral strategies are possible paths for responding to mood swings rather than reacting automatically and slipping into relapse.

Specifically, MBCT is a group intervention of eight sessions and a day or a half-day of silence. It is intended for people who are no longer depressed when they join the group but who want to work to prevent depressive relapse. During the group

session, participants gradually become familiar with mindfulness meditation, become aware through cognitive therapy exercises that thoughts are not facts, and identify which action plans might be activated when needed.

### *Personality Disorders*

According to the current recommendations issued by the Swiss Society for Psychiatry and Psychotherapy (Euler et al., 2018), the treatment of patients with borderline personality disorder may involve several modalities, with dialectical-behavior therapy (Linehan, 1987) as the one garnered with the most convincing empirical evidence. Switzerland has contributed to its validity with several studies, in particular with a study on mechanisms of change in DBT skills group training (Kramer et al., 2016) which showed that the increase of patient's use of assertive anger over the course of DBT skills training mediated its effect in terms of reduction of specific problems related with their social and professional role. According to Rudge et al. (Rudge et al., 2017), this study has received 25 out of 28 quality points of all studies conducted worldwide on the question of mechanisms of change in DBT. A second randomized controlled trial validated the effects of an integrative case conceptualization for borderline personality disorder: in this trial, one condition received psychiatric management, and the other the same augmented with an individualized case formulation (according to the Plan Analysis methodology) (Caspar & Ecker, 2008). The results demonstrated small outcome advantages favoring the individualized condition (Kramer et al., 2014) and showed that the decrease in behavioral coping strategies (i.e., patient's use of specific dysfunctional actions to cope with their stress or emotion) between sessions 1 and 5 into the treatment mediated the outcome effects of the individualized treatment (Kramer et al., 2017).

## CBT Research in Switzerland: An Example in the Application of Mindfulness

An example of research in the field of CBT in the French-speaking part of Switzerland can be illustrated by the developments at the Geneva University Hospitals in the field of mindfulness in the last 15 years. In the area of CBT, the development of mindfulness-based approaches has been a turning point. After behavioral and cognitive interventions, CBT has progressively included experiential strategies, and this has led to an exponential growth in the scientific literature. More specifically, in the field of depressive relapse prevention, the publication in 2002 of the MBCT book *Mindfulness-Based Cognitive Therapy for Depression: A New Approach to Preventing Relapse*, by Zindel Segal, Mark Williams, and John Teasdale, was decisive (Segal et al., 2013).

Guido Bondolfi and Lucio Bizzini, a psychiatrist and a psychologist practicing in the French-speaking part of Switzerland, who specialize in psychotherapy and are experts in the treatment of depression, have taken a close interest in the development of MBCT for the prevention of depressive relapse. In 2002, they participated in the first meeting organized by the authors of the MBCT book in the USA. Two research studies were published by the founders of MBCT, which showed that it reduces the risk of relapse by half in patients who have experienced more than two depressive episodes and therefore are at high risk of relapse (Kuyken et al., 2016). As is often the case with research in a non-English-speaking country, the first step was translating the work to allow the proposed therapeutic material to be used in another linguistic context. Thus, the original book was translated into French (2006). At the same time, the Geneva team submitted a request to the Swiss National Science Foundation to carry out a study on depressive relapse prevention with MBCT, and a research fund was awarded in 2005 for the project, "Mindfulness-Based Cognitive Therapy for the Prevention of Relapse in Depression: A Study of Its Efficacy and Its Effects on Cognitive Functioning and the HPA Axis." Thanks to this funding, the Geneva team was able to conduct a randomized controlled study aimed at evaluating the effectiveness of MBCT in a French-speaking population with instructors (therapists) who were not the founders of the method (Bondolfi et al., 2010). The study also allowed the study of the cortisol awakening response in patients recovering from depression (Gex-Fabry et al., 2012; Aubry et al., 2010) and the impact of MBCT on cognitive functioning (Jermann et al., 2013).

Over the years, the accumulated clinical and research expertise in the field of mindfulness has steadily increased. Several studies have been conducted to validate French questionnaires that enable us to assess mindfulness (Nicastro et al., 2010; Jermann et al., 2009) and to evaluate the interest in mindfulness in other clinical populations (Weber et al., 2012; Perroud et al., 2012; Weber et al., 2017). Given the widely recognized benefits of mindfulness, an exciting development for the coming years will be to extend clinical and research expertise in this area to those who care for patients. Our hope for the future: a mindful health staff for a mindful health service.

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# Chapter 31
# Cognitive Behavioral Therapy in Turkey


**M. Hakan Türkçapar, Kadir Ozdel, and A. Emre Sargin**

## Turkey Overview

Being located in a place where most essential elements were discovered and most important figures who changed the direction of humanity lived, today's modern Turkey has certainly taken advantage of its rich cultural, historical, and geopolitical accumulation. Indeed, home to many cultures between east and west, Mesopotamia and Balkan peninsula, ancient Persians and Greeks, many aspects in the history of mankind had the chance to originate from Anatolian peninsula from the first agricultural practice and many agricultural products (fig, wine, etc.) to one of the first settlements and the first temples (Curry, 2008; Turkey's Fauna, n.d.).

Besides the biological and cultural diversity, ancient Anatolian soil has witnessed many physicians who had significant effects on mankind. One of the first powerful individuals of the Anatolian peninsula were the Hittites who reigned between 1700 BC and 1200 BC. Hittites had much less information about medicine compared to Egyptians or Mesopotamians. The treatment used to be based on praying, magical practice, and herbs. Only 22 tablets describing medical practice have survived today (Yalcin et al., 2016).

After the Hittites collapsed, many great civilizations flourished. The area of today's Turkey has been inhabited by Assyrians, ancient Greeks, Thracians, Phrygians, Lydians, and Urartians, respectively. After Alexander the Great, Asia Minor was Hellenized which is followed by Romans and Byzantines. During that

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period, Anatolia has witnessed many historical figures who influenced or even "started" the history of medicine. Hippocrates was one of these influential figures who, for the first time in history, attributed mental disorders to natural causes instead of demons. After Hippocrates, Galenus and Arateus were the prominent physicians who tried to bring rational/empiric explanations to mental disorders (Ozkan, 2012).

With the coming of the Turks in the eleventh century, the Seljuks Turks built institutions as early as 1206 where there was mental and physical care (Ozkan, 2012). The first asylums were opened in the fifteenth century where mental patients were treated with music (Ozkan, 2012). But it took as long as 400 years for the first neuropsychiatric unit to open in 1898 (Ozkan, 2012). 1927 was another turning point when Mazhar Osman, the founder of modern psychiatry in Turkey, moved the old and out-of-fashion asylum to the modern Bakirkoy mental hospital (Ozturk, 2004).

Today Turkey is the most crowded country after Russia and Germany with a population of 80,810,000 in Europe and increasing 1.28 % every year, making the country one of the youngest countries in Europe. Healthcare in Turkey is subsidized mostly by the government. Government-financed social security institution pay covers about 80% of the total health expenses. Although increasing year by year, the costs paid to the private hospitals are still under the European average (Hurriyet, 2013; Yanik, 2007)

Mental disorders are also in common in Turkey just like in Western countries. According to the Mental Health Profile Study which was conducted in five regions with 16550 individuals in 1998, 17.2% of the population had at least one mental disorder during the preceding year. The percentage of problematic behavior in children and adolescents was found to be 11%. Individuals tend to apply to a psychiatrist most (39 %) in the first place. Specialists other than psychiatrists like neurologists and general practitioners were the second and third choices of the individuals who had psychiatric complaint (33% and 21%, respectively). The three disorders with the highest contact rates were panic disorder, obsessive-compulsive disorder, and somatization disorder (Erol et al., 1998).

According to the study conducted to detect the disease loads and distribute them in respect to basic disease groups, psychiatric disorders are found in second place with 19 % disease load right after cardiovascular diseases. The same study also states that there are 5 psychiatric disorders in the top 20 in males and 4 psychiatric disorders in the top 20 in females in the years lost disability (YLD) list. Unipolar depression was placed second in males and first in females causing 146.608 and 276,576 years lost to disability, respectively. Alcohol-related disorders, schizophrenia, bipolar affective disorder, and panic disorder were also the main psychiatric disorders who caused years lost disability (Alatas et al., 2011).

The number of psychiatrists in Turkey is 1625 according to 2011 figures, of which 25% work in the private sector. Compared to other European countries, Turkey is in the last place having only 2.20 psychiatrists per 100,000 population (Alatas et al., 2011).

There are 1370 psychologists working actively. The number of psychologists per 100,000 population is 1.85, being the lowest rank in Europe (Alatas et al., 2011). But after 2001, due to an increasing number of universities giving graduate

psychology education, there are 6770 students in 90 psychology departments (Sumer, 2016).

The number of social workers is 613, and the number of social workers per 100,000 is 0.92. The number of nurses working in the mental health field is 1677, which is again ranked last in Europe (Alatas et al., 2011).

In the world there are three different service models in the mental health field. These are a hospital-based model, a community-based model, and the community-hospital balanced model which is the synthesis of the first two (Thornicroft & Tansella, 2002).

The "hospital-based model" was in use from the 1800s to the 1960s. The hospital-based model can be summarized as outpatient service, treatment of patients who are having acute episodes, and taking care of patients who are not able to live on their own for a very long time (e.g., 50–60 years of age) (Yilmaz, 2012). The hospital-based model might be suitable for patients who have acute episodes; however, it has the disadvantage of insufficient monitorization of the patient after discharge and that patients are isolated from society.

During the 1960s, the hospital-based model was abandoned and the community-based model was adopted. In this model, World Health Organization (WHO) advises to transfer mental health service from central government to the local municipalities, leaving central government only responsible for planning and controlling (decentralization), establishing small units in the community instead of huge health establishments (deinstitutionalization), integrating the psychiatric services to the general health system, and having psychiatry clinics in the general hospitals instead of separate establishments (Yanik, 2007).

Until the 2000s, Turkey was practicing the hospital-based model but in the last decade the mental health system has undergone big changes. In the national mental health policy text which was declared in 2006, it was emphasized that for a better mental health service, a community-based model needs to replace the hospital-based model, and integration of the system to the general health and family physician system, carrying out community-based rehabilitation service, legislation about mental health, campaigning against the stigmatization of mental patients, more education, research, and human power, needs to be accomplished (Soygur, 2016).

According to the new model, decreasing the number of beds in large mental health hospitals, some of which have over 700 beds, and opening 16–20 bed small psychiatry inpatient units in the local/general hospitals is planned. It was also declared that the country will be divided into geographical regions with a population of 100,000–300,000 people and community mental health centers in each region with a total of 236 centers to be opened. Each center consists of a psychiatrist, psychologist, psychiatric nurse, social worker, occupational therapist, and attendant staff. The team is mobile and gives service in the living environment of the patient if necessary. The center is generally outside of a hospital establishment with a separate building. The team is structured in terms of duties and responsibilities. Every single patient has an individual treatment plan recorded. The main idea of this system is monitoring and treating patients in their living environment. Thus, it is aimed to prevent the isolation of the patient while in treatment (Alatas et al., 2011).

Besides medical treatment, individual and group therapy, social skill/assertiveness training, psychoeducation, and family education are given in these centers, and the mobile unit consisting of a psychologist, a nurse, and a social worker makes home visits to check the patient (Ensari, 2011).

Besides the establishment of these centers, other aims of the ministry of health are increasing the number of psychiatrists, psychologists (both graduate and postgraduate), social workers, psychiatric nurses, occupational therapists, and psychological counselors all of which are in the last rank compared with the other European countries, increasing the number of general psychiatry beds from 8 to 13 per 100,000 people, increasing the number of forensic psychiatry beds, opening high secure psychiatry hospitals making necessary legislative regulations, and establishing a mental health code.

## History of Psychotherapy in Turkey

Psychology and psychotherapy in Turkey, as everywhere else, have a long past but a short history. In Anatolia mainland of modern Turkey, there are only 22 tablets left from Hittites, but among these tablets, probably the first psychotherapeutic intervention in history can be found. According to that tablet, a female doctor organizes a religious ceremony to the male patient who probably has impotence. It is told that the patient was first taken to a room in full moon, and while praying he was given a spindle and a ball of string, and then the female physician hails to the patient "I am now taking the spindle and the ball of string which are the symbols of femininity from you and I am giving you bow and arrow which are the symbols of masculinity. You will leave the symbols of femininity back in this room and walk out of here as a man!!" Unfortunately, the result of the intervention was not mentioned in the tablets (Yalcin et al., 2016).

Long after the Hittites, Asklepion – the most famous one was in Pergamon – may be considered as the first mental health institution. In these institutions, patients were treated with dream interpretation, music, and incubations.

Psychology as a modern science discipline is still young. After all, Wundt's Laboratory of Experimental Psychology, as we all know, was only founded in Leipzig in 1879. Forty years after Wundt's laboratory was established, the scientific teaching of psychology and psychological experiments has been included in the curriculum of Istanbul University. 1915 seems to have been a good year for psychology in Turkey. In that year psychology was also introduced into teacher training institutions, a book on child psychology was published – the first of its kind in Turkey – and the famous Binet-Simon Test of Intelligence was translated into Turkish a year earlier than its American version (Beglân, 1956).

For, in 1915 as part of a plan to reform Istanbul University (then the only University in Turkey) and bring it into line with other Western Universities, 20 guest professors from Germany were invited to join the staff. They started teaching in newly established chairs at Istanbul University, in scientific human subjects, such as

economics, archaeology, early history, comparative philology, and psychology which were also fortunately established. Professor Anschutz from the University of Hamburg was appointed to the newly established chair of psychology where he started to teach psychology as an experimental science as was done in Germany at the time. He had brought apparatus with him from Germany and started to conduct experiments with his students at his laboratory.

Although he has inspirations from many physicians like F. Anton Mesmer, Hippolyte Bernheim, and Wilhelm Wundt, it was Sigmund Freud who is credited with establishing the essentials of modern psychotherapy. The Turkish doctor Izzettin Sadan was corresponding with Freud himself as early as the 1920s. Although Turkish physicians have been very interested in psychoanalysis, it took more than 60 years for the Turkish psychodynamic-oriented psychotherapists to complete their institutionalization process. The first psychoanalysis association was founded in 2001 in Istanbul (Erten, 2016). For a long period between the 1960s and 1970s, psychoanalysis was the main paradigm of mental health professionals. During those years "psychotherapy" meant psychoanalytic therapy in Turkey. Although a great theoretical interest in psychoanalytic theory in Turkey, its use as a psychotherapy in real life is very limited.

Behavior therapy had been a neglected psychotherapy in Turkey between 1950 and 1980. For example, none of Skinner's books have been translated into Turkish. The only behaviorist book which was translated into Turkish was Ivan Pavlov's *Conditioned Reflexes* in 1967 as a publication of Istanbul University. In the 1980s, the interest in behavioral therapy began to increase in Turkey. This behavioral therapy movement started at university training hospital's psychiatry clinics, in which psychologists and psychiatrists were working together, such as Istanbul University and Hacettepe University in Ankara. Because of this lateness of behavior therapy, the cognitive therapy movement started quickly in Turkey about 10 years after the behavior therapy movement.

In a worldwide scale, cognitive behavioral therapy (CBT) came into use about 40 years after psychoanalysis and became very popular in the 1980s among mental health professionals. This resulted in enrichment of the model and more evidence of the effectiveness of cognitive therapy (CT) in many disorders such as anxiety disorders (panic disorder, social phobia, obsessive-compulsive disorder, generalized anxiety disorder, posttraumatic stress disorder), personality disorders, eating disorders, somatoform disorders, and psychosis. Another result was probably the first of its kind: integration of two psychotherapy models. The integration of two evidence-based treatments and behavioral and cognitive approaches generated cognitive behavioral therapies (CBT) (Turkcapar & Sargin, 2012). Turkey was influenced by these developments in the 1990s. In parallel to these developments, cognitive therapy was gaining more popularity and was ranking among the topics which drew academic attention most in conferences. The first symposium in Turkey was organized in 1989 which was about the cognitive therapy model of anxiety disorders. Aaron T. Beck was an invited speaker for the National Psychology Congress in the beginning of the 1990s. The first organized and competent course was organized in April 1992 under the title "Intensive Course in Behavioral and Cognitive Therapies"

in Hacettepe University Ankara. The main figures of this CBT movement were Isik Savasir and Perin Yolac from Hacettepe University, Psychiatry Department, and Nesrin Hisli Sahin from Ankara University.

In 1995, a cognitive behavioral psychotherapy association was founded in Ankara (Association of Cognitive and Behavioral Therapies-KDTD), in collaboration with psychiatrists (Mehmet Sungur, Hakan Turkcapar, Haluk Ozbay, Ugur Yuregir), and also psychologists (Isik Savasir, Perin Yolac). In 2001, the 31st European Association of Behavioral and Cognitive Psychotherapies (EABCT) Congress was organized in Turkey. In 2006, KDTD moved the headquarters from Ankara to Istanbul, and the first national congress of cognitive and behavioral psychotherapies was organized by KDTD in Istanbul in 2007.

With the increasing number of psychiatry residents and psychology graduate students, and the enormous interest in the cognitive and behavioral psychotherapies, a second national association, Bilissel Davranisci Psikoterapiler Dernegi – BDPD (Association for Cognitive and Behavioral Psychotherapies-ACBP) was founded in Ankara in 2010. One of the most important contributions that ACBP-T brought to the Turkish mental health professionals community is disseminating the CBT trainings to many regions of Turkey. Up until 2010, CBT trainings were given only in Istanbul and Ankara, but as the demand is increasing, CBT theoretical and supervision training is now given in many cities such as Izmir, Antalya, Adana, and Gaziantep. The purpose of this dissemination is to give a standardized and structured CBT education which is approved and accredited by international associations like the Academy of Cognitive Therapy (ACT), Albert Ellis Institute, and EABCT.

## Current Regulations Regarding Psychotherapy Provision

The current healthcare system in Turkey is regulated by a law dating back to 1928. Although several changes have been made, the law is not sufficient to meet the expectations of the mental health system or to make clear some controversial issues like involuntary hospitalizations. Today the healthcare system in Turkey accepts psychiatrists as the main element in treatment procedures. Psychologists, psychological counselors, psychiatric nurses, and social workers are accepted as auxiliary staff, and they can only work under the supervision of a psychiatrist.

Since there is no separate mental health law, the definition of psychotherapy and who is licensed to do psychotherapy is lacking. In their 4 years of residency, it is a privilege for psychiatry residents to have a satisfactory education of any kind of psychotherapy. It is also the same for psychology students and psychological counselors. Psychiatric nurses were accepted as a title in 2012 in Turkey, and there are only some 100 psychiatric nurses who are working mainly in the university hospitals. This gap in psychotherapy service results in mental health professionals enrolling in private courses in big cities such as İstanbul and Ankara, but this brings another question into mind: Who is going to get accredited by whom and under which standards? The three main international institutions EABCT, ACT, and Albert

Ellis Institute have good reputations, and professionals seek to get the accreditation by them. There are many private courses who claim to accredit professionals, and none of these courses are controlled in terms of their quality of education; if they have a qualified trainer or supervisor, etc. This also brings another problem: Since there are no controlling bodies, people who have graduated from departments like sociology or philosophy also take these courses and obtain the so-called certificate, or they apply and complete a master's degree in applied psychology and introduce themselves as psychotherapists.

In the National Mental Health Action Plan which includes the projections between 2011 and 2023, it was planned to have a mental health law by the year 2015. After 2 years of delay in December 2017, the related nongovernmental organizations which are representing psychiatrists, psychologists, psychological counselors, and social workers had agreed on a draft text and asked the opinions of its members. In Spring 2018 the draft is on the waiting list of the National Assembly to be put on the agenda. However, a mental health bill has not yet been discussed in the parliament as of today.

When we look at what the draft regulation mentions about psychotherapy, we see that the law empowers the following to practice psychotherapy:

– Adult psychiatrists and child-adolescent psychiatrists (they are two individual residency programs in Turkey)
– Mental health professionals with a master's degree, who completed the theoretical and supervision training during their education and had also apprenticeship and/or working experience in clinical/mental health settings

These mental health professionals are allowed to provide psychotherapy if they are working within the boundaries, authorization, and competencies of their training and professional fields (Turk Psikiyatri Dernegi Ruh Sagligi Yasa Tasarisi Taslak Metni 2018)

Although not accepted by the parliament yet, this draft has brought several controversies in the mental health community in Turkey. First, unlike many other countries, psychotherapy is considered a medical intervention rather than a psychological intervention. Second, although it was mentioned that both adult and child-adolescent psychiatrists have the right to provide psychotherapy, it was not mentioned what kind of training they have to undergo, if any. In many European countries and in the USA, completing a residency training does not give one authorization to provide psychotherapy. Under these circumstances it is very certain that if these criteria are accepted, the number of mental health professionals will be very small in a country which is already in need of many types of mental health professionals.

Lastly, the law draft does not make any clarifications about how and by whom mental health professionals will be accredited. However, it is stated that regulations will be made by the Ministry of Health. This leads to criticisms by the nongovernment organizations stating that it would be more appropriate for the related professional associations to make the accreditation themselves (Aktuel Psikoloji 2018).

## Professional and Cognitive Behavior Therapy Organizations

The first association in the field of psychology in Turkey was the "Psychology Association" established in Istanbul in 1956. Throughout the 1970s, with the increasing need for psychological services, it was noticed that there were a number of occupational requirements of those working in the field. The Association of Psychologists (PD) was established in Ankara in 1976 to meet these needs and to be organized. In 1996, the Association of Psychology in Istanbul and the Association of Psychologists in Ankara joined the Association of Turkish Psychologists (TPD) in order to establish a more functional and united society.

Providing unity, solidarity, and professional solidarity among the employees in the field of psychological counseling and guidance, an association was founded in 1989 with the name of Psychological Counseling and Guidance Association (PDR-DER).

Another important mental health association in Turkey is the Psychiatric Association of Turkey (PAT) which is the organization of specialists and residents of adult psychiatry. PAT was instituted as a mono-specialist association in 1995 by four former psychiatric societies, some of which dated back to 1914 (Turkish Neuropsychiatric Society, Turkish Society for Mental and Neurological Health, Society for Specialists and Trainees in Psychiatry, Izmir Psychiatric Society). Due to its constitutional commitments, the PAT aims to provide and promote the scientific development of psychiatry in accordance with ethical standards in clinical practice and research. The PAT also aims to improve psychiatric training, patient rights, and treatment standards and to develop and follow-up on mental health policies and implementations in Turkey.

## CBT Associations in Turkey

In the 1990s, cognitive behavioral psychotherapy became popular among young psychiatrists and clinical psychologists. The first CBT association KDTD formed at that time. Today in Turkey, there are two CBT associations. The older "Kognitif ve Davranis Terapileri Dernegi-KDTD" (Association of Cognitive and Behavior Therapies – ACBT), which is based in Istanbul, and the second newer one Bilissel Davranisci Psikoterapiler Dernegi – BDPD (Association for Cognitive and Behavior Psychotherapies, ACBP) which is based in Ankara.

KDTD was founded in 1995 by Mehmet Sungur, Isik Savasir, Perin Yolac, Ceylan Das, Buket Erkal, and Haluk Ozbay. The first president of the association was Mehmet Sungur, and some members of the first board including Perin Yolac, Ceylan Das Tugrul, M. Hakan Turkcapar, Mehmet Akif Sayilgan, and Gonca Boyacioglu Soygut also served as first trainers of KDTD. KDTD joined EABCT in 1996 with about 40 members. Members of ACBT mainly consist of psychiatrists, psychologists, counselors, and some nurses.

Because of unmet needs and increasing demands in the field of CBT in Turkey, a group of clinical psychologists, psychological counselors, and psychiatrists from various universities, hospitals, and institutes have founded a new association, Association for Cognitive and Behavioral Psychotherapies of Turkey (BDPD in Turkish), in 2010. The president of this second association is Prof. M. Hakan Turkcapar, who is a professor of psychiatry and also trainer and consultant of the Academy of Cognitive Therapy. Other founding fellows of this association, including Ertugrul Koroglu and Olga Guriz, are also supervisors of Albert Ellis Institute. BDPD intended to promote and disseminate knowledge and training of cognitive behavioral therapies on a wider national scale. The association has attracted much attention of mental health professionals and academics of Turkey, and the number of its members has rapidly reached 400. BDPD was accepted by EABCT as a full member in 2014. BDPD provides training in all parts of the country and monitors the standards of training that is provided to ensure that they are acceptable. BDPD in a joint venture with Psychiatric Association of Turkey organized a training of trainers course in CBT.

BDPD has diversity of professions in the field of mental health including psychiatrists, psychologists, guidance counselors, psychiatric nurses, and social workers. From the beginning, the policy of BDPD has been to ensure that all cognitive behavioral schools are represented within the body of the association including cognitive therapy, behavior therapy, acceptance and commitment therapy, schema therapy, mindfulness-based cognitive therapy, and rational emotive behavior therapy. This is a distinctive aspect of BDPD from the other CBT organizations in Turkey.

Some of the trainers or members of BDPD's who are also leading figures in CBT schools are as follows: M. Hakan Turkcapar (former vice president and general secretary of KDTD; trainer and fellow of ACT), Emel Stroup (president of CBT Istanbul, leading figure of Beckian Cognitive Therapy in Turkey-Fellow-Trainer of Academy of Cognitive Therapy), Alp Karaosmanoglu (schema therapy – vice president of International Society of Schema Therapy-ISST), Fatih Yavuz (acceptance and commitment therapy – the representative of the Association for Contextual Behavioral Science of Turkey), H. Ertugrul Koroglu (rational emotive behavioral therapy – supervisor of Albert Ellis Institute), and Olga Guriz (rational emotive behavioral therapy – supervisor of Albert Ellis Institute).

## Training Opportunities in CBT in Turkey

The first formal CBT training program in Turkey was organized by Psychiatry Residents Associations and Hacettepe University as a short introductory course in 1992. The Turkish Psychological Association also organized short training courses for psychologists. After these first initiatives, the first long-running program was started by KDTD in 1997. The trainers of this first program were Mehmet Sungur, M. Hakan Turkcapar, Gonca Soygut, Perin Yolac, Buket Erkal, Mehmet Akif Sayilgan, and Ceylan Das. The program was conducted in Ankara and Istanbul as

two training groups consisting of a total of 50 psychologists and psychiatrists. Nowadays BDPD and KDTD are running CBT courses according to EABCT training criteria, and these two associations' training programs were accredited by EABCT.

Albert Ellis Institute also organized REBT primary and advanced certificate training programs in Turkey since 2008. There are two affiliated training centers of Albert Ellis Institute in Istanbul and Ankara. The centers in İstanbul and Ankara are directed by Dr. Murat Artiran, a certified REBT supervisor. These centers conduct trainings and lectures for mental health professionals.

## Training Program of the Association for Cognitive and Behavioral Psychotherapies – ACBP (Bilissel Davranisci Psikoterapiler Dernegi – BDPD)

One of the EABCT accredited training programs is conducted by Association for Cognitive and Behavioral Psychotherapies – ACBP (Bilissel Davranisci Psikoterapiler Dernegi – BDPD) in Ankara. Along with the dissemination of courses, BDPD also made some changes to raise the standards of training. Up until 2015, the education program was divided into two categories: theoretical education and supervision. Although theoretical training included satisfactory visual and audio materials, there was still a gap between theory and practice. It was observed that supervisees had deficits in integrating their theoretical background into their practice. From 2015, BDPD had begun to establish skills training classes before supervision. The purpose of skills training is to practice the theoretical knowledge by doing role-plays accompanied by the supervisors in small peer groups of 12 to 16 supervisees. By training this way, more CBT practitioners can be encouraged and can have the skills before being alone with the client in the therapy room. All these efforts generated promising results confirmed by international institutes: BDPD applied to become a member of EABCT in 2014, and the education program of BDPD was accepted as fulfilling the criteria of EABCT education standards which means that supervisees receiving adequate training can be certified by EABCT. Today among the 99 mental health professionals who have EABCT certificates, 37 are from BDPD, and more than half of the mental health professionals who have ACT certificates are from BDPD. The association is giving importance not only to the dissemination of the certification of the therapists but also increasing the number of the supervisors and trainers. Two of the three Turkish professionals are certified supervisors from Albert Ellis Institute, and four of the six ACT supervisors in Turkey are also from BDPD.

The Association of Cognitive and Behavioral Psychotherapies has also contributed to the academic improvements in CBT. It played a crucial role in the organization process of EABCT 2017. It also organized its first national congress in 2018 in Ankara (Association for Cognitive Behavioral Psychotherapies, 2018).

BDPD has added a new dimension to the Turkish CBT community by publishing the only peer-reviewed CBT journal in Turkey: *Journal of Cognitive-Behavioral Psychotherapy and Research* (JCBPR). JCBPR has been published since 2012 with an academically strong national and international advisory board three times a year. It has been listed in many of the national and international indexes (Journal of Cognitive Behavioral Psychotherapy and Research, 2018).

## The Content of BDPD CBT Training

The program of BDPD is designed to meet the needs of clinical training in cognitive therapy for mental health professionals. The program is in accordance with the training standards of the Academy of Cognitive Therapy and EABCT. It has consisted of two levels: the first level of the program is called "basic principles and applications of cognitive therapy," with 50 hours of clinical theoretical training. Some of the topics which are covered in the first part of the program are as follows: history and background of cognitive therapy, cognitive therapy for depression, cognitive therapy for panic disorder, cognitive therapy for social phobia, cognitive therapy for obsessive-compulsive disorder, and cognitive therapy for generalized anxiety disorders. Trainees are awarded a certificate of participation in this program. The second part of the program is 30 hours of skills training. After the theoretical part, a written examination takes part. If the attendee passes this exam, he or she can apply for the clinical supervision part of the training. In supervision all of the trainees' present verbatim text of one session, and audiotapes of actual sessions are listened. Each theoretical group has approximately 45 trainees, and supervision groups consist of 10 attendees. Each year, the theoretical course begins in March and October and lasts 4 months. At the end of 100 hours of supervision, trainees receive a certificate for 200 hours of supervision training. After this period, they can attend advanced training and supervision groups in cognitive therapy. Attendees also can apply for the certification after the total number of teaching hours reaches 450 hours. They can become certified members of the Association for Cognitive and Behavioral Psychotherapies (ACBP). The director of these training courses is Professor Hakan Turkcapar, president of the Association for Cognitive and Behavioral Psychotherapies, and also fellow, trainer, and consultant of ACT.

## Association of Cognitive and Behavioral Therapies – ACBT (Kognitif Davranis Terapiler Dernegi KDTD) Training Programs

KDTD, which is located in Istanbul, has an EABCT accredited training course in CBT, consists of 1 year of theoretical training in cognitive behavior therapy (CBT), followed by 1 year of CBT supervision. During the theoretical training, participants receive training about the fundamentals of CBT, including didactic presentations, discussions, and role-plays. Trainees are also educated about depression and anxiety disorders (phobias, panic disorder, OCD, GAD, and PTSD.) The second year of the training is devoted to group supervision, and each trainee is asked to bring cases for supervision. A group (peer supervision) is done initially, followed by a supervision session given by the program faculty. At the end of 200 hours, all of the trainees take an exam, and those who succeed receive a certificate for 200 hours of training. Once they learn more about the application of CBT in other areas of psychopathology (eating disorders, sexual disorders, schizophrenia, bipolar disorders, personality disorders, etc.) and the total number of teaching hours reaches 450 hours, they become certified members of the KDTD (Association of Cognitive and Behavioral Therapies (TACBP)).

## Other Programs

The third general CBT training program in Turkey is conducted by Emel Stroup, PsycD. The name of Dr. Stroup's institution is CBT Istanbul. In this course mainly the Beckian model of CBT is taught. It consists of individual modules such as assessment, anxiety disorder, depression, obsessive-compulsive disorders, etc. After taking the assessment module, participants may take these modules according to the order he/she prefers. After completion of the theoretical courses, Dr. Stroup also provides individualized training and supervision in cognitive therapy selected from the mental health professionals who have a master's degree or higher.

## CBT with Specific Clinical Populations

To the best of our knowledge, the overwhelming majority of clients (in other words patients) is receiving medical treatment for their psychological conditions (Yanik, 2007). This information is relevant for the hospital settings or outpatient clinics. We do not have much information about private psychotherapy providers in Turkey. Because of this consideration, we will discuss CBT with specific clinical populations by covering mainly clinical trials run for specific diagnoses and related applications mainly employed for the commonly seen clinical conditions.

Even today many therapists in Turkey describe themselves as eclectic (Savci et al., 2018). As that is the case, the use of structured CBT protocols seems to be rare in Turkish clinical practice. On the other hand, we can say that using CBT in clinical practice dramatically increased in the last decade. Interestingly CBT has become widespread in Turkey in parallel with the expansion of the treatment of sexual dysfunctions. Especially the treatment of vaginismus, which can be conceptualized as a derivative of coitus phobia, has been perceived as very rewarding by therapists and this approach motivated therapists to employ CBT techniques in a more structured manner. In 2003 Kabakci and Batur published a paper on clinical characteristics related to benefiting from cognitive behavioral therapy of vaginismus (Kabakci & Batur, 2003). Many studies have been published in later periods, mostly on vaginismus (Ozdel et al., 2012; Yasan & Akdeniz, 2009).

This dissemination of use, in our opinion, is not only related to the rewarding clinical applications of CBT. Qualified training options for CBT have increased in this period (for more detail please see the fifth part of this chapter).

In many epidemiological studies, phobias are usually the most prevalent psychological disorder, and this is also the case in Turkey (Erol et al., 1998; Kessler et al., 1999). Gold standard treatment for phobias is cognitive behavioral therapies that consist of exposure strategies. In an earlier study, authors compared rapid and slow exposure strategies. The definition of slow exposure was moving to the next hierarchy item after the initial anxiety provoked by exposure decreased by half in a 0 to 8 scale. The definition of rapid exposure was moving to the next hierarchy item after the initial anxiety provoked by exposure decreased by 25% in a 0 to 8 scale (Yuksel et al., 1984). This study provided the literature with an important contribution that the anxiety should not drop by half for the effective exposure treatment. Although there is little research or data we have on the use and effectiveness of CBT for phobias, we know from the relevant reports that CBT is mainly accepted as the treatment of choice for it in Turkey (Tukel & Alkin, 2006; Semerci & Gokler, 1999). However in a recent study, Dereboy et al. reported that patients were not good at both knowing and requesting CBT (Dereboy et al., 2017). In that study they identified psychotherapy service as follows:

> "Psychotherapy is concerned with a person's thoughts, emotions, and behavior and the problems may arise in their daily life and interactions with others. It is conducted by specially trained mental health professionals (psychiatrists, clinical psychologists etc.). It is a change and development process usually conducted in one-on-one sessions, using scientific methods. Psychotherapy is conducted through sessions, each lasting at least 30–50 minutes, convened at least 5 times, with the same therapist (s), with regular intervals (maximum twice a week, minimum every other week). The goals, process, progress, and results should be shared between the provider and the recipient; it must be open, cognized and measurable. Psychotherapy can be conducted in three forms: individual, group and couple or family therapy."

According to this definition, only 2.91% of patients received psychotherapy service (Dereboy et al., 2017). This finding is more striking when considering the developmental level of the region where the study was conducted. This might

suggest that even though CBT is a gold standard option for their condition, a very little proportion of the clinical population can receive that service.

As for specific clinical populations, people with depression are an important focus of treatment in CBT theory and clinical research. In Turkey according to our observations in depression treatment, therapists usually employ a modified Beckian approach in which behavioral strategies come first and cognitive restructuring comes later (Turkcapar, 2018; Greenberger & Padesky, 2015). Yet unfortunately, we have very little empirical data in this area. We found only two studies on the effectiveness of CBT, one in depressive adolescents and one in divorced women (Eskin et al., 2008; Ongider, 2013).

Another specific area is anxiety disorders. Panic disorder and social phobia are the psychological conditions in which Turkish therapists are keener to use cognitive behavioral techniques. For panic disorder (PD) and agoraphobia, both relaxation and exposure techniques are used. In a study Kilic et al. reported that both strategies have long-term effects in the treatment similar to medical treatment (Kilic et al., 1997). For social anxiety disorder, cognitive strategies such as cognitive restructuring, teaching cognitive distortions, and behavioral strategies such as graded exposure and skills training are usually employed by the therapists. Group format tended to be the treatment modality of choice (Aydin et al., 2010). Test anxiety is usually treated using behavioral strategies with test-taking skills training, studying skills training, and cognitive strategies like cognitive restructuring of dysfunctional beliefs about the exam or its meanings (Ulusoy et al., 2016). In a Turkish study, systematic desensitization and cognitive restructuring were found equally effective in test anxiety treatment (Baspinar et al., 2012). Like in social anxiety, CBT therapists in Turkey prefer to use the group format in test anxiety. A study by Safak et al. represents a clinical example in which group therapies are not used extensively. They conducted a group cognitive behavioral protocol in the treatment of people with obsessive-compulsive disorder and found it effective on not only obsessive compulsive symptoms but also depressive and anxiety symptoms (Safak et al., 2014). In that protocol psycho-education and cognitive technics were employed in earlier sessions. After three sessions exposure to feared stimuli began using the behavioral experiment paradigm. For other anxiety disorders, we have not much relevant data about what kind of techniques or protocols are in use. To the best of our knowledge, combined treatments are usually employed for many individuals with anxiety disorders. Medical treatments including benzodiazepines and selective serotonin reuptake inhibitors are usually the first treatment of choice in the field.

As for substance use disorders, motivational interviewing techniques and medical treatments are mainly used in Turkey. Psychological interventions are in "brief intervention" format. Nevertheless, cognitive behavioral interventions are considered an important part of case management. Ogel and Coskun showed that cognitive behavioral interventions had a lessening effect in substance misuse in a three-month follow-up period (Ogel & Coskun, 2011). Using, producing, or selling substances that have dependency potential are illegal in Turkey. When users are first caught, they are referred to the mandatory treatment program as a legal measure. These programs include many cognitive behavioral components including

psychoeducation about substance dependency; cognitive restructuring of the beliefs about substances and short-term and long-term effects of substances; craving; and skills training for coping and mindfulness practices.

People with psychotic disorders represent another important clinical population. Treatment of psychotic disorders is mainly medical all over the world. However, in recent years, psychological/behavioral rehabilitation facilities have begun to prominently appear as a health policy (Alatas et al., 2009). There is some research on the effectiveness of rehabilitation facilities in that skills training is implemented (Ensari et al., 2013; Ozdemir et al., 2017). A cognitive behavioral approach is important in the treatment of psychotic disorder at two levels. First, one consists of behavioral interventions related to skills training of the deficits that appeared during the course of the disorder. The second consists of cognitive behavioral interventions related to active psychotic symptoms such as delusions and hallucinations. In terms of active symptoms, there have been reports that used cognitive behavioral protocols in either an individual or group format. In their study, Sungur et al. found that the cognitive behavioral interventions in comparison to routine treatment were more effective in reducing psychotic symptoms, and these gains were stable for at least 2 years (Sungur et al., 2008). Mortan et al. examined a cognitive behavioral group therapy protocol in the treatment of the positive symptoms of schizophrenia and found this protocol was effective for at least for a 1 year period (Mortan et al., 2011).

When we look at other specific clinical populations such as people with eating disorders and personality disorders, we cannot find much research about using cognitive behavioral protocols. This doesn't mean those protocols aren't used in the field; however, it may suggest there are some clinical conditions less likely to be favorable for structured cognitive behavioral interventions. For instance, in eating disorders, clinicians in general use a multimodal treatment approach consisting of behavioral interventions, supportive therapy elements, and family therapy applications in combination with medical interventions.

## Adaptation of CBT in Turkey

As human beings we all have common universal characteristics, and on the other hand, all of us have our unique characteristics. We share common things more than unique features, but these minor unique features give our individuality. The psychosocial factors which shape our personality are our family origin, early life events, and society. Culture is one of the main factors that affect all these areas.

Definitions of the term culture include concepts such as shared values, beliefs, meanings, symbolic representations, and behaviors transmitted over time and across generations. As you can see from the definition, culture and cognitive characteristics of the individual are closely related. The prominent effect of culture on personal cognitive structures has been noticed and studied at a relatively recent time. Personality psychologists in Western countries have seen that assumptions used to describe and examine personality are not always used to describe people from

different cultures. What influences the development of personality is not just different experiences in different cultures. Psychologists have realized that people and their personalities exist in a cultural context. For this reason, cultural factors or culture of the patients must be taken into account when conducting psychotherapy (Gordon et al., 2015).

## Some Cultural Characteristics of Turkey

Turkey is a country with many ethnic and religious groups and also is a place where cultural influences from around the world congregate, intensify, contrast, and collaborate. Ethnic groups living in Turkey can be specified in many categories. Since 1965, the exact population of an ethnic group cannot be determined precisely because ethnicity is not required in the population censuses. Although some people and groups make predictions, they often fail to remain objective. Fisek and Kagitcibasi claim that, despite industrialization, urbanization, and increased educational opportunity, the Turkish culture is still closer to the collective and authoritarian pole, and the prototypic Turkish family is characterized by a strong hierarchy and a high degree of proximity, closeness, and interconnectedness. The authoritarianism in the Turkish family that they observe is manifested in a "gender and generational hierarchy," according to which women and the young are dominated by men and older members of the family. This hierarchical structure is characteristic also of the larger sociocultural system among Arabs and Muslims; males and elders have a higher status than females and young people (Fisek & Kagitcibasi, 1999).

Although all kinds of variations can be seen, Turkish culture is predominantly Islamic. The people of an Islamic background are often unfamiliar with some behavioral patterns that seem to be obvious and normal in Western culture. In addition, unlike Western culture, Turkish people are apt to communicate through nonverbal communication such as gestures and symbols (Poyrazli, 2003).

Despite these general sociological findings, there are limited studies of the cultural and cognitive characteristics of Turkish people. Turkey is composed of people who have different cultures, educational levels, and ethnic and religious backgrounds. People who have higher education mainly have more modern and secular characteristics. On the other hand, average Turkish people have a mixture of traditional Islamic and modern values.

Of the limited number of studies, one directly investigated the relationship of personality and culture in Turkey. It was conducted with university students using the temperament and character inventory (TCI). In this study it was found that the Turkish sample had higher scores for novelty seeking and avoidance of harm score than the American sample (Turkcapar, 2009).

In another study conducted by Nesrin Hisli Sahin, it was found that intermediate beliefs determined by dysfunctional attitudes scale (DAS-A) showed differences between Western culture and Turkish culture. In this study the mean score for the automatic thought questionnaire is comparable to the mean scores obtained with

North American students. However, the total mean score of DAS-A was found to be unusually high in the Turkish sample. The reason for this elevated mean score was found to reside in the response patterns of the subjects to the reverse items of DAS-A. None of the 10 reverse items discriminated the dysphoric and non-dysphoric groups in the Turkish sample. These 10 items are related to autonomous attitudes. According to the authors, this related to a cultural difference between Turkish people and Westeners: in Turkish culture nonautonomous attitudes don't reflect dysfunctionality as it does in Western culture (Sahin & Sahin, 1992a, b).

Although the theory and research on CBT emerged and developed in Western countries, CBT mainly is based on the universal cognitive and behavioral characteristics that are common to all human beings. Basic interventions of CBT rest on these universal cognitive and behavioral features. Some of the standard CBT techniques may be useful for those who fit well in the mainstream Anglo-Saxon culture, but they may need to be culturally adapted for those whose fit is not as good. Western psychology and psychotherapy have a great influence on psychotherapy applications in Turkey. This approach mainly works with educated people who live in bigger cities of Turkey. The cultural characteristics of Turkish people vary mostly according to educational level, geographical location, and type of settlement (big city, town, village).

People who have traditional values and strong family connections have some dependent features. Similarly, some Turkish people who do seek treatment typically take a passive approach to it. The therapist is viewed as the expert with the answers. The patient simply awaits instructions and carries them out. He or she is fully confident in the knowledge of the therapist and engages in therapy without questioning the reasons or method of the therapy prescribed. This possibly reflects the traditional relationship between the patient and the physician in Turkey and the expectation that results will follow from compliance with the doctor's orders.

In traditional big family settings, some of the problems of clients are related to family relations. Although extended family type has decreased with urbanization, family ties are still very close and strong in Turkey compared to the Western countries. Sometimes due to this reality, it is usual at a first session for the patient to be followed into the room by members of the family, friends, or even acquaintances. Sometimes one or more of them will want to meet with the therapist privately to offer background information or opinion. They may wish to attend the session or to see or call the therapist later to be "filled in" on what happened or what the patient had to say. The bonds among members of extended families and groups of friends can be so strong that it is difficult to untangle the patient from the rest. Sometimes they seem to feel responsible for the patient's problem and for having been unable to reverse its progress. It can surely be a strength for a patient to be surrounded by numbers of caring people sincerely eager to comfort and reassure him or her, but sometimes it can lead to aggravation of the patient's symptoms (Stroup & Elibol, 2012).

Cognitive-behavioral psychotherapy has to take into account the cultural characteristics of the individual, even if it is a psychotherapy based on the basic characteristics of human beings and the scientific knowledge of psychology. In a sense, the

general axioms of CBT are transcultural, but in practice the cultural characteristics of clients need to be taken into account. CBT practices should be conducted in a manner consistent with the individual, taking into account age, gender, and cognitive characteristics, as well as his/her culture. The cultural effect reveals itself in practice rather than the general characteristics of the theory and makes its effect felt.

Although individuals from different cultural backgrounds could benefit from the processes of cognitive reframing and behavioral activation, the CBT practitioner needs to be cognizant of the cultural characteristics of the client and to learn about the relative importance and role of the client's beliefs, emotions, and behaviors within the client's culture. Identifying and then changing the beliefs of patients is very important in the practice of CBT. Thus, cognitive therapists must recognize that beliefs, relative to self, family, and life in general, are central to one's culture. If the therapist takes these beliefs outside of the cultural context, this may lead to a disruption of the therapeutic relationship. For example, within the context of Western society and culture, values such as individualism, independence, and assertiveness are nurtured and encouraged. On the other hand, especially in traditional Turkish culture, there is not the same importance for these attributes. Therefore, an effective and culturally sensitive CBT practitioner in Turkey has to be capable of evaluating the client's beliefs, not just from the standpoint of a standard CBT perspective and, more importantly, is capable of understanding the relative importance and value of those beliefs within the cultural context that guides the process of making meaning for the client. The practitioner who is able to do this will avoid pathologizing thoughts and behaviors that may not be pathological and also will likely develop a deeper understanding and a more genuine connection with the client (González-Prendes et al., 2011).

## Research on CBT in Turkey

Psychotherapy practice cannot be considered independent without research. Research in the field of cognitive behavioral psychotherapy in Turkey started at the end of the 1980s parallel to the paradigm shift that manifested itself in the developing process of DSM (Diagnostic and Statistical Manual of Mental Disorders) (Andreasen, 2007). This process was a productive milieu for CBT worldwide, and Turkey had its share. In the 1970's (e.g., in 1975 by Morris and Beck et al.), cognitive behavioral protocols were proposed for the treatment of major depression. In the 1980s the scope of CBT widened to the extent that to recommend behavioral strategies on even physical problems such as chronic pain (Baltas et al., 1982; Beck et al., 1979). This process started somewhat later in Turkey. In early years research on CBT was mainly observational and correlational. The 1980s and the 1990s saw the adaptation of measurement tools that intended to examine main cognitive behavioral constructs. The Beck Depression Inventory was adopted to Turkish in 1988 and the Automatic Thought Questionnaire and Dysfunctional Attitudes Scale in 1992 by the same author (i.e., Nesrin Hisli Sahin) and her colleague (Sahin & Sahin,

1992; Hisli, 1988). The early 1990s saw many studies on measurement instruments were conducted and those measures were acquired in Turkish (Savasir & Sahin, 1997). Later, some experimental studies from Turkey contributed to the cognitive behavioral literature (Monkul et al., 2010). These studies contributed to the development of cognitive behavioral theory worldwide and dissemination of it locally in Turkey.

As for randomized controlled clinical trials conducted in Turkey, examples of clinical studies that used behavioral techniques (Yuksel et al., 1984) are scarce. This might be due to the limited number of CBT-oriented psychiatry clinics and psychology departments and the high cost of such studies. Nevertheless, there is a fair amount of efficacy and effectiveness research. The CBT model of depression is the first model, and the mother of the generic cognitive model has been tested theoretically and clinically (i.e., its effectiveness in the treatment of depressive disorders) many times in the literature. In Turkey, studies on the effectiveness of CBT for depression have been mainly conducted in more specific groups of people. An example of this is the study by Ongider. In her study she examined the efficacy of CBT in divorced women for depressive symptomatology (Ongider, 2013). Another example is the study by Eskin et al. (2008), in which they worked with a group of adolescents and young adults who were depressed and had suicidal potential. They found that cognitive behavioral-problem solving interventions were effective in reducing depressive symptomatology and suicidality. Those improvements lasted for at least a 12-month period. Acarturk et al. examined their transdiagnostic group CBT protocol for adolescents resistant to selective serotonin reuptake inhibitor treatment (Acarturk et al., 2018). In addition, a randomized clinical study aimed to determine a cbt-based anger management program for adolescents with anger and assertiveness issues has been conducted. Since test anxiety treatment is usually conducted in group format in Turkey, studies on test anxiety mainly used cognitive behavioral group therapy protocols. If we consider that test anxiety prevalence is high among Turkish adolescents and young adults (Kavakci et al., 2014), group cognitive behavioral therapy might help disseminate appropriate psychological help to individuals who need it (Ulusoy et al., 2016; Safak et al., 2014; Mortan et al., 2011).

Many research studies were conducted after the great 1999 earthquakes in Turkey which resulted in the deaths of over 25,000 people and the displacement of 750,000 more. After this traumatic event, CBT-oriented researchers were very active in the field (Basoglu et al., 2002). In addition to the studies that examine some cognitive-behavioral factors (Kilic et al., 2008) and posttraumatic stress relationship, various efficacy studies have been done after the incidence (Konuk et al., 2006; Basoğlu et al., 2005). In their study Basoglu et al. found that single-session modified cognitive behavioral therapy was related to an improvement to the extent of up to 83% in the posttraumatic distress and symptoms (Basoğlu et al., 2005).

Considering the abovementioned examples, Turkey still could benefit from additional randomized clinical trials with greater samples.

## CBT with Special Populations in Turkey

Special populations might be determined in various ways, and many different categorization schemes might be implemented. In this chapter however we consider it as a special group of people in terms of socioeconomic features that are of importance in understanding and treating the psychological disturbances from a CBT point of view. Nevertheless a list of special population can be endless. In this text the term special population covers disadvantaged groups of people that are at a higher risk of poverty, social exclusion, discrimination, and violence than the general population, including ethnic minorities, migrants, people with disabilities, and sexual minorities.

Given the geopolitical situation of Turkey, many people are at a higher risk for some disadvantageous conditions. Terrorism within the country and political unrest in neighboring countries are related to these risks. In addition to the abovementioned considerations, the developing nature of Turkey's social, economic, and cultural properties make people open to some risks. There are good examples of descriptive studies pertaining to risk factors for PTSD after various traumatic events (Basoglu et al., 2002; Taymur et al., 2012; Essizoglu et al., 2017). However we face a kind of deficiency for intervention studies on this issue. Several examples were mentioned in the section on a research on CBT in Turkey.

A relatively prevalent special population in Turkey is refugees, especially the children among them. After the Syrian civil war, Turkey hosted 2.5 million refugees; more than half of whom are minors under the age of 18 (http://www.unhcr.org/figures-at-a-glance.html.) CBT treatment of posttraumatic stress disorder, a prominent condition, was evaluated in a study (Acarturk et al., 2015). In another study, Gormez et al. examined a protocol-based, group CBT program delivered by trained teachers to see if it might reduce emotional distress and improve psychological functioning among the war-traumatized Syrian refugee students (Gormez et al., 2017). The results of this study were promising in that they found improvements in general psychological stress and trauma-related anxiety.

Laboring adolescents are also at risk for various psychological conditions. Bingol and Buzlu worked with a group of working adolescents in Turkey (Bingol & Buzlu, 2016). It was an examination of a prevention program on levels of depressive symptoms and ability to cope with distress. Findings were promising although the study had no placebo or control group.

As far as we know from the relevant literature, LGBT individuals in Turkey represent an important minority population in terms of high-risk trauma. It is not illegal or prohibited to identify as LGBT or disclose it. On the other hand, in the public it makes people vulnerable to exclusion, stigma, isolation, abuse, or insult (Namer & Hunler, 2014). However, we have no data about cognitive behavioral applications to help this specific group of people.

As a conclusion, although behavioral therapy had arrived with more than 30 years of delay, cognitive therapy was easily adopted by the Turkish clinicians and academicians in the late 1980s, and it was easily integrated with behavioral therapy.

Since the 2000s, Turkey had a rapid increase in the number of psychology, psychological counseling, and psychiatry nursing departments in the universities. Inevitably, this resulted in hundreds of clinicians who need qualified CBT trainings. Although there is a growing number of courses conducted in many cities, there is still a huge gap in the number of qualified trainers. Hopefully, having a new separate mental health law will regulate and standardize the CBT trainings and help to disseminate the application of CBT throughout the whole country including special populations.

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# Chapter 32
# Cognitive Behavioral Therapy in the United Kingdom


**Stirling Moorey**

## Overview of the United Kingdom

The United Kingdom (UK) consists of four separate countries: England, Scotland and Wales, and Northern Ireland (situated on the adjacent island of Ireland and bordering with Eire). The UK is a constitutional monarchy and parliamentary democracy with a degree of devolution to the four main regions. It remains the world's fifth largest economy by Gross Domestic Product (GDP) and is the second largest in Europe after Germany. Since 1974, it has been a member of the European Union, though in a referendum in 2016, the population narrowly voted to leave (52%: 48%).

The population of the UK is 66 million (Office for National Statistics, 2017). The main ethnic group is White British (86%) with ethnic minorities made up largely of people from the former British Empire (Asian/Asian British 7.5%, Black African/Caribbean or Black British 3.3%; mixed/multiple ethnic groups 2.2%; other 1%) (Office for National Statistics, 2011). Since 1948, the UK has had a National Health Service (NHS) funded through taxation where treatment is provided free at the point of delivery. In line with other countries, the proportion of GDP spent on health care has increased over the last 40 years, but following the world financial crisis of 2008, successive British governments from 2010 have followed a policy of austerity. The NHS budget increased by 8.6% between 2001 and 2005, but the increase from 2009 to 2020 will average 1.1% (The King's Fund, 2018). Despite this, there has been an expansion in the number of CBT therapists trained and available to help people manage common mental disorders.

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## History of Psychotherapy in the UK

During the first half of the twentieth century in Britain, psychoanalysis was undoubtedly seen as the most promising, if controversial, psychological treatment. Freud's most fervent English disciple was Ernest Jones who founded the British Psychoanalytic Society in 1919 and set up the Institute of Psychoanalysis in 1924. A debate was emerging in psychoanalysis between the wars which would shape its future in Britain. Melanie Klein pushed back the origins of neurosis to the first 6 months of life – to the preoedipal phase (Klein, 1992). Anna Freud, who came to the UK with her father in 1938, placed more emphasis on Freud's structural theory of the mind, exploring the way the ego functions to balance the competing demands of the id and superego (Freud, 1937). Anna Freud's theories influenced American psychoanalysis via the development of ego psychology, while Kleinian ideas have been more influential in Britain. The conflict between these two approaches (the "Controversial Discussion") led to a postwar split in the British psychoanalytic tradition which persists to this day: the Institute of Psychoanalysis is divided into Kleinians, Freudians, and Independents (King & Stenier, 1992).

Donald Winnicott and John Bowlby were two "Independents" who have been particularly influential on British psychotherapy. Winnicott relieved the guilt of psychoanalytically inclined mothers by reassuring them that the child needed "good enough" parenting rather than perfection (Winnicott, 1950). Bowlby's work on the effects of institutionalization and maternal deprivation led to attachment theory (Bowlby, 1954). Psychodynamic ideas gradually infiltrated psychiatry. It has been argued that the popularization of psychoanalysis occurred more "through the National Health Service, the Institute of Marital Relations, the Tavistock Clinic, and above all through the books and broadcasts of D. W. Winnicott" than through the Institute of Psychoanalysis (Alexander, 1996 p 140).

But almost as soon as psychoanalytic ideas began to achieve some respectability within the UK, they were challenged. Eysenck's seminal 1952 paper (Eysenck, 1952) asserting that there was no evidence for the effectiveness of psychotherapy set the cat among the psychoanalytic pigeons and was in part responsible for the interest in behavioral treatments which subsequently developed at the Maudsley Hospital and Institute of Psychiatry in London. The Maudsley psychiatrists Isaac Marks and Michael Gelder then developed exposure therapy for phobias, successfully extending this treatment to the previously intractable condition of obsessive-compulsive disorder (OCD) (Gelder et al., 1967; Marks, 1973; Marks & Gelder, 1969). Marks' empirical focus on the technique of exposure enabled him to establish its active ingredients – exposure needs to be in vivo, repeated, and prolonged for the best results.

At the Middlesex Hospital, Vic Meyer and Ted Chesser (Meyer & Chesser, 1970) worked with a formulation-based approach which tailored treatment to the individual patient; they set up an inpatient unit and founded the first behavior therapy course in the UK. Marks created a training course for nurse therapists (Marks et al.,

1975). The Institute of Psychiatry (IOP) psychology department under Eysenck's leadership became a center for behaviorally oriented clinical psychology, though elsewhere clinical psychologists often saw themselves as more eclectic.

The arrival of the *cognitive revolution* in the 1970s was met with some skepticism. Rush's 1977 randomized controlled trial seemed to demonstrate that Beck's cognitive therapy was as effective as antidepressant treatment (Rush et al., 1977). So to investigate this new treatment, a number of psychologists were sent to Philadelphia to train in Beck's therapy. John Teasdale and Melanie Fennell from Oxford and Ivy Blackburn from Edinburgh set up randomized controlled trials of cognitive therapy for depression (Blackburn et al., 1981; Teasdale et al., 1984). In 1983, Beck was invited to visit the IOP, and his lecture was so popular that it required a breakout room to be set up with a video relay. This was the first of yearly visits by Beck to the UK. Beck's charm, enthusiasm, and genuine interest in the younger generation of psychologists and psychiatrists went a long way to popularizing the cognitive component of CBT which grew rapidly in Britain through the 1980s and 1990s. The first cognitive therapy training course was established at the IOP in 1987 (Moorey et al., 1990).

In 1985, David Clark visited Beck's Center for Cognitive Therapy in Philadelphia, and the history of CBT in the UK took a further significant cognitive shift. Clark's cognitive model of panic was the first to place appraisals at the center of an anxiety disorder. Just as behavior therapy had shown that OCD was not untreatable, and cognitive therapy had shown that psychological treatment could hold its own with pharmacotherapy, so Clark's model showed that panic attacks could be understood and effectively treated. These developments in CBT have taken place within the context of the National Health Service which distinguishes the British therapeutic environment from many other countries. The existence of a nationwide service, free at the point of entry, allows for more consistent planning and funding of service provision. One example of this is the construction and dissemination of good practice guidelines. In the early 2000s, the National Institute for Clinical Excellence began to systematically review the evidence for the treatment of physical and mental health conditions. These guidelines recommended evidence-based therapies for specific disorders, CBT being the psychological treatment of choice for a range of conditions (National Institute for Health and Care Excellence, 2018): guidelines for schizophrenia (NICE, 2002); panic, agoraphobia, and generalized anxiety disorder (NICE, 2004a); depression (NICE, 2004b); eating disorders (NICE, 2004c); OCD (NICE, 2005a); PTSD (NICE, 2005b); and social anxiety (NICE, 2013). These publications were to prove an important step toward establishing CBT as the mainstream treatment it has become.

The next major development came in 2007 when David Clark joined forces with Lord Layard, an economist and Labor Party Peer, to use the NICE guidelines to lobby for an expansion of psychological therapies for common mental disorders. Their calculations suggested that the costs of increasing psychological therapies services would be outweighed by the benefits in savings to the health service and savings to the treasury through increased tax revenues and reduced spending on

benefits as people recovered and returned to work (Layard, 2007). Pilot sites in Doncaster and the London borough of Newham generated encouraging results, and IAPT was rolled out nationally with the aim of treating 900,000 patients by 2010. IAPT services now treat 960,000 patients each year and achieve recovery in 50% of cases and reliable improvement in 66% (Clark, 2018). CBT is now the most widely practiced form of psychotherapy in the UK.

No discussion of CBT in the UK would be complete without recognition of the unique contribution of Professor Windy Dryden who through his huge number of publications on CBT and Rational Emotive Behavior Therapy (REBT) has brought an awareness of these therapies to a wide lay and professional audience.

## *Current Regulations Regarding Psychotherapy Provision*

There is no statutory requirement in the UK that a psychotherapist should be registered. Therapy is delivered by various professions, and their professional bodies accredit them. Within psychology, there are subspecialties of clinical, counseling, educational, and forensic psychology, and it is possible to train as a CBT specialist in any of these (BPS, 2018). Psychiatrists also practice CBT, and a small number of medical psychotherapists specialize in CBT. They are registered with the General Medical Council (GMC, 2018) and have trained to obtain a Certificate of Completed Training from the Royal College of Psychiatrists (RCPsych, 2018). Most CBT specialists of any profession will also be registered with the British Association for Behavioral and Cognitive Psychotherapies (BABCP; see below).

## *Professional and Cognitive Behavior Therapy Organizations*

In 1972, a group of behavior therapists came together to form the British Association of Behavioral Psychotherapy. It has grown from 195 members to over 10,000, changing its name in 1990 to the British Association for Behavioral and Cognitive Psychotherapies (BABCP). The BABCP embraces a range of professions and different approaches to the practice and theory of behavioral and cognitive psychotherapy. Practitioners of these different approaches can join Special Interest Groups which include:

Acceptance and Commitment Therapy (ACT).
Behavioral Activation and Functional Analysis (BAFA).
Cognitive Behavioral Analysis System of Psychotherapy (CBASP).
Compassion Focused Therapy (CFT).
Couples Therapy.
Dialectical Behavior Therapy (DBT).
Low-intensity interventions.

Rational Emotive Behavior Therapy (REBT).
Schema Therapy.

There are also 21 regional branches which support networking and continuing professional development within their area. The journal *Behavioral and Cognitive Psychotherapy,* the magazine *CBT Today,* and other publications disseminate research and practical information about the applications of CBT.

As well as promoting and representing the interests of CBT and CBT therapists nationally and internationally, the BABCP sets standards for practitioners and accredits them. It has international links with the European Association for Behavioral and Cognitive Therapies (EABCT) and the World Congress of Behavioral and Cognitive Therapy (WBCT).

The other professional body which accredits CBT therapists is the Association of Rational Emotive Behavior Therapists (Association of Rational Emotive Behavior Therapists). Although much smaller in size than the BABCP, it represents the voice of Ellis' REBT in the UK and has links with the USA and New Zealand. Some CBT therapists will be accredited through their professional body rather than a CBT body (e.g., Royal College of Psychiatrists, British Psychological Society).

## *Training Opportunities in CBT*

The BABCP accredits CBT courses (BABCP, 2018). The majority of these train therapists in CBT for adults (only three offer training in CBT for clinical work with children and adolescents). Because of IAPT's central place in psychotherapy, provision training of IAPT therapists is a priority in the UK (10,500 therapists to be trained by 2021). There are 21 courses for IAPT High-Intensity Therapists (therapists delivering face-to-face evidence-based therapies). These focus on delivering the NICE recommended forms of CBT for depression and anxiety disorders. The courses include 2 days per week of lectures and workshops (50%) and experiential learning through live and video role plays and opportunities for skills-based learning (50%). In order to pass, trainees need to demonstrate competency in CBT through written assignments, case reports, and essays and most importantly through reaching a competent level on the revised version of the Cognitive Therapy Scale (Blackburn et al., 2001).

Courses for Low-Intensity Therapists or Personal Well-Being Practitioners (PWP; who deliver guided self-help and brief psychoeducational groups in IAPT) are also joint university and in-service trainings and are accredited by the British Psychological Society. There are 31 low-intensity courses in the UK. PWP training is for 1 day per week and includes learning assessment and engagement skills; delivering evidence-based low-intensity treatments; understanding values, policy, culture, and diversity; and working within an employment, social, and health-care context.

## CBT with Specific Clinical Populations

Most psychological therapy for anxiety and depression now takes place within these IAPT services. IAPT systematically implements psychological treatments that have been shown to be effective and monitor their impact. Services are set specific targets for access (16% of the community prevalence of anxiety and depression) and outcomes (50% recovery: defined as PHQ-9 and/or GAD-7 scores falling below 10). Over the 10 years IAPT has been operating services have risen to this challenge with recovery rates improving year on year. IAPT is now expanding to include patients with long-term health conditions such as cardiovascular disease and diabetes (NHS England, 2018). IAPT-like services are also being developed for children and adolescents and for those with serious mental illness. Psychotherapy in the UK could be said to have undergone an "industrial revolution" with IAPT leading the charge. It has moved from being a cottage industry to a systematically managed, target-driven enterprise.

IAPT sits between primary and secondary care. Patients with more severe anxiety and depression or other disorders will be treated in secondary care. Severe and complex anxiety and depression, psychosis, bipolar disorder, and personality disorder are generally treated in community mental health teams (CMHTs). Most teams will have a clinical psychologist attached to them who will often have a CBT training but may use a range of psychological treatments. Some CMHTs have dedicated CBT therapists. There has been a tendency to separate the functions of CMHTs so that some focus on early intervention for psychosis, some on general psychiatric work, some on long-term enduring mental illness, and some on the home treatment of severely ill patients. Prior to the implementation of IAPT, much CBT could be found in clinical psychology services or in integrated psychotherapy services. The gravitational pull of IAPT together with reduced funding for public services overall has had an influence on these units. There are still a few dedicated CBT services such as the Newcastle Cognitive Therapy Centre (NCBTC, 2018) and the Centre for Anxiety Disorders and Trauma at the Maudsley (CADAT, 2018) which combine the functions of teaching, research, and the treatment of highly complex cases.

The private psychotherapy sector in the UK is probably growing, but relatively few CBT therapists operate solely in private practice. It is more likely that they may work full- or part-time in the NHS and do some private work in addition. Much private work is funded through insurance companies such as BUPA who support therapy up to a set number of sessions of CBT. Larger private organizations such as The Priory group offer outpatient and inpatient treatments, and CBT (often as group interventions) is often a component of the treatment package.

## Adaptation of CBT in the UK

This chapter has already highlighted some of the unique adaptations of CBT in the UK, focusing on service developments for patients with anxiety and depression (IAPT). The treatment of anxiety in these services owes a great deal to the work of

Clark, Salkovskis, and Ehlers in refining CBT for specific disorders. Clark identified the key appraisals that fired a panic attack, while Paul Salkovskis recognized the importance of safety-seeking behaviors in maintaining panic and other anxiety disorders (Salkovskis et al., 1996).

Salkovskis also built upon work by Jack Rachman to develop a cognitive model for understanding OCD (Rachman, 1998; Salkovskis, 1999). It was proposed that it is not the intrusive thoughts that are the problem, for we all have these, but rather the meaning that we give to them. In addition to panic and OCD, Clark and his colleagues, based in Oxford and later the Institute of Psychiatry in London, developed models and treatments for health anxiety (Warwick & Salkovskis, 1990), social phobia (Clark & Wells, 1995), and post-traumatic stress disorder (Ehlers & Clark, 2000). This group's research is exemplary in its approach to developing effective treatments. Clark's approach is based on a "close interplay between theory, experiments and treatment development, with each leading to refinements in the others" (Clark, 2004). It follows the steps:

1. Use clinical interviews and cognitive psychology paradigms to identify the core cognitive abnormality in an anxiety disorder.
2. Construct a theoretical account which explains why the cognitive abnormality does not self-correct.
3. Test the hypothesized maintaining factors in rigorous experimental studies.
4. Develop specialized cognitive treatments which aim to reverse the empirically validated maintaining factors.
5. Test the efficacy of the treatments in randomized controlled trials.
6. Help make the treatments more broadly available through dissemination studies.

Now that these approaches have been found to be effective, work is being done to adapt them through wider dissemination. In PTSD, evidence is accumulating that CBT can move from the research institute into routine clinical care (Ehlers et al., 2013) and to find more cost-effective forms of delivery (Nollett et al., 2018). In anxiety disorders, novel methods of treatment delivery such as virtual reality (Slater et al., 2006) and intensive treatment are being explored (Ehlers et al., 2014).

Digital technology is also being used to enhance treatment by harnessing the potential of smartphones (Bucci et al., 2015). Patients can use their phones to monitor their thoughts and emotions, and therapists can have access to the results between face-to-face sessions; smartphones can similarly be used to prompt activities and homework assignments. Computerized and online CBT programs are already being used in many services and form the mainstay of much IAPT low-intensity treatment (Clark, 2018). There is clear evidence that these are most effective when therapists have some input to supporting the patient rather than simply prescribing computerized CBT and letting them get on with it. As Clark observes (Clark 2018), the challenge is now to determine which programs are most effective and which patients are most likely to benefit.

### *Research on CBT in the UK*

As will have become clear, research and clinical practice are integrally connected in CBT in the UK. Reference to the work of many researchers has already been made in relation to their historical contribution, contribution to clinical work and to new adaptations. In addition to the research on anxiety disorders, UK researchers have made breakthroughs in several areas. Chris Fairburn at Oxford pioneered CBT for bulimia (Fairburn et al., 1991), while at the IOP, Ulrike Schmidt and Janet Treasure developed the Maudsley Model of CBT for bulimia (Treasure et al., 1994) and anorexia (Schmidt & Treasure, 2006). Also at the IOP, Trudie Chalder and colleagues pioneered CBT for chronic fatigue syndrome (Deale et al., 1997), while Steven Greer and Stirling Moorey at the IOP and Royal Marsden Hospital applied CBT to people with cancer (Greer et al., 1992; Moorey et al., 1994). Perhaps the most revolutionary idea to come out of Britain was David Kingdon and Doug Turkington's work showing that CBT could treat schizophrenia (Kingdon & Turkington, 1991; Kingdon & Turkington, 1994). Philippa Garety and Elizabeth Kuipers at the IOP developed a related model, and CBT for psychosis is now established as an effective adjunct to medication (Garety et al., 1994; Garety et al., 2001; Kuipers et al., 1997). RCTs have demonstrated the effectiveness of CBT in relieving symptoms but not in preventing relapse (Garety et al., 2008). CBT for psychosis has been demonstrated to be effective not just in RCTs but also in clinical services (Peters et al., 2010). In the area of relapse prevention for depression, Teasdale and Williams in collaboration with Zindel Segal (from Canada) developed Mindfulness-Based Cognitive Therapy which has been accepted by NICE as an approved treatment for recurrent depression (Teasdale et al., 2000). Beginning with a focus on depression but expanding beyond this, Paul Gilbert developed a model of Compassion Focused Therapy based on evolutionary psychology that is proving highly influential as an adjunct to standard CBT in clinical practice (Gilbert, 2001, 2014). Some researchers are moving beyond disorder-specific models to investigate transdiagnostic approaches such as rumination-focused CBT (Watkins et al., 2011). These research groups continue to push forward the boundaries of CBT conducting RCTs demonstrating the effectiveness of their models, and their work informs the NICE guidelines for their respective disorders.

## CBT with Special Populations in the UK

Although Black and Ethnic Minority groups comprise up to 20% of the UK population, relatively little research has been done on adapting CBT for BME cultures. Kaur and Bennett (2018) found that service users in Birmingham from a South Asian background felt that CBT was not consistent with their cultural norms. Practical behavioral interventions were more acceptable than cognitive ones. Rathod and colleagues, however, have developed ways to make CBT accessible and

acceptable to people with psychosis from minority ethnic backgrounds (Rathod et al., 2010; Rathod et al., 2013). They have divided their approach into three areas of adaptation: (1) awareness of relevant cultural issues and preparation for therapy, (2) assessment and engagement, and (3) adjustments in therapy (Naeem et al., 2009). Local IAPT services are putting in place culturally appropriate group interventions for BME clients (e.g., Birmingham Healthy Minds IAPT offers group interventions facilitated by Personal Well-Being Practitioners who speak Hindi, Urdu, Punjabi, or Bengali; NICE 2017).

The UK has recently experienced traumatic events that have affected large numbers of people. In London, for instance, the London Bridge terrorist attack, the attack on the Finsbury Park Mosque, and the Grenfell Tower fire have presented CBT therapists with a public health challenge: how to make the therapy available as easily and quickly as possible to as many people as possible. NHS London has developed a four-step approach: Step 1, Prevention; Step 2, Early intervention/advice; Step 3, Targeted support; Step 4, Specialist support (NHS London, 2018). Trauma-focused CBT and Eye Movement Desensitization are the evidence-based therapies included in this pathway.

## *Summary*

There are certain distinctive features of CBT in the United Kingdom. These arise from overlapping contexts which contribute to a consistency in CBT practice not always seen in other countries. Firstly, there is a tradition of pioneering research which informs training and guidelines for practice through NICE guidelines. Secondly, the National Health Service helps to disseminate and support this evidence-based practice. Thirdly, there is a single unifying organization (BABCP) which the majority of CBT therapists, and the government, recognize as representing their interests and the interests of CBT, and so training and continuing professional development are of a consistently high standard.

The description so far perhaps creates a picture of a monolithic structure, but there is huge variation within IAPT services, and of course, much CBT goes on outside IAPT. One of the features of British CBT is in fact its use of formulation-based rather than protocol-based treatment. Drawing on Beck's emphasis on individualized case conceptualization as the basis of treatment planning, CBT therapists use the model for the specific disorder they are treating as a road map but refine this to reflect the patient's particular concerns.

This approach differs from certain types of CBT which may use more direct psychoeducation and discrete modules covering techniques such as relaxation, cognitive restructuring, and exposure as separate components in the therapy. Guided discovery is an important feature of this type of CBT. While all CBT therapists are collaborative, the nature of this collaboration varies across cultures. In the UK, guided discovery probably appears somewhat gentler than the approach one would see in the United States of America (USA), where questioning can sound quite abrupt to British ears.

In conclusion, the UK punches above its weight in terms of CBT research and service provision. Researchers in the UK have made innovative contributions to our understanding and treatment of many conditions. This research directly informs clinical guidelines and government policy leading on to evidence-based practice and evaluation within the National Health Service particularly through the IAPT services, and this makes British CBT unique.

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# Chapter 33
# Cognitive Behavioral Therapies in the United States


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Earlier chapters in this edited volume have presented an overview of cognitive behavior therapy (CBT) as well as its history and current status in countries around the world. This chapter will provide an overview of CBT in the United States, with a focus on the history of the development and utilization of CBT in the country, the current state of CBT with regard to training and professional development opportunities, with whom and how it is utilized, as well as the research evidence supporting CBT.

## An Overview of the United States: Demographics of the Country

The United States is located in North America and is comprised of 50 states and the District of Columbia. The total approximate population is 328,242,000 persons, with 1 birth and 1 death every 8 and 12 seconds, respectively (US Census Bureau, 2018). One-half (50.8%) of the population is female (US Census Bureau, 2017). With regard to age, approximately one-quarter (22.6%) of the population is under 18 years, and 15.6% are 65 years or older, with a median age of 37.7 years (US Census Bureau, 2017). Sixty-one percent identify as White alone (not Hispanic or Latino), followed by 18.1% who identify as Hispanic or Latino, 13.4% Black or African American, 5.8% Asian, 1.3% American Indian/Alaska Native, and 0.2%

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Native Hawaiian/Other Pacific Islander (US Census Bureau, 2017). In terms of educational achievement, 30.3% of persons 25 years older have earned a Bachelor's degree or higher (US Census Bureau, 2017).

A survey of household incomes in the US indicated that the median household income is $55,322, and the average is $77,866 (US Census Bureau, 2016). Approximately 11% of families and 15% of individuals have an annual income that is below the poverty level. Approximately eighteen percent receive financial assistance from the government, with 5.4% and 13.1% of households, respectively, receiving supplemental security income and food stamps as part of the Supplemental Nutrition Assistance Program (SNAP; US Census Bureau, 2016). Eighty-eight percent of the population has health insurance coverage, leaving 11.7% of all persons without health insurance including 10.1% of persons under age 65 years (US Census Bureau, 2017).

Approximately 1 in 5 adults in the United States (43.8 million or 18.5%) suffer from a mental illness in a given year (Substance Abuse and Mental Health Services Administration, 2017). The lifetime prevalence of severe mental illness is 21.4% among youth aged 13–18 and 13% among children aged 8–15 (Merikangas et al., 2010).

## History of Psychotherapy in the United States

The broader field of psychology in the United States began primarily as an academic discipline with William James, who founded the first psychology lab at Harvard University in 1861 (Benjamin, 2005; Lavin & McGinn, 2017). The term "clinical psychology," which is widely used at present to described research and treatment related to psychopathology, was first coined by Lightner Witmer. Witmer was also the first psychologist to emphasize the importance of applying scientific research to clinical work in the real world and later went on to found the first psychology clinic in 1896, which provided services in both assessment and treatment of learning and behavioral problems in school-aged children (Baron, 2007; Benjamin, 2005; Routh, 2011).

Prior to World War II (WWII; 1939-1945), clinical psychologists in the United States largely applied their research to assessment only, as opposed to therapeutic intervention and treatment. WWII had a major impact on the field of clinical psychology within the United States, as psychologists working within the military expanded psychological testing to include advances in cognitive and personality testing. The role of psychologists also broadened to include that of the treatment provider, rather than just assessor (Benjamin, 2005; Lavin & McGinn, 2017; Routh, 2011). As the field of clinical psychology grew and the roles of psychologists expanded, behavior therapy arose and gained prominence in the 1950s, as an alternative to psychodynamic psychotherapy (McGinn & Sanderson, 2001). Psychodynamic therapy had gained popularity in the United States in the early 1900s, putting forth an emphasis on unconscious processes with a goal of

improving an individual's self-awareness and understanding of the influence of the past on present behaviors (Shedler, 2010; Summers & Barber, 2009). Psychodynamic therapeutic practice relied on clinical judgment based on theory and experience; alternatively, behavior therapy endeavored to apply principles of learning, as established in the laboratory, toward the understanding and remediation of psychopathological behaviors (McGinn & Sanderson, 2001). The roots of behavior therapy can be traced as far back as the twentieth century, with Ivan Pavlov's work on classical conditioning conducted in Russia serving as the first animal model of learning (McGinn & Sanderson, 2001). Pavlov published extensively on the application of his techniques and theories to abnormal behavior in general, as well as in relation to disorders termed at the time as hysteria, obsessional neurosis, and paranoia (Pavlov, 1932, 1934; Pavlov & Gantt, 1941). In the United States, applications of conditioning principles to the study of emotional problems in humans also played a key role in the development of behavior therapy (e.g., Watson & Rayner's [1920] account of the conditioning phobia in Little Albert). Behavior modification developed later from the work of B. F. Skinner (1953), which emphasized operant/instrumental learning. Over the years, operant and instrumental principles have become integrated into the study of anxiety and mood disorders and presently inform many evidence-based treatments (McGinn & Sanderson, 2001). Modern behavior therapy now extends to models of learning beyond operant and classical conditioning.

Separately, cognitive therapy (CT) was developed by an American psychiatrist, Aaron Beck (1963), as a short-term and symptom-focused treatment of depression (McGinn & Sanderson, 2001). Beck's CT stemmed directly from his efforts to test Sigmund Freud's theory that depression is anger turned on the self. Through a series of experiments, Beck repeatedly found that depressed patients experienced streams of negative thoughts that seemed to arise spontaneously and that depression was actually characterized by interpretations of the self, the world, and the future characterized by defeat and negativity (Beck, 1976). Over time, CT evolved into a more general theory of emotional disorders, positing that thoughts, feeling, and behaviors are all inter-connected and that it is the way people perceive a given situation (through automatic negative thoughts), rather than the situation itself, that predicts their subsequent emotional or behavioral reaction (Beck, 1976, 2011). In contrast to the psychodynamic model, which assumes that individuals are motivated by unconscious motives and impulses, and to the behavioral tradition which assumes that individuals are controlled by external contingencies, Beck proposed that dysfunctional thoughts themselves are responsible for emotional dysfunction and represent an effective point of intervention (McGinn & Sanderson, 2001). Around the same time that Beck was developing cognitive therapy, Albert Ellis was pioneering rational therapy, known today as rational emotive behavior therapy (REBT; Ellis, 1957). Ellis put forth that irrational beliefs must be changed in order to change various dysfunctional psychological outcomes, such as a depressed mood (David, 2015). The general theory of REBT emphasizes the importance of cognitive processing (e.g., cognitions, beliefs), stating that such cognitions mediate the impact of life events on psychological consequences (e.g., feelings, behaviors; David, 2015; Ellis,

1962). Although CT and REBT arise from similar theoretical models, the two therapies stemming from these models have some differences.

During the last quarter of the twentieth century, cognitive and behavioral traditions became increasingly integrated into their treatment of emotional disorders. This marriage between cognitive and behavioral approaches has largely occurred due to their common emphasis on targeting symptoms and problems and on their use of the experimental method to understand, remediate, and assess changes in psychopathology (McGinn & Sanderson, 2001). CBT – considering both cognitive and behavioral principles – posits the assumption that a person's cognitions, behaviors, and emotions reciprocally determine each other (Bandura, 1977; Friedberg & McClure, 2015); that is, change in any one of these elements is expected to produce changes in the others. Over the years, a variety of CBTs have evolved and demonstrated efficacy in remediating a wide range of psychological problems (e.g., Ellis's Rational Emotive Therapy [1962], Lazarus's multimodal therapy [1976], Meichenbaum's cognitive behavioral modification [1977], and Linehan's Dialectical Behavior Therapy [1993]).

## The Use of CBT in the United States

The research to date makes it clear that CBTs have been used and shown to be effective for a wide range of psychological problems experienced by children, adolescents, and adults. The wide-ranging efficacy of CBT, across diagnoses and populations, can largely be attributed to the range of CBT strategies that can be tailored to address an individual's unique presentation and therapeutic needs.

When first-wave behavior therapies were first utilized in the United States, they did not focus on specific disorders but rather on an idiographic functional analysis of "abnormal behavior" patterns, which psychologists hypothesized were learned patterns that could be extinguished or shaped with behavioral strategies (Eysenck, 1959; Rachman, 2015). Although first- and second-wave CBTs continued to target specific behaviors, theory-driven, manualized-based treatments became more popular within the medical model as a way to document treatment efficacy and decrease reliance on intuitive clinical judgment (Wilson, 2012). Presently, CBT strategies are often delivered within such a manualized-based or protocol-based, approach. These approaches are brief, direct, and time-limited treatments for individual psychological disorders. Manualized-based approaches were developed and gained popularity when researchers wanted to gain credibility within the larger medical profession and test the efficacy of CBT; that is, standardized protocols allow researchers to ensure that CBT is delivered with fidelity and thus are able to draw conclusions about the treatment within a research study. That is, psychologists follow the same protocol for each client presenting with the same disorder. There are many CBT protocols for the treatment of disorders in adults; most CBT treatments were first developed for adults ages 18–65, and thus the bulk of the research and manualized approaches are available for this age range. For example, Judith Beck (1995, 2011)

published a manual for therapists to learn the fundamental principles and strategies in cognitive therapy. Similarly, the *Treatments That Work* series features therapists' guides and workbooks of evidence-based behavioral interventions for a range of anxiety, obsessive-compulsive, mood, eating, sleep, substance use, and mood disorders. Manualized-based approaches have been extended such that many are also available for the treatment of children and adolescents with a range of disorders. For example, the parent management training (PMT; Kazdin, 2005) protocol is an evidence-based treatment for children and adolescents with oppositional, aggressive, and antisocial behaviors. Another example is the coping cat (Kendall & Hedtke, 2006a, b), an evidence-based CBT manual for children (ages 7–13) with anxiety. The coping cat also has a version for adolescents (ages 14–17) known as the CAT project (Beidas et al., 2010). These protocols provide session-by-session outlines for therapists, allowing evidence-based treatments to be delivered with fidelity across clients.

The proliferation of CBT treatments and corresponding manuals available for separate disorders poses a challenge for clinicians who must sift through the range of manuals and decide which protocol is the "best" for a particular client. Further, manualized-based approaches task the therapist not only with identifying the best treatment for a given disorder, but also with learning (e.g., buying and reading a manual, receiving some form of training) a different approach for each disorder. In response to these limitations of clinical and practical utility, many researchers have attempted to go beyond a particular diagnosis or particular population and to develop a protocol to be used with a broader range of individuals. One example of such an attempt is the Unified Protocol (UP; Barlow et al. 2017), a form of CBT for individuals diagnosed with anxiety disorder, depression, and related disorders (referred to as emotional disorders), developed by David Barlow and a team of researchers at the Center for Anxiety and Related Disorders (CARD) at Boston University. The UP differs from traditional CBT protocols in that it is a transdiagnostic treatment, meaning that it can be applied across a range of disorders and problems; as such, the UP aims to address the core deficits shared across emotional disorders such that both individual and comorbid symptoms may be targeted (Barlow et al., 2011). The UP contains eight modules and focuses on five core CBT strategies: becoming mindfully aware of emotional experiences; reappraising rigid emotion-laden appraisals and attributions; identifying and preventing patterns of emotion avoidance and maladaptive emotion-driven behaviors; increasing awareness and identifying the role of physical sensations in emotional experiences; and facilitating exposure to cues associations with emotional experiences (Barlow et al., 2011). Research to date demonstrates the UP to have been used successfully to treat a number of anxiety disorders (e.g., panic disorder, social anxiety disorder, obsessive-compulsive disorder, generalized anxiety disorder, post-traumatic stress disorder) and mood disorders (e.g., major depressive disorder, persistent depressive disorder, bipolar depression), as well as borderline personality disorder, non-suicidal self-injury, insomnia, and eating disorders. In addition to the UP, other researchers have developed transdiagnostic interventions designed to tailor treatment to core pathology underlying anxiety disorders (Norton, 2012). Norton and Hope (2005)

published the first randomized controlled trial of a 12-week transdiagnostic group treatment and found promising results that showed a reduction in diagnostic severity to subclinical levels. Similar findings have also been found for this approach with regard to decreasing depressive symptoms and the severity of depressive disorders among those who received transdiagnostic CBT treatment (Norton, 2008). Taken together, the research demonstrates the efficacy of a transdiagnostic CBT approach for anxiety and depressive disorders. Future research may be warranted to continue to evaluate and refine these approaches.

In addition to the aforementioned burdens on the therapist to identify, learn, and implement a number of manualized interventions, there are other disadvantages to manualized-based approaches. For example, protocols do not provide guidance to clinicians in many challenging situations that come up with a number of clients (Persons, 2008). That is, manualized-based approaches do not offer flexibility for issues that may arise in therapeutic practice, such as situations in which a client has multiple comorbid disorders, a client is non-adherent to the protocol (e.g., homework noncompliance, treatment refusal), there are no evidence-based treatments for the client's problem, or there are multiple evidence-based treatments for the client's problem (Persons, 2008). Given these limitations of manualized-based approaches, CBT providers have moved toward utilizing a modular-based or moved back to using a case-formulation approach that now combines both behavioral and cognitive elements; these approaches use CBT as a treatment framework that flexibly meets the unique needs of the client. With this approach, the CBT therapist begins by collecting assessment data to obtain a diagnosis(es) and then develop an idiographic formulation and conceptualization of the person. The case formulation includes four elements, including the client's symptoms, disorders, and problems; hypotheses about the mechanisms causing the disorders and problems; recent precipitants of the current disorders and problems; and origins of the mechanisms (Persons, 2008). Ultimately, this formulation is a hypothesis about the factors that are causing and maintaining a particular client's disorders and problems. This formulation subsequently guides the CBT therapist in decision-making related to CBT strategies and interventions that encompass an individualized, tailored treatment plan.

## Adaptations of CBT

Behavior therapy can be categorized into three waves or generations, with each wave representing an emphasis on particular assumptions, methods, and goals that inform research, theory, and practice. As previously discussed, the history of CBT began with the emergence of behavior therapy in the 1950s or the so-called "first-wave" (Gaudino, 2008). Early behavior therapists relied on well-established scientific principles and they rigorously tested theory and techniques; the first wave focused directly on problematic behaviors based on principles of conditioning and other learning principles. The first wave of behaviorism was followed by the

"second wave," or cognitive revolution of the 1960s and 1970s, from which traditional CBT formed. This second-wave emphasized thoughts in addition to principles of behaviorism; irrational or dysfunctional thoughts, pathological cognitive schemas, and faulty information processing styles were examined and modified directly as a mechanism to ultimately reduce psychological suffering and produce behavioral change. Ultimately, the second-wave broadened the emphasis beyond behavioral principles and utilized change methods such that they could be used to target behaviors, emotions, *and* cognitions (Hayes, 2004; Hunot et al., 2013).

In the last several decades, traditional CBT has been adapted and modified in the United States such that a "third wave" of interventions has emerged, which emphasize acceptance-based strategies largely stemming from Eastern philosophies in addition to tradition CBT methods (Gaudiano, 2008; Hayes, 2004). Proponents of this new generation of behavior therapies suggest that modifying the believability of thoughts, a principal feature of CBT interventions, is less important and as such have emphasized the use of other strategies by which to achieve therapeutic change beyond traditional cognitive or behavior therapy (Longmore, 2007; Segal, 2002). Examples of these therapies include dialectical behavior therapy (DBT; Linehan, 1993), functional analytic psychotherapy (FAP; Kohlenberg, 1991), mindfulness-based cognitive therapy (MBCT; Segal et al., 2002), and acceptance and commitment therapy (Hayes et al., 1999), among several others. These methods are unified by an emphasis on acceptance as well as clinical interventions and philosophies including mindfulness, cognitive defusion, dialecticals, and values (Hayes, 2004).

Acceptance and commitment therapy (ACT) is one of the adapted approaches characterized in the "third wave" of CBT; this novel approach was developed by Steven Hayes (1999), and it emphasizes the acceptance (in contrast to control) of distressing thoughts and feelings. ACT also uses core strategies for directly changing behavior in accordance with the personal values and goals of the client. Rather than modifying the believability of cognitions, an ACT therapist aims to change the relationship between the experience of symptoms and difficult thoughts/feelings, such that symptoms no longer need to be avoided and become just uncomfortable transient psychological events (Harris, 2006; Hayes et al., 1999, 2004). A second prominent treatment adapted from traditional CBT is dialectical behavior therapy (DBT; Linehan, 1993), which was originally developed by Marsha Linehan as a treatment for chronically suicidal or self-injurious women with borderline personality disorder. DBT emphasizes the principle of dialectics, stating that two opposing tenants can both be true at the same time, with the core dialectic in DBT being the balance between change and acceptance. Traditional and comprehensive DBT includes four treatment components: individual therapy, skills group, phone coaching, and therapist consultation team. Skills training occurs in the domains of mindfulness, interpersonal effectiveness, emotion regulation, and distress tolerance. A DBT therapist works to replace a client's problematic behaviors with skillful behaviors, while promoting acceptance of the client as they are and working toward change to do better and be more skillful.

While these third-wave approaches are unique and differ from first- and second-wave CBTs, they do have features of traditional behavioral and cognitive therapies

(e.g., goal setting, skills acquisition), which continue to play an important role in helping to reduce pathological symptoms. Given that these treatments have been developed and evaluated only in recent years, future research is warranted to continue to refine these approaches. Research on CBT interventions is discussed further in the following section.

## Research on CBT

Space in this chapter does not permit a thorough review of the research literature supporting the efficacy of CBT. This section will provide an overview of the research, as well as highlight areas of growing research within the area of CBT.

One of the most telling pieces of research on CBT interventions comes from the American Psychological Association (APA) Division of Clinical Psychology's Task Force on Psychological Interventions, a group whose mission has been to develop criteria to judge "empirically supported" psychological interventions (Chambless & Hollon, 1998). These criteria are relatively conservative, as studies must include a comparison group (e.g., alternative treatment, placebo) in order to be included in the research review. CBTs represent approximately 90% of empirically supported treatments identified by this task force (McGinn & Sanderson, 2001), highlighting their efficacy in treating a range of disorders.

The evidence-based for CBT is also supported by many reviews and meta-analyses of the research to date. For example, Hofmann et al. (2012) conducted a comprehensive survey of contemporary meta-analyses in order to examine the evidence-base for the efficacy of CBT. There is a substantial amount of research on CBT for depression, and research over the years has supported CBT as more effective than control conditions (e.g., waiting list, no treatment; Hofmann et al., 2012; Beltman et al., 2010; van Straten et al., 2010); a large effect size has been found across studies for CBT for unipolar depression (Butler et al., 2006). Some meta-analyses have found that CBT is equally effective in comparison to other psychological treatments (e.g., as compared to problem-solving therapy or interpersonal psychotherapy; Beltman et al., 2010; Cuijpers et al., 2010, 2013), with some research citing that the effects of CBT may be over-estimated due to the fact that CBT is the most studied psychotherapy for adult depression. In contrast, others have found favorable results for CBT as the more effective treatment (Jorm et al., 2008; Tolin, 2010). At posttreatment, some research shows that CBT interventions yield a more favorable prognosis such that depressed individuals demonstrate fewer symptoms at a follow-up assessment (Tolin, 2010), and other research has demonstrated that CBT reduced relapse/recurrence rates with a magnitude of effect comparable to keeping depressed individuals on antidepressant medications (Butler et al., 2006; Driessen & Hollon, 2010). There is also robust research in the area of CBT for anxiety disorders, such that research demonstrates consistently strong therapeutic effects for the treatment of obsessive-compulsive disorder, social anxiety disorder, panic disorder, generalized anxiety disorder, specific phobias, and posttraumatic stress

disorder (Butler et al., 2006; Hofmann et al., 2012). Cuijpers et al. (2016), however, cautions that the evidence for CBT for anxiety disorders demonstrates mixed-effect sizes across studies. CBT has also been demonstrated as effective, with medium to large effect sizes, for addiction and substance use disorders, bulimia nervosa, insomnia, anger and aggression, marital distress, and stress management (Butler et al., 2006; Hofmann et al., 2012). In sum, the research points to CBT as efficacious across a range of disorders, demonstrating its clinical utility for varying client presentations.

The majority of research on CBT has been conducted with adults; over the last several decades, CBT has been adapted and tailored for children, with robust support for treating internalizing disorders (e.g., mood and anxiety symptoms; Butler et al., 2006; Hofmann et al., 2012). As such, future research may continue to examine the efficacious adaptation of CBT techniques and principles for children, including with regard to optimizing the treatment for a broader range of disorders (e.g., externalizing disorders).

The research on these third-wave approaches, including ACT and DBT, is promising, suggesting that these approaches are becoming empirically supported alternatives to traditional CBT (Gaudiano, 2008). The American Psychological Association, Society of Clinical Psychology (Division 12) provides data regarding research-supported psychological treatments. According to this review (APA, 2006), ACT has strong research support in its treatment of chronic pain (e.g., McCracken & Vowles, 2014; Veehof et al., 2011) and modest research support for treating depression (e.g., Forman et al., 2007; Tamannaeifar et al., 2014; Zhao et al., 2013), mixed-anxiety (e.g., Avdagic et al., 2014; Swain et al., 2013), obsessive-compulsive disorder (e.g., Bluett et al., 2014; Twohig et al., 2010), and psychosis (e.g., Bach et al., 2012; White et al., 2011). DBT has strong research support as an evidence-based intervention for borderline personality disorder (e.g., Bohus et al., 2004; Linehan et al., 2006; Neacsiu et al., 2010). Emerging research also suggests that DBT may be effective in the treatment of eating disorders (e.g., Chen et al., 2008; Salbach-Andrae, et al., 2008), substance use disorders (e.g., Axelrod et al., 2011; Rizvi et al., 2011), and posttraumatic stress disorder (e.g., Steil et al., 2011). Similar to the research on traditional CBT, some studies that have examined DBT have found comparable outcomes as compared to other treatments. For example, a randomized controlled trial that examined DBT for adolescents (DBT-A) compared to enhanced usual care (EUC) concluded that DBT-A was superior to EUC in reducing self-harm, suicidal ideation, and depressive symptoms (Mehlum et al., 2014). However, many of the outcome measures (e.g., suicidal ideation, hopelessness, borderline symptoms) no longer showed significant differences at the 1-year follow-up point (Mehlum et al., 2014). Another study compared DBT to general psychiatric management for adults with borderline personality disorder; the study concluded that adults with BPD benefited equally from DBT and a well-specified treatment delivered by a psychiatrist with expertise in BPD (McMain et al., 2009). In sum, the emerging research of third-wave CBTs is exciting and suggests that adaptations of CBT may also be effective in treating a wide range of disorders. Future research

should continue to examine third-wave approaches to optimize treatments and provide data on the mechanisms of therapeutic change.

In addition to further evaluating CBTs for the treatment of childhood disorders and third-wave CBTs, future research will likely focus on neurobiological processes that change in the context of CBT. In the United States, the National Institute of Health (NIH) and National Institute of Mental Health (NIMH) are major funding organizations for treatment research of physical and mental health conditions. Overtime, these institutions have provided less research funding to show that a psychotherapy treatment works for a particular disorder; rather, funding has moved toward neuroscience research to identify mechanisms of treatment efficacy and of change in symptoms. As such, future research in CBT may examine the neurobiological mechanisms of change that occur during the therapeutic process.

## Regulations Regarding Psychotherapy Provision

In 1947, Connecticut became the first state to regulate the practice of psychology with the implementation of requirements for licensure. Since then, each state has developed its own licensing requirements, such that at present, only psychologists who have completed state licensing requirements are permitted to practice independently. Following a psychologist's completion of their graduate degree, most states require the completion of 1–2 years of postdoctoral training before psychologists can take the Examination for Professional Practice in Psychology (EPPP). The EPPP is the licensing exam used by all states, and the exam is designed to assess the psychologist's comprehensive knowledge of all aspects of practicing psychology. The exam is multiple-choice, and psychologists must obtain a predetermined passing score in order to complete this portion of their licensure. Once licensed, some states require psychologists to obtain a certain number of continuing education credits (e.g., on a yearly basis) before their licenses can be renewed. As licenses are issued at the state level, psychologists are not automatically qualified to practice if they move across state lines.

In the United States, psychologists can work in a wide range of professional roles, with the majority of practicing psychologists performing in more than just one role. Providing psychotherapy is the most common activity, and a 2010 survey of members of the Society of Clinical Psychology (APA Division 12) found that approximately 76% of respondents reported conducting psychotherapy for more than one-third of their professional time (Norcross & Karpiak, 2012). Within this role as psychotherapeutic practitioner, psychologists assess, diagnose, and treat psychological problems and behavioral dysfunction related to mental health. Nearly 41% of psychologists are primarily employed in private practice (Norcross & Karpiak, 2012), and other clinical employment settings include psychiatric and general hospitals, outpatient clinics, and the Veteran's Affairs (VA) health system. In addition to providing psychotherapeutic interventions in clinical settings, psychologists may also engage in assessment (e.g., cognitive, personality,

neuropsychological), consultation (e.g., with other health or behavioral health professionals and groups), teaching (e.g., at the undergraduate or graduate levels), and research (APA, n.d.-b).

Historically in the United States, changes in insurance coverage for psychological services have had major impacts on the practice of clinical psychology. Initially, psychologists providing clinical services (e.g., psychotherapy) could not be reimbursed for their services by medical insurance companies because they lacked medical degrees. Lobbying efforts by psychologists in the 1970s prompted state legislation to pass "freedom-of-choice" laws, allowing anyone licensed to practice mental healthcare to be reimbursed. Presently, clinical psychologists can be reimbursed for psychological services in all 50 states. However, there are many psychologists who opt out of working with third-party insurers, thus providing services "out-of-network." That is, many psychologists and mental health providers choose not to accept insurance, largely due to the fact that many insurance companies have not increased the reimbursement rate for psychologists in nearly 20 years, despite the rising administrative costs of running a psychological practice (APA, n.d.-a). As a result, some insurance plans have trouble attracting mental health professionals to participate in their networks. This trend has ultimately created inequalities in access to quality mental health care, such that there is a negative impact on the availability of mental health services to ethnic minority individuals and communities (La Roche & Turner, 2002).

Large-scale changes in insurance coverage and potentially of access to mental healthcare in the United States are underway through a combination of the 2008 Mental Health Parity and Addiction Equity Act (MHPAEA) and the 2010 Patient Protection and Affordable Care Act (PPACA; Beck et al., 2014). Mental health parity is the requirement that health insurance policies do not impose limits on mental healthcare coverage beyond those imposed on medical/surgical coverage (e.g., number of sessions, size, and scope of provider network). The Affordable Care Act (ACA) is aimed at reducing disparities, increasing prevention and wellness initiatives, and is intended to promote healthcare efficiency by measurement and tracking of healthcare outcomes. The intended combination of these two acts is to extend coverage for mental health and substance use disorder treatment to Americans who previously lacked this coverage. Many of the coverage-expanding provisions in the ACA took effect in 2014, and it remains to be seen how these changes will impact access and utilization of services. However, even with full implementation of the ACA, there will be Americans who do not functionally have access to the behavioral healthcare they need. That is, barriers to access to care remain despite these provisions, including high deductibles which require paying for large portions of medical services until the deductible is met for the year. As such, public mental health systems continue to be necessary even for those with health insurance, as well as for those not covered by the ACA such as undocumented immigrants, those who elect not to take insurance coverage, and individuals with insurance coverage that cannot afford to use their insurance due to high deductibles (Goldman & Karakus, 2014; Wharam et al., 2013). Promisingly, the ACA provides incentives for the creation of integrated healthcare centers and the organization of health homes to manage and

coordinate the care of severely mentally ill patients and those with multiple chronic physical conditions (Katon & Unutzer, 2013; Mechanic, 2012). Integrated care has the potential to enhance physical and mental healthcare outcomes for a wide range of patients and expand the role of psychologists in the broader medical system.

## Professional Training and CBT Organizations

Psychologists and other mental health professionals in the United States must earn an advanced degree. For clinical psychologists in particular, the American Psychological Association (APA, 1947) set forth training guidelines including the requirement that clinical psychologists be trained as both scientists and practitioners and earn a doctoral degree. In 1949, the Boulder training model, or the scientist-practitioner model, was established (Lavin & McGinn, 2017). Later in 1973, the practitioner-scholar model was formulated; this model places greater emphasis on preparation for professional practice, including the ability to integrate apply scientific work to clinical practice (Lavin & McGinn, 2017). As such, graduate programs in clinical psychology emphasize training in therapeutic interventions and are one of the primary modalities through which a practitioner receives training in CBT. Graduate students in clinical psychology may receive CBT training in many different forms, for example, formal didactic training (e.g., classes, lectures), practicum experience, and externship/internship experience. Many postgraduate psychologists are either required by law (for maintaining their licensure) or have independent motivation for foundational or advanced training in CBT techniques. In the United States, there are several formal training institutions that provide opportunities for training. For example, the Academy of Cognitive Therapy, a nonprofit organization founded in 1998 offers principle-guided, case-conceptualization-based training in CBT (e.g., workshops followed by individual consultation) as well as certification in CBT. That is, the academy offers a comprehensive training process through which clinicians' knowledge and competence in CBT is achieved. The academy also grants certification in CBT to clinicians through a rigorous and objective process. Other training and clinical centers in the United States offer both formal training via foundational workshops and opportunities for an ongoing professional consultation to practitioners who seek specialized and individualized consultation to help them implement CBT. These centers include the Beck Institute (Philadelphia, PA), Cognitive & Behavioral Consultants (New York, NY and White Plains, NY), the Ellis Institute (New York, NY), and Behavioral Tech (Seattle, Washington) (see Appendix A).

In the United States, there are also several professional organizations that provide opportunities for training through conferences on topics related to cognitive-behavioral therapy. The Association for Behavioral and Cognitive Therapies (ABCT), a multidisciplinary CBT organization founded in 1966 is committed to the enhancement of health and well-being by advancing the scientific understanding, assessment, prevention, and treatment of human problems through the global

application of behavioral, cognitive, and biological evidence-based principles (ABCT, 2018). ABCT has an annual convention that aims to bring together the cognitive-behavioral community to explore current developments in research and practice that surround CBT. Another leading organization is the American Psychological Association (APA), which has a membership of more than 115,700 researchers, educators, clinicians, consultants, and students. However, APA's focus is not restricted to the science and practice of CBT. The APA has 56 divisions, which are interest groups organized by members, which may represent subdisciplines of psychology (e.g., clinical, social, experimental) or specific topic areas (e.g., aging, trauma, ethnic minorities). There are several divisions focused on clinical psychology and CBT, including Division 12 – Clinical Psychology and Division 53 – Society of Clinical Child and Adolescent Psychology and Section III of Division 12 (Society for Scientific Clinical Psychology). The APA hosts an annual convention, and divisions of APA may offer specific training workshops, poster presentations, and member meetings relevant to their specific topics. In addition to ABCT and APA, there are many other organizations that operate at the local, national, and/or international levels. Appendix B outlines these organizations and provides links to their websites where additional information regarding their mission, membership, and conventions can be found.

## Appendices

### *Appendix A: CBT Training Institutions*

1. Academy of Cognitive and Behavioral Therapies (ACBT)
   (a) Mission and Information: The Academy of Cognitive Therapy, a nonprofit organization, was founded in 1998 by a group of leading clinicians, educators, and researchers in the field of cognitive therapy. As part of its mission, the academy supports continuing education and research in cognitive therapy, provides a valuable resource in cognitive therapy for professionals and the public at large, and actively works towards the identification and certification of clinicians skilled in cognitive therapy. Certification is awarded to those individuals who, based upon an objective evaluation, have demonstrated an advanced level of expertise in cognitive therapy. The Academy includes physicians, psychologists, social workers, and other mental health professionals from around the world. To date, there are over 750 members of the academy.
   (b) Web Link:
2. Beck Institute for Cognitive Behavior Therapy
   (a) Mission and Information: Beck Institute for Cognitive Behavior Therapy was founded in 1994 by Dr. Aaron Beck and his daughter, Dr. Judith Beck,

as a new setting for state-of-the-art psychotherapy and professional training. Through their vision, Beck Institute has carried out its mission of enhancing the lives of individuals through the provision of exceptional training in CBT to health and mental health professionals worldwide. Beck Institute offers online www.academyofct.orgresources and training opportunities both for individual professionals and for organizations and also provides clinical services to clients at the Philadelphia headquarters. In addition to professional and client services, Beck Institute remains an international authority and source for CBT information and research.

(b) Web Link: https://beckinstitute.org/

3. Behavioral Tech

(a) Mission and Information: Founded in 2002 as a wholly owned subsidiary of the Linehan Institute, Behavioral Tech trains mental healthcare providers and treatment teams who work with complex and severely disordered populations to use compassionate, scientifically valid treatments and to implement and evaluate these treatments in their practice setting. Behavioral Tech specializes in dialectical behavior therapy (DBT) training for mental health providers, agencies, and large systems.

(b) Web Link: https://behavioraltech.org/

4. Cognitive and Behavioral Consultants

(a) Mission and Information: Founded on the belief that mental health treatment should be compassionate, dignified, and effective, founders Alec L. Miller and Lata K. McGinn formed CBC as a center where like-minded professionals could work together to offer a powerful resource for their clients. With offices office located in Manhattan and Westchester, CBC is an internationally recognized evidence-based center that provides clinical and wellness services, custom designed programs for organizations, and continuing education for professionals. CBC specializes in cognitive behavioral therapy and dialectical behavioral therapy. Through the use of evidence-based approaches, CBC provides the necessary structure and tools to assist individuals with issues ranging from life stresses and problems to the full range of mild to severe psychological disorders. CBC provide services to adults, adolescents, children, couples and families, consultation to schools, agencies, and businesses, and education and training for therapists.

(b) Web Link: https://www.cbc-psychology.com/

5. Albert Ellis Institute

(a) Mission and Information: Albert Ellis Institute (AEI) was established in 1959 by Dr. Albert Ellis. AEI is committed to promoting emotional well-being through the research and application of effective, short-term therapy with long-term results. AEI's therapeutic approach is based on rational emotive behavior therapy (REBT), the pioneering form of cognitive behavior therapy. AEI conducts research and provides continuing education for

mental health professionals, self-help workshops for the public, and affordable psychotherapy and psychological assessment.
(b) Web Link: http://albertellis.org/

## *Appendix B: Professional Cognitive Behavior Therapy Organizations*

1. World Confederation of Cognitive and Behavioral Therapies (WCCBT)
   (a) Mission: The World Confederation of Cognitive and Behavioral Therapies (WCCBT) is a global multidisciplinary organization dedicated to the prevention, assessment, and treatment of mental distress and suffering, and the promotion of health and well-being through the scientific development and implementation of evidence-based cognitive and behavioral strategies.
   (b) Web Link: www.wccbt.org/
2. Association for Behavior and Cognitive Therapies (ABCT)
   (a) Mission and Information: ABCT is a multidisciplinary organization committed to the enhancement of health and well-being by advancing the scientific understanding, assessment, prevention, and treatment of human problems through the global application of behavioral, cognitive, and biological evidence-based principles.
   (b) Web Link: www.abct.org
3. American Psychological Association (APA)
   (a) Mission and Information: APA is the leading scientific and professional organization representing psychology in the United States. The mission of APA is to advance the creation, communication, and application of psychological knowledge to benefit society and improve people's lives.
   (b) Web Link: www.apa.org
4. American Psychological Association (APA) – Division 12: Society of Clinical Psychology
   (a) Mission and Information: The mission of the Society of Clinical Psychology is to represent the field of clinical psychology through encouragement and support of the integration of clinical psychological science and practice in education, research, application, advocacy and public policy, and attending to issues of diversity.
   (b) Web Link: www.div12.org

5. American Psychological Association (APA) – Division 53: Society of Clinical Child and Adolescent Psychology (SCCAP)
   (a) Mission and Information: SCCAP aims to serve children, adolescents, and families with the best possible clinical care based on psychological science. SCCAP strives to integrate scientific and professional aspects of clinical child and adolescent psychology, in that it promotes scientific inquiry, training, and clinical practice related to serving children and their families.
   (b) Web Link: http://sccap53.org
6. Association for Psychological Science (APS)
   (a) Mission and Information: APS is the leading international organization dedicated to advancing scientific psychology across disciplinary and geographic borders. APS members provide a richer understanding of the world through their research, teaching, and application of psychological science. APS supports psychological scientists in these pursuits by sharing cutting-edge research across all areas of the field through journals and conventions; promoting the integration of scientific perspectives within psychological science and with related disciplines; fostering global connections among members; engaging the public with research to promote broader understanding and awareness of psychological science; and advocating for increased support for psychological science in the public policy arena.
   (b) Web Link: https://www.psychologicalscience.org/
7. International Association for Cognitive and Behavioral Therapies (IACBT)
   (a) Mission and Information: IACP is an international professional, scientific, interdisciplinary organization whose mission is to alleviate human suffering by facilitating the worldwide development, utilization, and growth of cognitive psychotherapy as a scientific discipline and professional activity.
   (b) Web-Link: i-acbt.com
8. Association for Contextual Behavioral Science (ACBS)
   (a) Mission and Information: ACBS is an international community of scholars, researchers, educators, practitioners, and others whose mission is to support a dynamic interaction between basic and applied research; disseminate contextual behavioral science; continue to develop principles, theories, and practical applications grounded in empirical knowledge and guided by the best available scientific evidence; and support all members who wish to participate in this work.
   (b) Web Link: www.contextualscience.org
9. Additional Related Organizations
   (a) Anxiety Disorders Association of America (https://adaa.org/)
   (b) International Obsessive-Compulsive Disorder (OCD) Foundation (https://iocdf.org/)

(c) Society of Behavioral Medicine (https://www.sbm.org/)
(d) International Society for Traumatic Stress Studies (ISTSS; https://www.istss.org/)
(e) International Society for the Improvement and Teaching of Dialectical Behavior Therapy (ISIT-DBT; http://isitdbt.net)

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