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Portraits in CBT: Interview with Emel Stroup

BDT'den Portreler: Emel Stroup ile Röportaj

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BACKROUND

Dr. Emel Stroup obtained her doctorate in Clinical Psychology from Alliant University in San Diego, California. She is board certified in Clinical Psychology by the American Board of Professional Psychology, and is a Fellow of the Academy of Cognitive Therapy, where she is also a certified CBT Trainer/Consultant. Additionally, she is both certified as a psychotherapist by the European Federation of Psychologists' Associations, and is licensed to practice in the State of California.

Dr. Stroup lives and works in Istanbul, Turkey, where she both maintains a private practice, and serves as the head of the CBT Unit at the Humanity Psychiatric Medicine Hospital. She is also an Associate Professor teaching clinical psychology to masters and doctoral students at Okan University. Additionally, she conducts private supervision to a limited number of carefully selected practicing therapists, and she teaches a popular series of workshops every year addressing general psychotherapy practices and techniques, as well as specific disorders, all from a CBT perspective.

Dr. Stroup brought the highly-regarded books "Mind over Mood" and "Clinician's Guide to Mind over Mood" by Doctors Christine Padesky and Dennis Greenberger to Turkey, where they have also become best-sellers. She also participated in the development of the DSM-V as a collaborating investigator during its field trials.

Dr. Stroup is the founder and director of CBTiSTANBUL, where she conducts many of the activities described above, and where she provides intensive training in the professional practice of clinical psychology and CBT to a small team of psychology interns every year.

1. What are the factors that led you to choose psychotherapy as your major focus in the field of mental health?

When I first began working in the field, it was in a culture where the locals thought that medical intervention could solve their problems – they supposed the doctor could give them a pill and everything would be okay. As a result, I knew that psychotherapy had to be not only effective, but also brief. It was while investigating solutions to this puzzle that I discovered Cognitive Therapy. I immediately ordered all the books and material I could find on the subject, and I travelled to the United States to take an extensive, in-depth course of study at the Beck Institute in Bala Cynwyd, Pennsylvania. As my final exercise, I was selected to present a case to Dr. Aaron Beck, the founder of Cognitive Therapy. At the time, I had a master's degree, and Dr. Beck encouraged me very enthusiastically to get my doctorate, even having his staff develop a list of schools as suggestions for me to attend (and I did attend one of them).

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2. What changes did you experience in your psychotherapy practice after making Cognitive Therapy your main orientations?

I found that clarity both for me and for my patients increased dramatically as we examined presenting problems from the perspective of the Cognitive Therapy Model, and using Cognitive Therapy methodologies. Related to this in an important way, patient engagement and collaboration dramatically improved and therapy became much more focused and effective.

3. What are the unique properties of Cognitive Therapy when compared to other psychotherapy approaches? Which features of other psychotherapy does it oppose to?

There are two main differences here. One is the scientific basis of Cognitive Therapy. It is based on a testable scientific model, and so science-based protocols can be developed from it, and they can be tested empirically. Only Behavioral Therapy shares this aspect of Cognitive Therapy.

The other difference, however, separates Cognitive Therapy from Behavioral Therapy as well. This is that in Cognitive Therapy the patient is at the center of the therapeutic process. The patient's wishes and decisions are at the center of the therapeutic process in Cognitive Therapy; the therapist is the expert guide, but the patient must understand and agree with all elements of the therapy as recommended by the therapist, or the therapy will not only be ineffective – it will not continue. All other psychotherapeutic orientations, including Behavioral Therapy, are therapist-driven – therapy is directed by the therapist with the patient as a largely passive object of the therapy. The patients in these other orientations receive the therapy; in CT they drive it.

4. What are the relationships between the environment, feelings/emotions, thoughts (cognitions) and behaviors? Are any of these aspects more important or more primary than the others?

According to the Cognitive Therapy Model, the primary relationship is that between a person's cognitions and the environment. That is, how does the person interpret the environment? Are these interpretations correct, realistic, functional? Sometimes we interpret events in the environment incorrectly and sometimes so much so that these misinterpretations become so dysfunctional as to result in psychological problems. These problems can be chronic, they can occur for limited periods of time (which can be days or years), or they can be specific repetitions of the environmental events that are misinterpreted – these events, then, are "triggers" of the pathology. The Cognitive Therapy Model shows us that these psychological problems, then, arise from erroneous cognitions. They then transform into a combination of dysfunctional emotions and/or behaviors that are the pathology which itself can become so severe as to require treatment. The aim of Cognitive Therapy is to drill directly down to the level of cognition that is causing the dysfunctional responses, and to help the patient examine those cognitions so that the patient him- or herself re-assesses the meaning of the environmental cues involved and reinterprets them in realistic, functional ways that remove the dysfunctional chain reactions that previously grew from the misinterpretation, leaving functional interpretations and functional responses. Because the patient does this him- or herself, this also results in one of Cognitive Therapy's most important benefits: a dramatic reduction in the incidence of relapse in patient pathology.

5. What kinds of projects related to cognitive behavioral therapy, either theoretical or practical, do you have in mind for the near future?

I am a practitioner and teacher, and so my projects related to CBT are along those lines. Accordingly, I constantly scan the research literature for information about improvements to current CBT protocols, and the development of CBT for the treatment of additional disorders. I also scan it for signs that so-called "new wave" CBT approaches are developing into methodologies that can successfully enter the CBT family of scientifically testable, evidence-based therapies. When this becomes demonstrably established (but not before), I will study and incorporate them into my practice and teaching as appropriate.

Regarding the current scientifically-founded CBT methodologies and protocols, I am exploring new ways to use communications technology to reach more student therapists, in the hopes that we can spread the professional, competent practice of evidence-based CBT to ever-larger portions of the psychotherapy communities here in Turkey, and thus to their patients as well. The challenge is to be able to ensure that objective requirements of the teaching of CBT are not compromised – this will invalidate and cease any efforts at such instruction. However,

newer communication technologies do show promise of removing these concerns to effective instruction, and I am following them closely.

6. What do you believe are applications of CBT in the fields of education and public mental health that could help preventing psychological/ psychiatric problems?

Dr. Dennis Greenberger and Dr. Christine Padesky have written a wonderful book called "Mind over Mood" which is designed both to complement a patient's work with a CBT therapist, and to help people successfully and durably deal with problems which do not necessarily rise to a clinical level requiring professional treatment. This book is available in Turkish under the title "Evinizdeki Terapist," and there is a workbook version entitled "Evinizdeki Terapist – Klinisyen El Kitabı" as well; these books were developed for Turkey under my direct supervision. As a consequence, I am fully familiar with how well they might be used or adapted in education by both public and private institutions or in the development of public mental health policies and activities by governmental bodies. Adapted and taught in this way, the Cognitive Therapy Model can be used to help the general public develop stronger, healthier ways to understand and direct their own cognitive processes, as well as to recognize and respond properly when they detect that the things might be turning dysfunctional. I am a strong proponent of the adaptation of Cognitive Therapy to this broader use for general good of the public, and would be very pleased to see it occur, and to find a way to contribute, myself.

7. From your point of view, what kinds of developments do you expect in the theory and practice of CBT?

Cognitive Therapy has grown from its original form as a treatment for depression, to an effective – and primary – treatment for a wide range of psychological, and even medical, disorders. I don't doubt that new productive avenues for its use will be discovered and developed.

I also am very interested in the diverse efforts to adapt other mental health endeavors – from mindfulness and one end of the spectrum, to acceptance and commitment therapy at the other – to, or to find a way to effectively fold them into, CBT. The mental health and medical fields are in a bright period of new discovery about how the "mind" and body work and interact, and how we exist and interact ourselves both as individuals and members of communities. It seems inevitable that this renaissance will come to shed new light on how we can extend the Cognitive Therapy Model more effectively and constructively not only into the practice of psychotherapy, but for the wider benefit of people's lives in general, as well.

8. May I have your opinions about newer (third wave) cognitive and behavioral perspectives? How can 'mindfulness and acceptance based approaches' influence the CBT and psychotherapy world?

These methods have not yet demonstrated their ability to fold scientifically into the Cognitive Therapy Model. As a result, replicable empirical tests to examine and validate them cannot yet be designed and executed in the classic manner of scientific research.

Nevertheless, many of these seem plausibly effective on the face of it, and their association with CBT seems to be logical as well. Accordingly, I follow developments in these fields with great interest, and eagerly await scientific validation of their inclusion in the family of evidence-based Cognitive Therapy methods and protocols. It seems inevitable to me that this will happen in time, to the great benefit of CBT, either in the form of one or more of the current approaches, or as an entirely new approach yet to be developed.

As a result I follow developments in these areas with great interest and anticipation.

9. You organized very professional training/ workshops as CBTiSTANBUL. What are your new projects?

I and the CBTiSTANBUL team continue to look for new ways to introduce and entrench a fully competent understanding and practice of CBT in the professional psychotherapy community in Turkey. We look for new books in the field to bring to Turkey, both for the general public and for use by therapists in practice. We also explore new ways to present and teach CBT to mental health professionals throughout the country; we are examining developing communications technologies, especially, in this regard.