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SPEECH SUMMARIES

KONUŞMA ÖZETLERİ

Addressing Chronic Depression from the Perspective of "Cognitive Therapy"

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According to the DSM-IVTR, chronic depression is defined as a mental health disorder characterized by long-term depressive symptoms lasting at least two years. In DSM-5TR, it is included under the heading of Ongoing Depression Disorder. It usually has an early onset, is associated with severe disability, and has a high prevalence of comorbid disorders such as personality disorders and substance abuse. A diagnosis of depression is observed in childhood life events and family history. Changes in the prefrontal cortex, anterior cingulate, amygdala, and hippocampus have been described. Cognitive therapy is a practical psychotherapy approach developed by Aaron Beck in the 1960s, focusing on the relationship between thought, emotion, and behavior, and its effect on depression has been proven by many studies (1–3). Studies indicate that cognitive behavioral therapy (CBT) improves patients' quality of life and positive neurophysiological changes (4, 5).

Beck defined depression as a cognitive triad consisting of a negative view of the world, self, and the future and took an essential step in the treatment of depression by using the overgeneralization made by patients in therapy. The cognitive model of depression has become more comprehensive with the definition of learned helplessness by Seligman and the presentation of features such as discontent, expectation of lack of control, attribution of adverse events to one's own internal causes, and attribution of positive events to external causes by Abramson and colleagues in the theoretical infrastructure of depression (2).

However, in the case of chronic depression, the symptoms tend to persist for a more extended period, and many factors such as the disability of a long-term illness, previous psychotherapies that have not been beneficial, medication use, medication side effects etc. cause the hopelessness that emerges as a symptom to deepen. In this state, the reconstruction of the desire-action-desire cycle takes time. Comorbid personality disorders in these patients also have a negative impact on the study of the illness and the therapeutic relationship.

When the illness started, how long it has been going on, how the person has coped with the illness so far, and his/her strengths are the issues that need to be taken into consideration in the assessment interviews of patients with chronic depression. While the initial sessions proceed as a classical CBT process with psychoeducation about the illness, CBT, and behavioral interventions, the aim is to work on schemas in the following sessions. Instead of trying to persuade directly, following the structuring of the sessions and skillful use of techniques appear to be the most functional way to cope with hopelessness from the first sessions. In patients with whom a sufficient therapeutic relationship has been established and automatic thoughts have been studied, it is necessary to determine the strategies they use to cope with their problems and depression, to present the maladaptive ones to the patient with a longitudinal formulation, and to study the schemas. In patients with disability, studies can be planned for the areas where they are inadequate. In patients with chronic depression, psychiatrists, clinical psychologists, nurses, and, in some cases, occupational therapists may need to work as a team. The use of medication is not an obstacle to psychotherapy; on the contrary, it often facilitates and increases the effectiveness of treatment.

In the wrap-up sessions, new skills and strategies are reviewed, and plans can be made for possible challenging situations.

In conclusion, cognitive therapy for chronic depression requires the study of schemas, a multidisciplinary perspective, and a strong therapeutic relationship.

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Treating Chronic Depression from the Perspective of 'Schema Therapy'

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Depression is one of the most common mental health disorders and a leading cause of disability. It is well-established that multifaceted factors contribute to the development of depression, with biological, genetic, and psychosocial factors playing key roles. Depression often presents with comorbid conditions and has a tendency to relapse or follow a chronic course. Chronic depression (dysthymia) is characterized by a clinical condition where the individual feels persistently unhappy, experiences reduced productivity, loses interest in their surroundings, and exhibits vegetative symptoms. Depressive symptoms persist for over two years, with no periods of well-being lasting longer than two months. The prolonged duration of symptoms, typically spanning two years or more, raises questions about the influence of personality traits in chronic depressive disorder. Studies have reported a correlation between chronic depression and personality traits. Considering these features, therapeutic interventions should target both the acute symptoms of depression and the personality traits, beliefs, and attitudes that may be linked to its chronic course.

Schema Therapy (ST), developed by J. Young, originates from cognitive-behavioral therapy and was initially designed to address chronic, lifelong issues. It is an integrative approach that combines effective techniques from cognitive-behavioral therapy, psychodynamic theory, interpersonal relations theory, attachment theory, and object relations theory. Although originally developed for chronic issues, research has demonstrated its efficacy in treating acute psychological pathologies as well. In depression, the cognitive triad—negative perceptions of the self, the future, and the world—along with automatic negative thoughts, cognitive biases, and dysfunctional schemas, are significant factors. Early maladaptive schemas are deeply ingrained cognitive constructions, encompassing dysfunctional thoughts, emotions, and behaviors. In addition to cognitive and behavioral methods, experiential techniques are central to schema therapy sessions. Techniques such as imagery rescripting and chair work are among the most prominent experiential methods.

These dysfunctional systems play a critical role in the course, severity, and recurrence of the illness. Therefore, interventions targeting these thought patterns and beliefs are effective in achieving remission from depression and reducing the likelihood of relapse. Treating depression at the schema level is essential in clinical practice, as such interventions are known to strengthen the clinician's ability to manage the disorder during treatment.

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Cognitive Behavioral Analysis System of Psychotherapy for Persistent Depressive Disorder

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Cognitive behavioral analysis system of psychotherapy (CBASP) was developed by James P. McCullough specifically designed for treating chronic depression. It combines elements from first and second wave cognitive-behavioural therapy (CBT) and uses Piaget's theory of cognitive development to understand the cognitive characteristics of chronically depressed individuals. McCullough, as a result of his studies that he started in the 1970s, noticed that the thoughts, behaviours and relationship styles of patients with chronic depression were similar to the characteristics of children in the preoperational stage and that their repertoire of interpersonal relationships was narrow. In the case of a child living in a home environment where there is a danger of neglect and abuse, it is seen that the child's vital energy and behaviour focus on survival instead of development, and this can negatively affect the developmental processes, that is, the child focuses its vital energy on not losing and not being harmed instead of developing and winning. For the treatment, CBASP suggests using a combination of cognitive and behavioural techniques that are appropriate for the individual's cognitive developmental stage. CBASP integrates behavioural, cognitive, interpersonal, and psychodynamic components into its treatment approach. The European Psychiatric Association recommends CBASP as a first-line psychotherapeutic treatment for chronic depression.

CBASP, identifies fear avoidance and perceptual disconnection as the main factors contributing to the persistent of the disorder. The treatment goals in CBASP include develop thinking at the formal operational stage level skills, understanding the relationship between the effects of his/her own behaviour on the other individual and the reactions of the other individual and his/her own actions, reducing the negative consequences of relationship traumas (which are reflected in the current situation), to find out how to behave in accordance with his/her goals and to develop thoughts that will help him/her to behave accordingly, and improving empathy and interpersonal relationships.

The therapy process involves several stages: assessment, considering the involvement of significant others(SOs), conducting a coping survey questionnaire to analyze the situation, engaging in disciplined personal involvement(DPI) through interpersonal discrimination exercise(IDE), and Contingent Personal Responsivity (CPR), transferring what is learned to various situations, and providing essential skills training such as assertiveness and problem-solving. These stages aim to address the underlying issues and support individuals in overcoming chronic depressive disorder.

CBASP involves several techniques. One technique aim to understand patients' interpersonal-emotional history, information is obtained through the SOs History. CBASP identifies malevolent SOs that contribute to the patient's destructive generalized expectations. The therapist generates causal hypotheses about SOs in the individual's life and their effects on the individual's life, personality, behaviour and interpersonal-emotional field. These are then used as material for the transference hypothesis.

Another technique is situational analysis, the major technique used in CBASP. The aim of situational analysis (SA) is to perceptually connect to the social-interpersonal environment and demonstrate to patients the consequences of their behavior. CBASP recommends administer this technique in every session when appropriate. A distinctive feature of the CBASP therapist role is DPI. This technique is a type of objective counter-transference that includes components for the therapist understands and responds to the patient's feelings and reactions. Another technique, IDE, teaches patients to discriminate between the behavioral consequences of the therapist and the interpersonal consequences imposed by mistreating SOs in the fear-avoidance domain, as patients tend to generalize their hurtful experiences with significant others in their lives to all their relationships. The goal is to achieve "felt safety" as patients learn that practitioners will not harm them in specific experiential contexts where they have previously experienced hurt. The IDE helps the patient differentiate between hurtful experiences in their relationships. Lastly, the interpersonal circumplex model is a useful framework for understanding interactions between individuals. For individuals with chronic depression, avoidance behavior caused by fear in social situations can lead to functional impairment. Like the laws governing the physical world, there are also rules that govern interpersonal relationships.

CBASP is a therapy approach that has been shown to be effective in the treatment of depression by numerous studies and meta-analyses, and is recommended in addition to antidepressant medication, not alone. The interpersonal problems of patients with personality disorders are similar to the pre-operational stage characteristics of chronically depressed patients. CBASP therapy has been proven effective in treating depression and may have potential in other diagnoses as well.

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Rational Use of Medicines

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Rational Use of Medicines is the ability of individuals to easily obtain the appropriate medicine, at the appropriate duration and dose, at the lowest price, according to their clinical findings and individual characteristics. According to estimates of the WHO, more than 50% of drugs are prescribed, supplied or sold inappropriately (1).

As in the worldwide, inappropriate and unnecessary use of medicines is a serious problem affecting public health in our country. Irrational use of medicines leads to decreased patient adherence to treatment, drug interactions, development of resistance to some drugs, recurrence or prolongation of diseases, increased incidence of adverse events and increased treatment costs (1).

Examples of irrational use of medicines (1):

- Use of medication when drug treatment is not indicated
- Use of the wrong medication in a special condition requiring medication
- Use of medications of questionable or incompletely proven efficacy
- Use of medications for which there is no complete information on safety
- Inappropriate route of administration, dose and duration

Drug interactions can be seen in medication groups frequently used in psychiatry. It is important to prescribe medications by taking these drug interactions into consideration.

Some SSRIs are strong CYP inhibitors. Fluvoxamine is a strong CYP1A2 inhibitor that can cause elevated levels of theophylline and clozapine. Paroxetine may cause failure of tamoxifen treatment through CYP2D6 inhibition (2).

Since lithium has a narrow therapeutic index, caution should be exercised in terms of drug interactions. Lithium level increases with ACEI, thiazide diuretics and NSAID. Valproate is highly bound to proteins and may be displaced by other protein-binding drugs such as aspirin and cause toxicity. Aspirin may also inhibit the metabolism of valproate. Valproate can displace drugs that bind lowly to proteins, such as warfarin, leading to higher free levels and toxicity. Valproate is metabolized in the liver; drugs that inhibit CYP enzymes (e.g. erythromycin, fluoxetine and cimetidine) may increase valproate levels (2).

Carbamazepine is a CYP inducer and causes induction of its own metabolism as well as the metabolism of other drugs, including some antipsychotics. Its half-life is reduced with chronic use. Plasma levels of most antidepressants, some antipsychotics, benzodiazepines, warfarin, zolpidem and some cholinesterase inhibitors, methadone, thyroxine, estrogens and other steroids may be reduced by carbamazepine. It is metabolized by CYP3A, fluconazole, cimetidine, diltiazem, verapamil, erythromycin and some SSRIs that inhibit CYP3A4 may cause toxicity by increasing carbamazepine levels (2).

Drugs that lower the seizure threshold may decrease the anticonvulsant effect of carbamazepine. Drugs with the potential to suppress bone marrow (e.g. clozapine) may increase the potential of carbamazepine to cause neutropenia. The risk of hyponatremia may increase if taken concomitantly with drugs that reduce sodium (e.g. diuretics).

Valproate inhibits lamotrigine metabolism. Lamotrigine levels increase up to two-fold with concomitant use of valproate with lamotrigine. Therefore, the dose and titration should be half the dose. Carbamazepine induces lamotrigine metabolism. Lamotrigine levels are halved with the use of carbamazepine in combination with lamotrigine. Therefore, the dose and titration should be doubled (2).

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Development of the Concept of Metacognition in Children and Adolescents

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Metacognition is a multifaceted concept comprising knowledge, processes, and strategies that evaluate, monitor, or control cognition. As a higher-order system, metacognition entails an individual's awareness of the events and functions occurring within their own mind, as well as their capacity to deliberately direct these processes. It can also be defined as "the knowledge an individual has about their own knowledge, their thoughts about their cognitive processes, or an internal reflection on their own cognitive processes." The relationship between metacognition and mental health or disorders in adult populations has prompted interest in whether children and adolescents exhibit comparable metacognitive beliefs. It has been documented that metacognition commences to develop in conjunction with the advent of the theory of mind during the preschool years. As posited by Flavell, the development of metacognitive knowledge and meta-memory in children commences between the ages of three and five and persists throughout the lifespan. It has been demonstrated in studies that children around the age of four possess metacognitive knowledge, including the understanding that their thoughts can include things that do not physically exist. Nevertheless, other metacognitive processes, such as monitoring and control, emerge later in childhood. Subsequently, from the age of six onwards, children become aware of the circumstances and processes involved in the acquisition of knowledge. It has been demonstrated that children between the ages of 6 and 7 begin to demonstrate an awareness of the existence of alternative perspectives and thought processes. Between the ages of 5 and 8, children also learn that their attention is selective and limited. By the age of 9, children may begin to understand, much like adults, that thoughts can be automatic and challenging to control. Metacognitive regulation largely reaches adult levels after the age of 13. It is believed that certain metacognitive skills, such as monitoring and evaluation, mature later than others, like planning. Further research is required to gain a deeper understanding of this topic.

Metacognitive Models in Childhood Psychopathologies

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Metacognition refers to the cognitive structure that enables the individual to recognize, understand, evaluate, and organize their own thought processes. Often referred to as "thinking about thinking," metacognition helps individuals evaluate their thoughts, adjust strategies, and refine their approach through self-reflection and feedback.

Metacognition stands as an executive function above cognition, regulating the cognitive or behavioral responses an individual uses to react to internal or external stimuli. This interaction among cognitive processes is identified as the Self-Regulatory Executive Function (S-REF), which is utilized to explain various psychopathological disorders. According to this model that was developed by Wells, the emergence of psychiatric disorders originates from dysfunctional metacognitive beliefs, which are defined in the concept of "Cognitive Attentional Syndrome (CAS)". Worry, rumination, fixed attention on threats (e.g., threat seeking, controlling and suppressing thoughts, filling the memory gaps) and dysfunctional self-regulation strategies (e.g., avoidance and alcohol/substance misuse) are among the maladaptive coping strategy components that are frequently used in CAS. These metacognitive beliefs can be either positive or negative. Positive beliefs may involve thinking that certain cognitive strategies, like worrying help solve problems; while negative beliefs often relate to viewing thoughts as uncontrollable or harmful. While most individuals experience these sensations temporarily, if they become chronic and persistent, they can lead to the development of mental disorders. These mechanisms may disrupt the self-regulatory system that the individual use to cope with negative emotions and experiences, leading to a feeling of lack of control over their emotions, cognition, and thoughts.

The adolescent period, during which awareness of one's own thoughts and decisions becomes crucial, can also contribute to the emergence of various psychopathologies, particularly if accompanied by prolonged negative metacognitive beliefs. In the literature, although most studies on the metacognitive model and the development of psychopathologies focus on adulthood, there are also a limited number of studies examining these issues in childhood and adolescence. Studies have shown that maladaptive metacognitions are often linked to internalizing disorders, such as Generalized Anxiety Disorder (GAD), Major Depressive Disorder, and Obsessive-Compulsive Disorder(OCD). Negative beliefs about worry, cognitive confidence, the need for control, and cognitive self-consciousness have been found to be significantly associated with anxiety disorders and depression in children and adolescent, with negative beliefs about worry showed the strongest relationship. Data on positive metacognitive beliefs are less consistent; some studies suggest that these beliefs may have a regulatory role in moderating the connection between metacognition and stress. Studies indicate a link between negative beliefs regarding the uncontrollability and danger of thoughts and the development of GAD, whereas heightened cognitive self-consciousness is more associated with OCD. Adolescents diagnosed with attention deficit hyperactivity disorder are suggested to suffer developing metacognitive skills due to existing executive function deficits. Moreover, growing literature suggests an association between metacognitive dysfunction and the etiology of psychopathologies such as psychotic disorders, eating disorders, and borderline personality. Despite the increasing body of research on this topic, further studies are needed to clarify the specific relationship between metacognitive dysfunction and adolescent psychopathologies.

Metacognitive Therapy in Children and Adolescents

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Metacognitive Therapy (MCT) is a psychotherapeutic approach aimed at enhancing individuals' cognitive flexibility, fostering awareness of their thought processes, and making these processes more functional. Developed by Adrian Wells, MCT differs from cognitive behavioral therapy (CBT) in that it focuses on the process of thinking rather than the content of thoughts. The core theory of MCT posits that the primary factor underlying psychological disorders is individuals' metacognitive beliefs about their thoughts. Wells categorizes these beliefs into two types: positive and negative metacognitive beliefs. Positive metacognitive beliefs include ideas about the benefits of worrying, rumination, threat perception, and thought control, such as "Worrying helps me prepare." Negative metacognitive beliefs, on the other hand, revolve around the uncontrollability of thoughts and their perceived danger or importance, such as "I cannot control my thoughts." In this process, patients are taught that cognitive processes are temporary and controllable, enabling the replacement of maladaptive cognitive habits with more functional coping strategies.

MCT has been found effective in treating various psychopathologies in children and adolescents, including anxiety disorders, depression, obsessive-compulsive disorder, attention deficit hyperactivity disorder, and post-traumatic stress disorder. The primary interventions of the therapy include thought monitoring, modification of metacognitive beliefs, attention training, and behavioral experiments. Typically, it is a time-limited therapy lasting between 8 and 12 sessions. It can be administered in both individual and group formats. This therapeutic method facilitates the recognition and regulation of harmful cognitive processes, while targeting the restructuring of dysfunctional cognitive patterns. Although studies on the use of MCT in children and adolescents are still limited, its empirical basis and effectiveness in treating various psychological disorders suggest it is a promising intervention. Particularly in anxiety disorders and mood disorders, the teaching of cognitive control strategies through MCT and the positive long-term effects on psychological well-being significantly contribute to its clinical effectiveness. Teaching metacognitive strategies to this age group and incorporating supportive environmental factors into the therapy process may further enhance the efficacy of MCT.

Travmanın 50 Tonu: Travmanın Farklı Klinik Yansımalarına Transdiagnostik Terapi Yaklaşımları

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Bir travmatik olay sonrası en sık karşılaşılan ve ilk akla gelen bozukluklardan biri Travma Sonrası Stres Bozukluğudur (TSSB). Fakat travma sonrası ortaya çıkabilen psikolojik zorluklar TSSB ile sınırlı değildir. TSSB için tanı kriterlerini karşılayan bireylerin çoğunun aynı zamanda bir veya daha fazla komorbid bozukluk için de kriterleri karşıladığına dair kanıtların yanı sıra, belirli klinik görünümlerin komorbidite denilemeyecek kadar TSSB'nin temel semptomları ile güçlü bir ilişkiye sahip olduğu da bildirilmiştir. Depresyon, yas, intihar düşünceleri, agorafobi, özgül fobiler, sosyal fobi, obsesif kompulsif bozukluk, ikincil psikotik belirtiler, duygudurum epizodları, psikosomatik belirtiler, yeme bozuklukları, uyku bozuklukları, madde kullanım bozuklukları, kişilik değişiklikleri travmatik bir olay sonrası kronik süreçte ortaya çıkabilecek durumlardan bazılarıdır.

Yüksek komorbidite oranları ve farklı klinik görünümler vaka karmaşıklığını artırabilir ve kimin tedavi ihtiyacı olduğu ya da tedavide hangi psikolojik zorluğa nasıl öncelik verileceği konuları klinisyenleler için zorluk yaratabilir. Tedavi kılavuzları TSSB'nin tedavisi için kanıta dayalı tek tanı protokollerini altın standart olarak kabul etmekle birlikte farklı klinik durumlar için doğrudan bir öneri sunmamaktadır. Bu noktada birçok psikolojik bozukluğun hem gelişiminden hem de iyileşmesinden sorumlu ortak mekanizmaların tanımlanması önem kazanmaktadır. Travma ilişkili bozukluklarda da ortak olan bu transdiagnostik mekanizmaların tespiti ve tedavide bu mekanizmalara daha bilinçli bir şekilde odaklanılması mevcut tek tanı tedavi protokollerine daha verimli ve etkili bir alternatif sağlayabilmektedir.

Bu oturumda travmayla ilişkili olarak ortaya çıkabilecek farklı klinik görünümlere ve bu klinik görünümlerle ilişkili utanç, benlik algısı, yaşantısal kaçınma, anksiyet duyarlılığı, ruminasyon, kendini eleştirme gibi transdiagnostik mekanizmalara yer verilecektir.

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Şefkat Odaklı Terapi (ŞOT) Uygulama

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Paul Gilbert (2009) evrimsel biyoloji ve psikoloji temelinde bio-sosyal modeli temel alarak geliştirdiği ŞOT, gelişen özünde BDT devamında etkinleşen bir modeldir. ŞOT, Bowbly (1950) bağlanma kuramında hareketle iyi ve şefkatli bir bağ kurmak sürecinde önem vermiştir. ŞOT salt BDT bağlantılı değil terapi ekolleri üzerinde her ekole eklenebilen bir bileşen gibi de görülebilir. Özellikle ŞOT depresyon sürecinin gelişiminde aşırı düşünme ve yıkıcı özeleştiri yapmanın etkilerinden yola çıkar. Öte yandan iç denge sistemimizde yer alan 3 ana duygu sisteminden söz eder. Tehlike aktivasyon sistemi ve yatıştırma becerisinin eksikliği önemli bir tükenme nedenidir. Terapini bir amacı öz-yatıştırma becerisinin geliştirilmesidir. Duygu düzenleme süreci için kendine onarıcı yaklaşmanın öğretilmesi mümkün olabilmektedir. Şefkat ve öz-şefkat becerisi geliştirme değişimin temel mekanizması olarak kabul edilir.

Şefkat kişinin kendisinin ve diğer canlıların çektiği acının derin farkındalığıyla birlikte bunu hafifletmek için istek ve çabasına eşlik eden temel bir iyilik halidir. Birçok kültürde ruhsal ve manevi bir pusula olarak görülür.

P. Gilbert uzun yıllar depresyonlu olgularla çalışmalar yürütmüş ve depresyonun üstesinden gelme için şefkat odaklı modeli geliştirmiştir. Öz-şefkatin depresyonda iyileştirici gücüne vurgu yapmaktadır. Depresyonlu olgularda kendine yöneltilen yıkıcı eleştirilerin sık ve sürekli devam etmesinin kişiyi bir tehlike moduna sürüklediğini ve bu durumda uzun süre kaldığında kişinin tükenme ile karşılaştığını ve depresyonun gelişiminde tükenmenin rolünü vurgulamaktadır.

Evrimsel olarak insan zihninin iyi hissetme ve keyif verici yaşantılara gereksinim duyduğunu belirtmektedir, kişi kendisinde yatıştırıcı bir beceri geliştirmemiş ise bunların eksikliğinde içine girilen tehlike modunun tüketici duruma geldiğini anlayabiliriz. O halde iyileşme için temel düzenek kişinin kendisine yatıştırıcı bir biçimde yardım edebilmesidir.

«İnsan mutsuzluğunun aşırı tıbbileştirilmesi» çözümü de zorlaştırmış görünüyor. Yani uzun süren ve ağır seyreden duygusal ve davranışsal durumların birer bozukluk, hastalık olarak ele alınıp iyileştirilmeye çalışılması birçok durumda işlemiyor olabilir. Bu perspektiften yaklaşarak transdiagnostik bir çerçevede ruhsal sorunlara yaklaşan, getirilen içerikten daha fazla kendin ile, belirti ve duygularla kurulan ilişki üzerine odaklanan BDT sonrası 3. Dalga bir terapidir.

ŞOT, mindfulness temelinde BDT ile benzerlikler gösterir ve hem bireysel hem grup terapi uygulaması olarak geliştirilmiştir. İyileşme sürecinde kendini kabul ve koşulsuz kabul, sevgi ve özen verebilme önemli bir anahtar olabilir. Farkındalık ile elde edilen boşluk ve kendine uzaktan bakabilme ayrışma sürecinde iyileşmeye giden yol onarıcı bir yaklaşım ile kendine iyi davranmaktan geçmektedir. Gilbert'in 2017'de şefkatli benlik geliştirme kavramı ile model olgun halini almıştır.

Bu kısa kursta kuramsal temel yanı sıra şefkat ve öz-şefkat becerilerine bir giriş niteliğinde benden tarama, şefkatle nefes aralığı, bir başkasına şefkat ve öz-şefkat, şefkatli arkadaş imgesi gibi uygulamalar çalışılmıştır.

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Tanısız Danışanlarda BDT Temelli Farklı Modellerinin Kullanımı

Turkan Aghakishiyeva
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Tanısı olmayan danışanlarda BDT, çeşitli sorunların ele alınmasında etkili olabilir. BDT, düşünce, duygu ve davranış arasındaki ilişkileri keşfetmeye ve değiştirmeye odaklanır. Tanısı olmayan danışanlarda BDT uygularken dikkate alınması gereken bazı önemli noktalar şunlardır:

1. Sorunların Belirlenmesi

- Danışan Anamnezi
- Hedef Belirleme.

2. Bilişsel Çarpıtmaların Tanımlanması

- Düşünce Kalıpları: Danışanın olumsuz düşünce kalıplarını ve bilişsel çarpıtmalarını tanımlamak önemlidir.
- Bilişsel Yeniden Yapılandırma: Bu çarpıtmaları daha gerçekçi ve olumlu düşüncelerle değiştirmek için teknikler uygulanabilir.

3. Davranışsal Stratejiler

- Davranışsal Aktivasyon
- Maruz Bırakma Teknikleri.

4. Farkındalık ve Duygu Düzenlemesi

- Mindfulness Teknikleri: Danışanın mevcut anı kabul etme ve farkındalık geliştirme becerilerini artırmak için kullanılabilir.
- Duygu Düzenlenmesi. Danışanın duygularını tanıma ve yönetme becerilerini geliştirmek için stratejiler uygulanabilir.

5. Esneklik ve Uyarlama

- Bireyselleştirilmiş Yaklaşım: Her danışanın ihtiyaçlarına ve özelliklerine göre terapinin uyarlanması önemlidir.
- Esneklik: Terapistin yöntem ve teknikleri, danışanın ilerlemesine ve geri bildirimlerine göre esnek bir şekilde uyarlaması gerekebilir.

7. Psiko-eğitim

- Bilgilendirme: Danışana bilişsel davranışçı terapi ve kullandıkları teknikler hakkında bilgi vermek, terapinin etkisini artırabilir.
- Kendi Kendine Yardım: Danışanın kendi başına kullanabileceği strateji ve teknikler öğretilmelidir.

Evaluating Individual Change in Psychotherapy: Single-Case Experimental Designs

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Assessing the effects of psychotherapy on individuals is essential for developing personalized approaches in clinical practice. Traditional methods, such as randomized controlled trials (RCTs), focus on group averages to assess general efficacy. However, RCTs have limitations, including high costs, the need for large sample sizes, and a lack of focus on individual variability in treatment responses. These limitations make it challenging to comprehensively assess individual treatment effects. At this point, Single-Case Experimental Designs (SCEDs) provide a valuable alternative by allowing for detailed, individualized analyses of therapeutic change.

SCEDs treat each individual as their own control, observing changes before and after interventions. In SCED types such as AB and ABAB designs, treatment phases are repeated to capture direct effects, enabling within-subject comparisons and causal inferences. Unlike group-based designs, SCEDs can be implemented at a lower cost and are adaptable for daily clinical use. Techniques like visual analysis allow for detailed, phase-by-phase examination of individual responses, making SCEDs ideal for studies with smaller samples and for understanding individual differences in treatment outcomes. Variants like multiple baseline designs further support flexible applications by addressing individual variability in intervention timing.

In Turkey, the greater adoption of SCEDs would be a critical step toward assessing individual treatment responses in psychotherapy research and advancing personalized treatment practices. This session will address the analytical advantages and applications of SCEDs in psychotherapy research, aiming to foster individualized evaluation in both clinical and research settings.

Çocuk ve Ergenlerde Nörogelişimsel Bozukluklarda Kabul ve Kararlılık Terapisi

Şeyma Coşkun
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1980'li yıllarda geliştirilmeye başlanan Kabul Kararlılık Terapisi (ACT), bilimsel kanıt düzeyi yüksek 3. dalga psikoterapi yöntemlerinden bir tanesidir. ACT'in temel amacı; içsel yaşantılara (duygu, düşünce, dürtü, anı vs.) uygun yanıtlar oluşturabilme becerilerini desteklerken değer odaklı davranışlarla temasın arttırılmasıdır. Bu sayede kişinin psikolojik esnekliğinin geliştirilmesi amaçlanır. Bunun için de altıgen dediğimiz yapı üzerinde yer alan 6 farklı alanla ilgili (anla temas, duyguların kabulü, bilişsel ayrışma, değerlerle temas, değer odaklı davranışlar, bağlamsal benlik) bir takım müdahaleler yapılır.

Yetişkin popülasyona ait çeşitli psikopatolojilerde etkinliği gösterilmiş olan ACT'in çocuk ve ergen psikoterapilerinde kullanımına artan bir ilgi bulunmakta ve bu konuda araştırmalar yapılmaktadır. Bireysel, grup ve internet temelli ACT müdahalelerin değerlendirildiği bir dizi çalışmada; ACT'in içselleştirme ve dışsallaştırma semptomlarını azaltmanın yanı sıra çocuk ve adolesanlarda yaşam kalitesinde artışla ilişkili olduğu gösterilmiştir. Ayrıca çocuk ve ergen psikiyatri alanında önemli bir yer tutan nörogelişimsel bozukluklarda ACT uygulamaları günden güne artmakta ve bununla ilgili literatür zenginleşmektedir. ACT'in nörogelişimsel bozukluklarda psikolojik esneklik, kognitif işlevler, bilişsel ayrışma, yaşantısal kabul gibi alanlarda iyileşme sağladığı gösterilmiştir.

Çocuk ve Ergenlerde Nörogelişimsel Bozukluklarda Kabul ve Kararlılık Terapisi adlı bu sunumda;

1. DEHB, otizm, öğrenme güçlüğü gibi nörogelişimsel bozuklara sahip çocuklarla, ergenlerle ve onların bakım verenleriyle yapılan ACT çalışmaları
2. Nörogelişimsel bozuklara sahip çocuk ve ergenlerle tipik gelişen çocuk ve ergenlerdeki ACT müdahalelerinin ortak noktaları ve ayrışan noktalarının neler olduğu
3. Örnek vaka(lar) üzerinden nasıl bir değerlendirme yapılacağı ele alınacaktır.

Meeting with Expert / Title: Metacognitive (Metacognitive) Training, a New Cognitive Behavioural Method Developed

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Psychotic disorders are psychiatric disorders whose main symptoms are delusions and hallucinations, which seriously affect the life and functionality of the individual. Until recently, it was thought that medication could be the only method in terms of treatment, but in recent years, the idea that psychosocial treatments can make important contributions in addition to medication has come to the fore. In this direction, in addition to the known and used CBT approaches, Metacognitive (Metacognitive) Training, a new cognitive behavioural method developed in recent years, effectively complements the treatment of psychotic disorders. The Metacognitive (Metacognitive) Training programme (MBT) is based on the psychosis model of cognitive behavioural theory and its unique feature is that it focuses on the metacognitive domain in practice. Cognitive behavioural therapy methods used in the psychosocial treatment of schizophrenia base their applications on explanations at the level of perception, cognition and schema regarding the formation of psychosis. Developed in 2005 by Steffen Moritz and Todd S. Woodward, Metacognitive (Metacognitive) Training is a new method developed for the treatment of positive symptoms in psychosis, especially delusions. This training has been supported by research that psychotic individuals can contribute to gain insight. Metacognitive training is suitable for inpatient groups and outpatients. It can be applied in both individual and group format. Since the aim of the training is to enable the patient to see the negative consequences of cognitive biases, a large number of examples are used with the prepared materials.

In conclusion, it is expected that the role of metacognitive training in the treatment of psychotic disorders will increase in the future. Especially its integration into the treatment approaches provides a great advantage. The benefits and limitations of using metacognitive training together with cognitive-behavioural therapies and pharmacotherapy should be reviewed.

Metacognitive Approach in Undiagnosed Clients

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In general, it is reported that there are factors that not only contribute to the occurrence of a particular disorder, but are also partially responsible for comorbidity between disorders. Such factors that transcend the specific nature of the disorders are referred to as transdiagnostic factors (Harvey ve ark. 2004, Ehring ve Watkins 2008).

Metacognition includes all types of information and cognitive processes that are related to the interpretation, monitoring, and control of cognitions. Case formulation, attention training techniques, detached mindfulness, postponing worry or rumination, and challenging positive and negative metacognitive beliefs are interventions that can be used when implementing MCT with undiagnosed clients (Capobianco ve ark. 2018, Callesen ve ark. 2019).

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Tekrarlayan Düşünmeler için İşlevsel Analiz Temelli Yaklaşım

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Tekrarlayan düşünme, bireyin kendisi ya da dünya hakkında uzun süreli, derinlemesine ve tekrar eden düşünme süreci olarak tanımlanmaktadır (Segerstrom vd., 2003). Tekrarlayıcı düşünme; ruminasyon, endişe, plan yapma, hayal kurma ve kendini eleştirme gibi çeşitli formlarda ortaya çıkabilir. Bu düşünme sürecinin hem adaptif hem de maladaptif olabileceği, dolayısıyla bireyin hayatında yıkıcı ya da yapıcı sonuçlar doğurabileceği vurgulanmaktadır. Klinik ortamda en sık rastlanan maladaptif tekrarlayıcı düşünme biçimlerinin endişe, ruminasyon ve kendini eleştirme olduğu belirtilmektedir. Araştırmalar, bu formların depresyon, anksiyete, uykusuzluk, yeme bozuklukları ve psikotik bozukluklar gibi çeşitli psikopatolojilerin gelişiminde ve sürdürülmesinde önemli rol oynadığını göstermektedir (Ehring ve Watkins, 2008; Harvey vd., 2004).

Bu oturumda, tekrarlayan olumsuz düşünme, radikal davranışçı geleneğe dayanan işlevsel bağlamsalcılık perspektifi çerçevesinde ele alınacaktır. Radikal davranışçılığa göre organizmanın yaptığı her şey, düşünme dahil olmak üzere, bir davranıştır. Düşünmek, bu bağlamda örtük bir davranış olarak kabul edilmektedir. İşlevsel bağlamsalcı yaklaşım ise bir davranışın tam anlamıyla anlaşılabilmesi için yalnızca o davranışın ne olduğuna değil, aynı zamanda hangi bağlamda gerçekleştiğine ve işlevine odaklanılması gerektiğini öne sürer. Bu doğrultuda, psikoterapi ortamında tekrarlayıcı olumsuz düşünmenin etkilenmesi ve değiştirilmesi, ancak bu davranışın ortaya çıktığı bağlamın anlaşılması ve işlevlerinin belirlenmesi ile mümkün olacaktır.

Oturumda, örnek vakalar üzerinden endişe, ruminasyon ve kendini eleştirme davranışları Skinner'ın geliştirdiği "Davranışın ABC Analizi" yöntemi ile analiz edilecektir. Ardından, bu analiz ışığında psikoterapide kullanılabilecek müdahale yöntemlerine değinilecektir.

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Functional Dysphonia with Clinical Features

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Functional neurological symptom disorder (FND) is characterized by neurologic symptoms such as weakness, abnormal movements, or nonepileptic seizures, which involve abnormal nervous system functioning rather than structural disease. In addition, clinical findings on examination provide evidence of incompatibility between the symptoms and recognized neurologic disease. The diagnosis is frequently missed or delayed, which in part explains the generally poor prognosis.

FND meaning that the symptoms arise from abnormal nervous system functioning in the absence of structural pathology. In patients with neurologic symptoms that are not caused by recognized neurologic disease, the diagnosis of FND should be made after the physician has identified the typical, positive clinical findings that establish the diagnosis. FND is not a diagnosis of exclusion. In DSM-5-TR, as well as the ICD-11, clinicians can make the diagnosis of functional neurological symptom disorder without identifying psychological factors associated with the neurologic symptoms.

Assessment of patients presenting with possible FND includes a medical history, physical examination, and indicated laboratory tests, as well as a psychiatric history and mental status examination. It is essential to look for neurologic and other general medical conditions, particularly early-stage diseases. Successfully presenting the diagnosis of FND to patients is a fundamental aspect of treatment.

The prevalence of functional neurologic symptoms in neurologic settings ranges from 9 to 16 percent, making it one of the most common disorders. Multiple studies indicate that FND is more likely to occur in females than males. Many biological, psychological, and social factors have been found to be more common in patients with functional neurological symptom disorder than patients with comparable symptoms due to recognized disease. Different hypothetical models attempt to explain how FND symptoms develop; the models are not mutually exclusive. Symptoms persist or worsen in approximately 40 to 66 percent of patients.

In functional dysphonia there is a (usually) sudden or intermittent loss of volitional control over the initiation and maintenance of phonation despite normal structure and function as observed during laryngoscopy and clinical examination. Systematic reviews of randomised controlled trials exploring the efficacy of symptomatic voice therapy for 'functional dysphonia' report moderate-to-good evidence for the direct symptomatic and behavioural voice therapies, either alone, or in combination with indirect therapies that may involve education and vocal hygiene. Therefore, functional dysphonia is an interesting model for the diagnosis, evaluation and treatment of functional neurological disorders. As psychogenic dysphonia symptoms and psychological factors mutually affect each other, the combination of voice therapy and psychotherapy for symptoms seem to be the gol standard treatment for now. The gold standart pschotherapy is cognitive behavioral therapy.

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Olgu Örnekleriyle Metakognitif Terapinin Temel Teknikleri

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Metakognitif terapi (MKT), geleneksel bilişsel davranışçı terapi (BDT) ekolünden bazı yönleriyle farklılaşan, sağlam bir kuramsal arka plana sahip, ruhsal bozuklukların tedavisinde etkili olduğu gösterilmiş, kanıta dayalı bir psikoterapi yöntemidir. MKT'nin temel vurgusu bilişlerin içeriğinden ziyade bilişsel süreçler ve kişilerin bu süreçlere verdikleri tepkiler üzerinedir. Geleneksel BDT yaklaşımlarından temel farklılık noktası da zaten vurgusundaki bu farklılıkta yatmaktadır. MKT'de terapistin ana amacı ruhsal bozukluğun sürdürülmesinde rol oynadığı düşünülen bu bilişsel süreçlere odaklanmak ve kişinin bu süreçlere verdiği uyuma dönük olmayan tepkileri değiştirmeye aracılık etmektir. Nitekim MKT'nin geliştirilme sürecinde yapılan gözlemler ve bunları doğrulmak için yapılan klinik araştırmalardan elde edilen sonuçlar, ruhsal bozuklukların hem ortaya çıkmasında, hem de sürmesinde bilişlerin içeriğinden çok, bu bilişlerin hangi süreçleri etkilediğinin, bu süreçlerdeki bozulmaların bir sonucu olarak da kişilerin hangi uyuma dönük olmayan tepkileri gösterdiklerinin ve bu tepkileri kontrol altına alabilmek için devreye soktukları başa çıkma yöntemlerinin daha ön planda olduğunu öne sürmektedir. MKT, kişinin biliş ve davranışlarını kontrol altına alabilmek için üstbilişlere önem verir. Üstbilişler, bilişlerin işleyişini anlamada, kişinin neye dikkat ettiğini saptamada, düşünme ve davranışların düzenlenmesinde kullanılan stratejileri etkilemede görev alır. Burada bahsedilen tüm maddeler, bilişsel süreçlerin bir parçasına karşılık gelir. Bu yönüyle bakılacak olursa, üstbilişler, kişiyle ilgili bilişlerin seçilmesi, izlenmesi, yorumlanması ve kontrolünden sorumludur. Geleneksel BDT yaklaşımı, topografik açıdan bilişleri yüzeyden derine doğru otomatik düşünceler, ara inanışlar ve şemalar olarak konumlandırır. Üstbilişler bu şekildeki bir konumlandırmada, tüm bu bilişlerin de altında yer alan ve kişiye gelen içsel veya dışsal uyaranlara göre hangi bilişlerin seçilip devreye sokulacağını, hangi davranışsal tepkilerin verileceğini belirleyen, yürütücü güç gibi tahayyül edilebilir. Üstbilişler tüm bu üç biliş katmanı arasındaki etkileşime aracılık eden bir üst köprü gibi de düşünülebilir. Bu yerleşim farklılığının MKT'de uygulanan tekniklerin sıralamasının neden geleneksel BDT'den ayrı bir yol izlendiğini açıklayabilir. Ayrıca bu her üç katman arasında yayılan ve MKT'nin kuramsal arka planındaki dayanağı temsil eden kendini düzenleyen yürütücü işlevin (KDYİ) de anlaşılmasında bu topografik açıklama yardımcı olabilir. KDYİ, her biri birbiriyle etkileşim içinde olan üç katmanlı bir yapıya sahiptir. En alt katmanda otomatik bilgi işleme süreçleri (alt düzey işlem), ara katmanda bilinçli şekilde bilgi işleme süreçleri (bilişsel tarz), en üst katmanda ise üstbilişlerin depolandığı bir kütüphane (üst düzey işlem) yer alır. MKT'ye göre, ruhsal bozuklukların sürdürülmesi veya kontrol altına alınması, bu üç katmanda tepeden aşağıya doğru ilerleyen bir süreç aracılığıyla gerçekleşir. Uzun yıllar boyunca laboratuvarda, sonrasında da klinik ortamda KDYİ modeli test edilmiş ve bu modelin ruhsal bozuklukları açıklamakta geçerli olduğu sonucuna varılmıştır. Bu modelin merkezinde dört temel kavram yatmaktadır: (1) Bilişsel dikkat sendromu (BDS), (2) Üstbilişsel inanışlar, (3) Dikkat ve yürütücü işlevlerin kontrolü, (4) Zihinsel modlar. KDYİ modeli, MKT'de ruhsal bozuklukları açıklamak için özetle bu dört temel kavramı kullanmaktadır. Farklı ruhsal bozukluklarda bu kavramların farklı oranlarda bir araya gelmesi söz konusudur. Yine de MKT, özü itibarıyla transdiyagnostik bir yaklaşım gibi düşünülebilir. Zira MKT'deki tüm müdahaleler birtakım ortak ilkelerden hareket etmektedir. Bu ortak ilkelerin ışığında, ruhsal bozuklukları açıklamada şu patolojik sürecin işlediği söylenebilir. İlk aşamada kişide bir tehdit / tehlike algısı olur. Kişi bu algıyı nesne modunda değerlendirir. Bu sayede BDS etkinleşir ve işe yaramayan başa çıkma stratejilerinin de devreye girmesiyle ruhsal sıkıntı oluşur. Psikopatolojinin bu jenerik üstbilişsel açıklaması aynı zamanda MKT'nin neden transdiyagnostik bir yaklaşım olarak görülebileceğini de gösterir. Nitekim MKT'yi geleneksel BDT'den ayıran en önemli nokta, aynı zamanda transdiyagnostik olarak da kullanılabilecek olgu kavramsallaştırmasıdır. Bu kavramsallaştırmaya göre bir biliş ya da duygudan teşekküllü tetikleyici durum, bilişlerin aracılığı ile duygusal ya da davranışsal sonuçlara yol açar. Bu modeldeki farklılık, aradaki bilişler noktasının BDS ve üstbilişsel inanışlar tarafından kontrol ediliyor olmasıdır. Özetle, MKT'nin kuramsal dayanağı oldukça kuvvetli, kanıta dayalı, kendine has birtakım müdahale teknikleri olan bir psikoterapi yaklaşımı olduğu söylenebilir.

Anahtar Sözcükler: metakognitif terapi, psikoterapi, üstbiliş, bilişsel davranışçı terapi

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Geçmişten Geleceğe Annelik Sürecine Bilişsel Bakış Annelik mi Anne Olmamak mı?

Özlem Baş Uluyol
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Kadın kimliği tarihsel olarak çocuk doğurmak ve anneliğe dair semboller etrafında inşa edilmiştir. Bu ataerkil toplumsal düzenlemede kadın için doğal ve istenir olduğu kabul edilen anneliğin, anne olan ve olmayan tüm kadınlar açısından disipline edici ve kadın olmanın bir koşulu olduğu inancı dikkate alınmaktadır. Bu bilişler ile anne olan kadınlar anneliklerinin niteliği hakkında sürekli sorgu altında yaşarken, anne olmayan kadınlar, kadın olmanın gereğini yerine getirmedikleri iddiasıyla norm dışı kabul edilip kendileri ile ilgili olumsuz bilişlere sahip olabilirler.Tüm bunlar feminist literatürde anneliği ataerkil toplumsal düzenlemenin kadını sınırlayan, baskı altına alan bir kurumu olarak gören yaklaşımla ilgili tartışmalar devam ederken 1970'lerden, ağırlıklı olarak da 1990'lardan itibaren annelik tartışmaları kadar yaygın olmasa da anne olmamak da feminist literatürde kendine yer bulan bir konu olmuştur. Literatürde biyolojik olarak çocuk sahibi olamayan bireyler için "çocuğu olmayan-childless", çocuk sahibi olmak istemediği için yapmayan bireyler için "çocuk yapmayan-childfree" ya da "gönüllü çocuksuzluk-voluntary childlessness" kelimeleri kullanılmaktadır.

Çocuk sahibi olmak istediği halde biyolojik engellerle karşılaşan kadınlar için çevre baskısı, sosyal rol eksikliği ile birlikte değersizlik ve yetersizlik şemaları aktive ruhsal sorunlar ortaya çıkmakta, yaşam kalitesi ve benlik saygısı önemli ölçüde düşmektedir. Özellikle ilkokul mezunu, işsiz, sosyal güvencesi olmayan ve gelir durumu kötü olan veya geliri olmayan kadınların infertiliteden daha çok etkilendiği; depresyon ve anksiyete oranlarında artma olduğu yapılan çalışmalarda gösterilmiştir.

Çocuk sahibi olmak istemediği için çocuk yapmayan (gönüllü çocuksuzluğu seçenler) ve bunu ifade edebilen kadınlar da toplum baskısına, sosyal dışlanmaya ve yargılanmaya maruz kalmaktadır. Özellikle Kuzey Amerika ve Batı Avrupa'da kadınlar arasında gönüllü çocuksuz kadın sayısının arttığı görülmektedir. Tipik olarak yüksek eğitimli, kariyer odaklı, ekonomik özgürlüğü olan, ve beyaz kadınlar arasında gönüllü çocuksuz sayısı daha fazladır. Bu durumun eğitim düzeyinin ve evlilik yaşının yükselmesi, ücretli işgücüne katılımın artması, doğum kontrolünün yaygınlaşması gibi yaşam biçimlerini etkileyen toplumsal değişimlerle ilişkili olduğu belirtilmektedir. Son yıllarda elde edilen sonuçlara göre artan eğitim durumu ve iş hayatına katılım sonucunda çocuk sahibi olmak isteyen kadınların sayısında azalma yada ileri yaşlarda çocuk sahibi olma yönünde eğilim görülmekte olup ABD, Kanada, İngiltere'de olduğu gibi ülkemizde de ilk doğum yaşı ileri yaşlara doğru kaymaktadır.

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Travmada Anlamı Yakalamak: ACT Perspektifinden Travma ve Değer Müdahaleleri TSSB'de Değerleri Keşfetmek Kanıta Dayalı TSSB Terapilerine Değer Müdahalesinin Eklenmesi

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Kabul ve Kararlılık Terapisi (ACT), değerleri terapötik sürecin rehberi olarak kullanan bir psikoterapi yaklaşımıdır. Davranışçı geleneklere dayanan ACT, işlevsel bağlamsalcılık ve İlişkisel Çerçeve Teorisi (RFT) zemininde geliştirilmiştir. Travma sonrası stres bozukluğu dahil olmak üzere birçok psikopatolojide ACT'in etkinliğini gösteren randomize kontrollü çalışma bulunmaktadır. ACT psikopatoloji modeli, 'psikolojik katılık' olarak tanımlanırken, işlevsellik modeli ise psikolojik esneklik olarak ifade edilmektedir. ACT'nin amacı, kişinin psikolojik esneklik becerilerini geliştirerek işlevselliğini artırmaktır. Semptomları azaltmaktan ziyade, ACT, bireyin davranışlarının kendi değerleri tarafından yönlendirilmesini sağlamayı hedeflemektedir.

Değerler, eylemin arzulanan nitelikleri olarak tanımlanmaktadır. Kişinin nasıl biri olmak istediği ve bu doğrultuda nasıl davranmayı istediğiyle ilgilidir. Değerler, davranışlar için bir rehber ve motivasyon kaynağıdır. Travmatik olay sonrasında kişinin değerleri ile teması azalabilir. Değerler travmatik olay sonrası geleceği inşa etmede bir pusula işlevi görmektedir. Değerlerle temas arttırılarak "travma sonrası büyüme" sağlanması hedeflenir. Travma ve değerlerin konu edileceği ve yaşantısal tekniklerin kullanılacağı bu kurs ile katılımcıların;

1. Psikolojik esneklik altıgeninin bir boyutu olan değerleri öğrenmesi,
2. ACT'te kullanılan değer müdahale tekniklerini tecrübe edebilmeleri,
3. Değer müdahalelerini farklı psikoterapi modellerinde de uygulayabilmeleri hedeflenmektedir.

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OSB-Autism Spectrum Disorder from Adolescence to Emerging Adulthood

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Autism Spectrum Disorder (ASD) presents a unique set of challenges that evolve as individuals transition from adolescence into emerging adulthood. During these developmental stages, the complexities surrounding both diagnosis and daily living increase, necessitating a nuanced understanding of the experiences faced by individuals with ASD. Adolescence is a critical period characterized by significant physical, emotional, and social changes. For individuals with ASD, these changes often come with additional difficulties. Puberty can heighten sensory sensitivities, lead to increased anxiety, and intensify behavioral issues such as irritability and aggression. The social demands of adolescence, including forming friendships, navigating peer relationships, and interpreting social cues, become more challenging. Many adolescents with ASD struggle with social communication and may face exclusion or bullying, further impacting their mental health and self-esteem.

The presence of comorbid conditions such as anxiety, depression, and Attention Deficit Hyperactivity Disorder (ADHD) is more prevalent during adolescence among those with ASD. These comorbidities can complicate the diagnostic process, making it challenging for clinicians to differentiate whether certain symptoms are attributable to ASD or another condition. This complexity underscores the need for a comprehensive, multidisciplinary approach to diagnosis and treatment during adolescence.

Emerging adulthood, typically defined as the period from ages 18 to 25, introduces new roles and responsibilities that can be particularly daunting for individuals with ASD. This phase involves significant life transitions, such as graduating from high school, pursuing higher education or vocational training, entering the workforce, and developing independent living skills. These changes require not only adaptive functioning but also robust executive functioning skills—areas where many individuals with ASD often face difficulties.

During this period, challenges often include managing time, maintaining organizational skills, and fostering social relationships in more independent settings. The lack of structured support that is typically available in high school settings further exacerbates these issues, leading to an increased risk of unemployment, social isolation, and mental health problems. The transition from pediatric to adult healthcare systems can also pose significant challenges, as adult providers may have less experience with ASD and its complexities.

The journey from adolescence to emerging adulthood for individuals with ASD is marked by unique challenges that require thoughtful consideration and tailored support. Addressing the diagnostic complexities and the difficulties in social adaptation and daily functioning can significantly impact outcomes. By understanding these challenges and providing appropriate support, clinicians, educators, and families can better guide individuals with ASD through this critical transition, helping them achieve a more fulfilling and independent adulthood.

ASD Presentation in Adults

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Autism Spectrum Disorder (ASD) is a neurodevelopmental disorder characterised by retardation in social and language development, communication and social interaction problems, restricted interests and repetitive behaviours. In adulthood, unlike in childhood, the picture may appear different with the comorbidities added or the comorbidities may hide the underlying main disease. Therefore, knowing the possible clinical pictures and differential diagnoses is of great importance for treatment planning. In recent multicentre studies conducted in our country, attention deficit and hyperactivity disorder, mental retardation and behavioural disorders were considered as the most common comorbidities. In our study in which patients without mental retardation were included, it was observed that anxiety disorder was diagnosed most frequently. In our talk, we will discuss the profile of high-functioning autism patients in our clinic and in our research and clues for differential diagnosis.

CBT Strategies for Femal Sexual Disorders

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Diagnostic and Statistical Manual of Mental Disorders-5 criteria classified female sexual disorders into female sexual interest/arousal disorder, female orgasmic disorder and genito-pelvic pain/penetration disorder. These disorders negatively impact quality of life for many women. It is important to identify habits that may impair sexual functioning such as alcohol abuse, excessive exercise, smoking, sleep disorders, obesity, as well as cardiovascular diseases, endocrine diseases, etc. As much as the physical condition is important for sexual functioning, the psychological condition is just as important. CBT adopts a holistic approach for the understanding and treatment of sexual dysfunctions. Low self-esteem, negative body image, low sexual self-confidence and performance anxiety, spectatoring, inappropriate and unrealistic cognitions, attention problems or excessive mental occupation, poor body awareness, sexual inexperience, lack of self-satisfaction skills and negative beliefs about masturbation, history of physical or sexual abuse are psychological factors that can cause sexual dysfunction. In addition, relational factors may also significantly affect couple sexuality. Improving psychosexual skills and cooperation of couples, eliminating deficiencies in emotional intimacy, resolving relationship conflicts, ensuring regular sexuality, creating alternative sexual scenarios are among the strategies to solve relationship problems. CBT offers specific treatment strategies that address all these factors. CBT may help women with sexual dysfunctions to identify which factors enhance and which factors generate sexual limitations, as well as to restructure maladaptive thoughts about their sexuality, and reduce the tendency to avoid certain sexual behaviors. Although the central objective of CBT in these dysfunctions is an improvement in sexual function and sexual satisfaction, there are specific aspects to be addressed in each form of female sexual dysfunction. CBT aims to focus on the awareness of the physiological sensations present during sexual arousal, as well as reducing the negative anticipation of sexual experiences. In order to achieve these objectives, techniques such as psychoeducation, cognitive restructuring, pelvic muscle training, sensate focus exercises, minfullness trainig, masturbation exercises or dilator therapy are used.

Process-Oriented CBT for Anxiety Rationale, Formulation and Intervention Strategies

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CBT is a well-established, evidence-based treatment for the anxiety disorders. In recent years outcome studies and meta-analyses on very large samples have shown that CBT produces large effect sizes in clinical practice, with treatment gains maintained through follow-up periods. However, 30-40% of participants do not show significant improvement, and many individuals find standard CBT draining and difficult. Clearly, CBT is an effective treatment for anxiety but there is considerable room for improvement. In their seminal book Process-Based CBT (2018), Hayes and Hofmann offer a perspective that focuses on the core clinical competencies of CBT used to create change in key biopsychosocial processes that characterize an individual's emotional distress. This workshop presents a process-oriented approach to CBT for anxiety based on the Hayes and Hofmann perspective. Thirteen critical processes are identified that define the experience of excessive and disturbing anxiety. In this workshop participants will learn how to adopt a process-oriented approach to case formulation and treatment planning. Specific cognitive and behavioral interventions are described that target each process, along with case illustrations and worksheets. Practitioners with experience in CBT will readily see how the process-oriented framework offered in this workshop can bolster their effectiveness in treating anxiety and its disorders.

Philosophical Origins of Cognitive Behavioral Therapy

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Cognitive Behavioural Therapy (CBT) is a modern psychotherapy method that examines how individuals' thoughts and feelings affect their behaviour. The ideas of CBT pioneers such as Albert Ellis and Aaron Beck were inspired by philosophy as well as psychology, especially the ancient Stoics (Epictetus and Marcus Aurelius).

Cognitive Behavioural Therapy (CBT) overlaps with the Stoics' statement that "individuals" emotional reactions are shaped not by events, but by their reactions to events'. Ellis defines the meanings we give to events as negative automatic thoughts and argues that when these thoughts cause emotional distress in the individual, healthier emotional reactions can be developed by recognising and restructuring these thoughts. Thus, both CBT and Stoicism recognise the strong influence of thoughts on emotions.

In Rational Emotional Therapy (RDT), Ellis, in parallel with Stoicism, aims for long term pleasures, i.e. eudaimonia (Greek for happiness or 'good life'), instead of short term pleasures. This idea argues that individuals should aim for long-term happiness rather than immediate gratification. Both Ellis and Stoics believe that lasting happiness can only be achieved through rational thought and emotional balance.

Another similarity is between the 'Stoic Conditional Mode' and the concept of rational choice in Ellis' theory of Rational Emotive Therapy (RDT). The conditional mode is an understanding that advocates considering all kinds of possibilities in terms of consequences, accepting the existence of elements that are not under one's control, and emphasising the part that one can control is the most important. This concept encourages the individual to find emotional balance by focusing on his/her own rational choices and actions, rather than focusing on the elements beyond his/her control.

The Stoic understanding of 'life in accordance with nature' is parallel to Beck's cognitive therapy. Stoics advocate individuals to live in harmony with natural and rational thoughts. Beck also addresses the thought processes of individuals in the therapy process in the context of common sense-based approach. Beck argues that when individuals develop irrational beliefs, these distorted thought processes lead to misperceptions about external reality and cause emotional disorders.

Paul Dubois, as one of the pioneers of cognitive therapy, developed parallel ideas about the concept of ethics, which the Stoics defined as ethos, about 50 years before Ellis and Beck. According to Dubois, for the Stoics, what is ethical is what contributes to one's happiness and well-being. Dubois started his therapy with a psychoeducation with this concept.

Another name that influenced the antecedents of cognitive therapy was Coué, whom Ellis worked on for a while. Focusing on how individuals' positive or negative suggestions towards themselves affect their cognitive processes, Coué took the foundations of this approach from Pitagoras and Aristotle, that is, again from ancient philosophy.

Cognitive Behavioural Therapy (CBT) has its philosophical roots in ancient philosophy in general and Stoic philosophers in particular. In addition, thinkers such as Spinoza, Russell and Kant have also made important contributions to CBT, inspired by the Stoic tradition. The cognitive and emotional suggestions developed by all these thinkers have played a role in shaping the theoretical structure of modern CB.

Kabul ve Kararlılık Terapisi'nin Felsefi Kaynakları

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Kabul ve Kararlılık Terapisi (Acceptance and Commitment Therapy-ACT), uzun süreli bir araştırma ve entelektüel gelişim programının bir sonucu olarak ortaya çıkmıştır. Felsefi ve kuramsal temeli ile uygulama ayağı bir bütün olarak tutarlılık sergileyen ACT'in ontolojik ve epistemolojik duruşuna dayanak sağlayan felsefi temeli İşlevsel Bağlamsalcılık (Functional Conetxtualism-İB), teorik ve ampirik çalışmalara rehberlik ederken; kuramsal dayanağı olan İlişkisel Çerçeve Kuramı (Relational Frame Theory-İÇK), insan dili ve bilişine dair kapsamlı ve tutarlı bir açıklama sunarak uygulamaları yönlendirir.

Pepper'ın (1942) felsefi dünya görüşü, bir kök metafor ve doğruluk ölçütü etrafında şekillenir. Bir dünya görüşü, kök metafor ve ona bağlı olan doğruluk ölçütlerini içerir. Kök metafor, varlık ve varoluş hakkında ontolojik varsayımlar sunarken; doğruluk ölçütü bilgi iddialarını değerlendirmek için kullanılan epistemolojik görüşleri yansıtır. Pepper, formizm, mekanizm, organisizm ve bağlamsalcılık olmak üzere dört dünya görüşü tanımlamıştır. Bağlamsalcılığın kök metaforu bağlamdaki-eylem ikeni doğruluk ölçütü başarılı işlerlikdir. Bu bağlamda İB, temel varsayımlarını felsefi pragmatizmden ve bağlamsalcılıktan alan bir felsefi yaklaşımdır. Bir davranışı değerlendirirken ontolojik özelliklerin değil işlevin referans alınması gerektiğini öneren İB, organizmanın içinde bulunduğu tarihsel ve durumsal bağlamla etkileşim halinde olduğunu ve dolayısıyla bir davranışın işlevinin anlaşılmasının ancak bu etkileşime odaklanılarak mümkün olabileceğini öne sürer.

Bağlamsal Davranışçı Bilimler (BDB, Contextual Behavioral Science) ise İB zemininde geliştirilmiş bir bilimsel disiplindir ve insan davranışlarını anlamayı, öngörmeyi ve etkilemeyi amaçlar. Bu amaç doğrultusunda, davranış içinde bulunduğu bağlam ile birlikte değerlendirilir; zira bir davranışın işlevini anlamak için ortaya çıktığı bağlamdaki değişkenlerin bilinmesi gerekir. Tarihsel olarak davranışçılık ve davranış analizi ekollerinin içinde yer alan BDB, B. F. Skinner'in radikal davranışçı yaklaşım prensiplerini benimsemektedir. Bu yaklaşım; düşünce, duygu gibi içsel yaşantıları da birer davranış olarak ele almakta ve dolayısıyla bu içsel davranışları etkileyen faktörleri de öngörmeyi, anlamayı ve etkilemeyi amaçlamaktadır. Bu doğrultuda yürütülen araştırmalar sonucunda insan dili ve düşüncesine dair kapsamlı bir kuram olan İlişkisel Çerçeve Kuramı (Relational Frame Theory, RFT) geliştirilmiştir. İÇK, insan dili ve bilişinin temelini keyfi-uygulanabilir ilişkisel yanıtlama olarak adlandırılan davranışın oluşturduğunu öne sürer ve temel uyaran işlevlerinin sözel süreçler ve ilişkiler tarafından nasıl değiştirilebileceğini açıklar.

Bu oturumda, katılımcıların ACT'in felsefi ve kuramsal temellerine dair genel bir bilgi sahibi olması ve ACT'in yaşantısal kaçınma, bilişsel birleşme, ayrışma ve değerler gibi temel süreçlerinin felsefi ve kuramsal temeller ile ilişkisine değinilmesi hedeflenmektedir.

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Enhancing Psychological Research and Practice with the Experience Sampling Method (ESM): Capturing Real-Time Experiences and Insights

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Traditional psychological and psychiatric research has primarily relied on standardized self-report tools. While these instruments offer certain benefits, they also present notable limitations, such as recall bias, where participants may inaccurately remember past experiences. Moreover, these methods often fail to capture the complexity and dynamic nature of human experiences as they occur. These shortcomings have led to growing interest in intensive longitudinal approaches like the Experience Sampling Method (ESM). ESM is defined as a technique for assessing individuals' internal experiences—such as emotions, thoughts, bodily sensations, symptoms- and contextual factors in real-time and within their everyday life. By collecting data from participants multiple times a day in their natural settings, ESM enables researchers to track real-time changes in psychological states.

One key benefit of the Experience Sampling Method (ESM) is its ability to mitigate recall bias, as participants report their experiences shortly after they happen, minimizing the need to rely on memory. ESM also allows researchers to explore within-person variability, offering insights into how an individual's experiences fluctuate over time and across different contexts. By assessing psychological constructs, such as emotions, multiple times during the day, ESM provides a clearer understanding of their temporal dynamics and how they are shaped by various factors. This method can reveal patterns in emotional regulation, responses to daily stressors, and other dynamic processes that might be overlooked by traditional measurement techniques. ESM also sheds light on individual differences in psychological experiences, both within person and between persons, helping researchers grasping the complexity of human behavior and mental health. Beyond its research applications, ESM can be a valuable tool in therapeutic settings. When integrated into therapy, ESM enriches the therapeutic process by deepening the understanding of clients' experiences and fostering more personalized and context-specific interventions, ultimately enhancing treatment outcomes.

This workshop provides a fundamental overview of the Experience Sampling Method (ESM) and its potential to enhance research and clinical practice in psychology and psychiatry. Attendees will learn how ESM can overcome the limitations of traditional measurement approaches, offering a deeper understanding of human behavior and experiences. The knowledge gained from this workshop will contribute to advancing both scientific research and therapeutic practices.

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Neurobiological and Psychosocial Foundations of Behavioral Addictions

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Behavioral addictions are excessive, uncontrollable, repetitive behaviors that cause significant harm or distress (1). Gambling, online gaming, shopping, and sexual behaviors can become compulsive pursuits for some individuals. Many of these behaviors are easily reinforced online, especially through activities such as gaming, shopping, social media, and pornography, which are facilitated by smartphones and other mobile devices.

Neurobiological Foundations of Behavioral Addictions

It has been shown that psychiatric disorders are fundamentally neurobiological disorders that affect certain brain circuits, leading to cognitive, emotional, and behavioral symptoms. Illuminating the neurobiological mechanisms underlying these repetitive and maladaptive behaviors is of great importance (2).

Dopamine has long been known to be a major factor in reinforcement and reward regulation. The mesolimbic pathway, extending from the ventral tegmental area to the nucleus accumbens, is crucial for reward. Substance abuse, in particular, can lead to explosive dopamine release in the mesolimbic pathway, influencing behavior. The activation caused by substance use leads to changes in the reward pathway, creating a vicious cycle of intense mental engagement, craving, addiction, and withdrawal. This conceptualization is also applicable to behavioral addictions such as gambling addiction, internet addiction, and shopping addiction (3).

Psychosocial Foundations of Behavioral Addictions

In addition to neurobiological mechanisms, there are also psychosocial foundations of addiction. Psychosocial foundations play a critical role in understanding behavioral addictions. This text will address the psychosocial foundations of behavioral addictions and their effects on addictive behaviors.

Stressful life events can lead individuals to seek ways of relaxation and escape. Identity development and self-perception also play an important role in behavioral addictions. Individuals may turn to these addictions to strengthen their self-perception or in search of an identity. Especially among adolescents, social media addiction is associated with the formation of self-perception and the search for social acceptance (4). Family dynamics and childhood experiences can also influence the development of behavioral addictions (5). Social environment and support systems play a significant role in the formation and maintenance of behavioral addictions. An individual's social environment, particularly peer groups, can be influential in the initiation and continuation of these addictive behaviors (6).

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Cognitive Behavioral Theory and Behavioral Addiction

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Recently, behavioral addictions that have similar characteristics to substance addictions and some of which are included in current diagnostic systems have been identified. Internet Gaming Disorder and Gambling Disorder are behavioral addictions that are now included in the diagnostic systems. In addition, research is ongoing on many behavioral addictions such as sex, porn, the internet, exercise and shopping.

Cognitive behavioral therapy is one of the most important treatment approaches that has been shown to be effective in the treatment of behavioral addictions. The ABC model of Cognitive Behavioral Therapy is also applicable to both behavioral and substance addictions. Internal stimuli such as anxiety, depression, pain or external stimuli such as people, places and times related to addictive behavior trigger thoughts and beliefs related to addiction. Cognitive processes are categorized into three types: core beliefs, addiction-related thoughts/beliefs and automatic thoughts. Core beliefs are principles, ideas or values central to an individual's identity regarding self, the world, the future, others and relationships. Negative core beliefs can include helplessness or hopelessness which can lead to failure to control addictive behaviors and relapse. Addiction-related thoughts and beliefs are those associated with addiction behaviors, such as "If I continue gambling, I will recover all my losses". Automatic thoughts are transient words, phrases or images that enter and exit a person's consciousness rapidly, without deliberate design or reasoning. Imagined scenes and sounds from a casino can trigger intense urges and cravings in a gambler. Additionally, specific cognitive processes related to addiction behaviors, such as self-efficacy and outcome expectancies, have been identified. Self-efficacy includes individuals' beliefs about their ability to achieve recovery or engage in non-substance-related activities. Individuals who believe they lack effective coping skills are at higher risk of relapse. Outcome expectancies are beliefs about the results associated with specific addiction behaviors. Positive outcome expectancies include core beliefs and automatic thoughts about the good or desired outcomes resulting from engaging in addiction behaviors, such as "Gambling provides me with enjoyable experiences," which increase the likelihood of engaging in addiction behaviors. Negative outcome expectancies include beliefs about problematic or undesirable consequences resulting from addiction behaviors, such as "If I continue gambling, I will lose my family" which reduce the likelihood of engaging in addiction behaviors. The primary role of cognitive-behavioral therapy is to help patients identify and address these thoughts and beliefs.

Another component of the ABC model is behaviors. Behaviors are actions or activities performed to achieve a goal or obtain a result. The pleasurable effects of addictive behaviors serve as positive reinforcement, while withdrawal symptoms are considered negative reinforcement. Addictive behaviors aim to increase comfort and reduce discomfort. As these behaviors are repeated, they become habitual. The automatization and habituation of behaviors are significant mechanisms in addictive behaviors.

According to the cognitive-behavioral ABC model triggers, thoughts, perceptions and interpretations, emotions and behaviors are interrelated. The cognitive-behavioral treatment of behavioral addiction aims to identify triggers, recognize cognitive processes arising from these triggers, correct cognitive errors and implement behaviors that break the addiction cycle.

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Cognitive Behavioral Therapy Interventions in the Treatment of Behavioral Addictions

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Cognitive-behavioral therapy aims to change the dysfunctional thoughts that affect a person's emotions and behaviors with more realistic and adaptive alternative thoughts. When people learn to evaluate thoughts in a more realistic and adaptive way, improvement is achieved on emotions and behavior (1).

The behavioral addictions where cognitive-behavioral therapy methods are most commonly experienced are gambling addiction and internet addiction. The positive effect of the cognitive-behavioral approach in the treatment of internet addiction has been emphasized many times (2, 3). In addition to the cognitive-behavioral approach in the treatment of internet addiction, "motivational enhancement" techniques, in which the client and therapist work together to create a treatment plan and set achievable goals, also make important contributions (4). It is thought that dysfunctional automatic thoughts, intermediate beliefs and core beliefs contribute to the development of Internet addiction. Automatic thoughts are cognitions that accompany moments of emotional distress and occur instantaneously specific to the environment and situation. They are often unrecognized; they are associated with certain emotions according to their content and meaning (5). In cognitive behavioral therapy, cognitive treatment aims to focus on automatic thoughts and reduce the belief in these thoughts.

In the CBT (cognitive behavioral therapy) program of Young and et al. cognitive behavioral therapy for internet addiction consists of 12 structured sessions on average (6). Individualized formulations are made by learning the spread of internet use over the days of the week, hours of the day, total daily use time, the place where the internet is used, the purpose of use, the characteristics of the environment used, the conditions affecting the desire to use the internet and if there is resistance to internet use (6). In order to control the time to be connected to the Internet, a weekly schedule about Internet use is created. In order to facilitate the controlled use of the internet and to create a sense of control, internet access is planned at frequent intervals but for short and limited periods (6). Behavioral interventions such as taking a break and setting an alarm may be beneficial (6). Behavioral exercises for uncontrolled use, behavioral practice, 'coaching', desensitization, relaxation techniques, self-control or acquiring new social skills are the main techniques used (7).

When treatment studies are examined, it is seen that cognitive behavioral approaches and motivational interviewing techniques provide positive results in the treatment of gambling addiction (8,9). Cognitive behavioral approach considers pathological gambling as a learned maladaptive behavior and aims to change this behavior based on learning principles (10). CBT techniques include therapeutic approaches such as avoidance therapy, systematic desensitization, exposure, imaginary relaxation and stimulus control (11). Reinforcement technique, which is one of the CBT techniques, is frequently used in CBT therapies for gambling as reinforcing non-gambling activities and improving this behavior with homework in order to eliminate gambling behavior in the treatment of gambling disorder (12).

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A Schema Therapy Perspective on the Treatment of Behavioral Addictions

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Behavioral addiction is a recent concept in psychiatry and psychotherapy. Its consist of food addiction, gambling disorder, internet addiction. All of these addictions, however, are associated with a pattern of emotional dysregulation and cognitive distortions, which are typical of behaviors that people use to seek immediate gratification. Some studies have investigated the relationship between Behavioral Therapy and early maladaptive schemas. According to the Shematherapy model, psychiatric disorders result from the development of Early Maladaptive Schemas in response to unmet emotional needs in childhood. 18 Early maladaptive Schemas are grouped into four domains:

1. Disconnection and rejection

2. Impaired autonomy and performance

3. Excessive responsibility and standarts

4. Impaired limits

The domain Disconnection and Rejection (which includes the schemas abandonment, emotional deprivation, defectiveness, mistrust and abuse, social isolation) is the most strongly related domain across all behavioural addiction. Individuals with high scores in these schemas often develop several coping mechanisms to reduce psychological distress and emotional pain, including maladaptive self-soothing strategies such as compulsive pornography use, binge eating, gambling, problematic social media use and risky sexual behaviours.

Impaired Limits, are second higher schema domain associated with behavioural addiction, is related to problems with setting both personal and interpersonal boundaries. Individuals with high scores in this schema domain are vulnerable to struggle in regulating their emotions, managing their impulsesm and engaging in goal-oriented behaviours. The most strongly related early maladaptive schema in this domain is Insufficient Self-Control, which is characterized by impaired emotional tolerance and self-discipline. This schema is accosiated with short term gratification and with a lack of consequential thinking.

The pain of Early Maladaptive Schemas formed by the frustration of core needs leads to the development of addictive protector modes. These protector modes serve as one of three points in a Triple Mode Cycle which is present at the core of all addictive disorders. Specifically, this TMC is comprised of a Child Mode, an Addictive Protector mode and an Internalized Critic mode.

Exploratory Review of eHealth Interventions for Anxiety Management in Young Children and Adolescents

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The World Health Organization estimates that around 20% of the world's children and adolescents have a mental health condition, a rate that is almost double compared to the general population. Anxiety disorders in children and adolescents are associated with substantial burdens and an increased risk for other mental disorders which often tend to persist in adulthood. Cognitive behavioral therapy (CBT) is generally regarded as the treatment of choice for depression and anxiety in youth. There is growing interest in providing psychological treatments via the Internet to increase access to evidence-based therapies. This is particularly salient for child anxiety disorders as most children who would benefit do not access treatment. The relevance of leveraging digital mental health solutions has further increased because of the COVID-19 pandemic leading to the increased prevalence of mental illness and the growing demand for telemedicine services.

However, up to 80% of children and adolescents with mental health needs receive no treatment. The reasons include not only a lack of treatment availability, but also a reluctance to seek help because of the perceived stigma associated with mental illness, discomfort discussing mental health problems, and a preference for self-help.

Using Internet-based mental health measures to provide CBT may overcome some limitations of traditional treatment services. Advantages of internet-based CBT (iCBT) include availability, anonymity, accessibility at any time and place, flexibility in self-direction and self-pacing, and reduced travel time and costs for both participants and clinicians. Given the digital dominancy of younger generations, these advantages might be even more relevant for youths than adults. On the other hand, ethical concerns have been raised about the effectiveness, clinical validation, user-centered design, and data privacy vulnerabilities of current iCBT products in youngsters. This age group is particularly vulnerable and susceptible to manipulation, especially through digital devices and methods. Consequently, the use of digital technologies for mental health treatment among adolescents and children presents both benefits and ethical issues. Therefore, deploying digital solutions that can reliably monitor and identify mental health needs during the early phases of psychological development is an inherently ethical task. These technologies hold promise for alleviating the burden of mental illness, reducing the risk that critical health needs during this sensitive time of child development remain undetected, providing novel assistive and therapeutic resources for young people in need, and improving practical aspects of mental healthcare delivery.

We will discuss the recent findings of systematic searches in bibliographical databases (Pubmed, Cochrane Controlled Trial Register, PsychInfo) regarding iCBT interventions for anxiety Management targeting young children and adolescents covering the last ten years in the field of CBT.

Çocuklarda Anksiyete Tedavisinde Sanal Gerçeklik (VR): Güncel Yaklaşımlar ve Gelecek Yönelimler

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Anksiyete bozuklukları, çocuk ve ergenlerde en sık görülen psikiyatrik bozukluklar arasında yer alır ve dünya genelinde çocukların %7'sini etkiler. Tedavi edilmediğinde anksiyete bozuklukları çocukların sosyal, akademik ve mesleki yaşamlarını olumsuz etkiler. Anksiyete bozukluklarının tedavisinde en yaygın kullanılan yöntem bilişsel davranışçı terapi (BDT) ve bu terapinin bir parçası olan maruz bırakma terapisidir. Maruz bırakma terapisi, korkulan uyaranlara kontrollü bir şekilde maruz kalmayı içerir. Ancak, bu tedavi yönteminde bazı zorluklar yaşanabilir; örneğin, çocuklar terapi seansları arasında verilen ev ödevlerini yapmada zorlanabilir veya kaçınma davranışları gösterebilir. Bu noktada, sanal gerçeklik (VR) maruz bırakma terapisinde alternatif bir yöntem olarak dikkat çekmektedir.

Sanal gerçeklik (VR), dijital olarak oluşturulmuş 3 boyutlu ortamların, fiziksel dünyayı simüle ederek kullanıcının bu ortamda bulunuyormuş gibi hissetmesini sağlayan bir teknolojidir. VR, özellikle anksiyete bozukluklarının tedavisinde, bireyleri korktukları durumlarla güvenli bir ortamda karşılaştırma imkânı sunduğu için oldukça umut verici bir araçtır. Teknolojideki gelişmeler sayesinde, VR daha erişilebilir ve uygun maliyetli hale gelmiş, eğitimden sağlığa pek çok alanda kullanılmaya başlanmıştır. VR, özellikle çocuklarda maruz bırakma terapisini daha etkili kılmak için kullanılabilecek yenilikçi bir çözüm olarak öne çıkmaktadır.

VR'nin Anksiyete Tedavisinde Kullanımı

Sanal gerçeklik, anksiyete bozukluklarının tedavisinde canlı maruziyete göre çeşitli avantajlar sunar. Canlı maruziyet, hastaların korktukları durumlarla gerçek hayatta yüzleşmelerini gerektirirken, VR kullanarak bu durumlar sanal bir ortamda simüle edilebilir. Bu yöntem, çocukların terapiye daha kolay uyum sağlamasına yardımcı olabilir ve maruziyetlerin daha az kaynak gerektirmesi tedavi sürecini hızlandırabilir. Ayrıca, terapistler VR ortamında uygulamayı kontrol ederek hastalarına kişiye özel bir tedavi sunabilirler. Örneğin, sosyal fobisi olan bir çocuk, bir VR ortamında topluluk önünde konuşma pratiği yaparak kaygısıyla güvenli bir şekilde yüzleşebilir.

VR uygulamaları, farklı yaş gruplarındaki çocuklar için de çeşitli faydalar sunar. Sharar ve ark. araştırmasına göre, çocuklar VR deneyimlerini yetişkinlere kıyasla daha canlı ve gerçekçi olarak algılamaktadır. Bu, çocukların korktukları durumlara karşı verdiği tepkilerin daha doğru bir şekilde gözlemlenmesini ve tedavinin daha etkili olmasını sağlar. Ayrıca, VR terapilerinde kullanılan sensörler, çocukların tedaviye verdikleri yanıtları objektif olarak ölçerek terapiste daha net geri bildirimler sağlayabilir.

VR, maruziyet temelli tedavilerde çocukların hayal gücünü kullanmakta zorlandığı durumlarda daha yüksek bir immersiyon derecesi sunar. Ayrıca, çok duyulu uyaranlar sağlayarak hastaların tedaviye daha derinlemesine katılımını sağlar. Canlı maruziyete kıyasla daha az kaynak gerektirdiği için, VR terapileri daha geniş bir hasta kitlesine ulaştırılabilir. Ancak, VR kullanımının bazı dezavantajları da mevcuttur. Bazı hastalar baş dönmesi, mide bulantısı gibi yan etkiler yaşayabilir. Ayrıca, tüm hastanelerde bu teknolojinin kullanılması için gerekli altyapı ve mali kaynaklar mevcut olmayabilir.

Sonuç ve Gelecek Yönelimler

VR teknolojisi, çocuklarda anksiyete tedavisinde gelecek vaat eden bir araç olarak kabul edilmektedir. Özellikle spesifik fobiler, sosyal anksiyete gibi bozuklukların tedavisinde VR'nin etkili olduğu görülmüştür. Ancak, bu teknolojinin panik bozukluğu ve TSSB gibi diğer anksiyete bozukluklarında kullanımına dair daha fazla araştırma yapılması gerekmektedir. VR'nin anksiyete tedavisindeki potansiyelini anlamak için uzun vadeli randomize kontrollü çalışmalara ihtiyaç vardır. Teknolojinin gelişmesiyle birlikte, VR'nin tedavi süreçlerine entegrasyonu yaygınlaşacak ve çocukların kaygı ile başa çıkmalarında önemli bir rol oynayacaktır.

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Anksiyete Bozukluğu Tanısı Alan Çocuklar İçin Dijital ve Oyunlaştırılmış Bilişsel Davranışçı Terapi (BDT)

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Son yıllarda dijital bağımlılıkların artışı, gençler için olumlu etkiler sağlayabilecek dijital alternatiflerin geliştirilmesi gerekliliğini gündeme getirmiştir. Oyunlaştırılmış Bilişsel Davranışçı Terapi (BDT), geleneksel BDT tekniklerinin oyun mekanikleriyle birleştirilerek sunulmasıyla bu ihtiyaca yanıt verebilecek bir yöntem olarak öne çıkmaktadır. Dijital ve oyunlaştırılmış BDT'nin, erişim kolaylığı, zaman ve mekan esnekliği, kullanıcı verileriyle özelleşebilme, düşük maliyet, ölçülebilir ilerleme ve gerçek zamanlı geri bildirim gibi özellikleri, terapi sürecinin işlevselliğini artırabilir. Özellikle çocuk ve ergenlerde motivasyonu artırmaya yönelik ödüller, seviyeler ve puanlar gibi oyun unsurları, terapiye devamlılığı olumlu yönde etkileyebilir.

Ancak, çocuk ve ergenlere yönelik oyunlaştırılmış BDT uygulamalarının sayısı, yetişkin popülasyonuna göre oldukça sınırlıdır. Literatürde, oyunlaştırılmış BDT'nin etkinliğini gösteren çalışmalar bulunsa da, daha geniş örneklemli, metodolojik açıdan güçlü ve randomize kontrollü çalışmaların gerekliliği vurgulanmaktadır. 2024 yılında yapılan bir meta-analizde, 18 dijital BDT uygulamasını kullanan 1290 genç değerlendirildiğinde, ergenlerin kendi geri bildirimlerine dayalı ölçeklerde etki boyutu düşük olmasına rağmen, anksiyete skorlarında istatistiksel olarak anlamlı bir düzelme gözlemlenmiştir. Ayrıca, Lancet'te yayınlanan 2024 tarihli bir çalışmada, standart tedaviyle dijital BDT karşılaştırılmış ve dijital BDT'nin, standart BDT'ye benzer bir işlevselliğe sahip olduğu, tedaviye devamlılığın ise dijital grupta daha yüksek olduğu belirtilmiştir.

Geleceğe yönelik olarak yapay zeka (AI) ve makine öğrenimi algoritmalarının terapilerin kişiselleştirilmesinde önemli bir rol oynayabileceği düşünülmektedir. AI, her bireyin gelişimsel ve kişisel ihtiyaçlarına göre özelleşmiş müdahaleler sunarak çocuklar ve ergenler için terapinin daha etkili hale getirilmesini sağlayabilir. Artırılmış Gerçeklik (AR) ve Sanal Gerçeklik (VR) entegrasyonu ile çocukların korkularıyla sanal ortamda yüzleşmeleri, özellikle anksiyete bozuklukları ve travma sonrası stres bozukluğu (TSSB) tedavisinde etkili olabilir. Giyilebilir cihazlar aracılığıyla biyolojik verilerin (kalp atış hızı, solunum gibi) takip edilmesi ve bu verilere dayalı anlık geri bildirim sağlanması da terapi sürecini hızlandırabilir.

Sonuç olarak, dijital ve oyunlaştırılmış BDT'nin gelecekte çocuklar ve ergenler için daha motive edici, eğlenceli ve etkili bir terapi yöntemi haline gelmesi muhtemeldir. Puan toplama, seviyeleri geçme, ödüller ve sosyal destek sistemleri gibi unsurlar, terapiye katılımı artırabilirken, oyun içi sosyal etkileşimler ve işbirlikçi oyunlar, sosyal becerilerin gelişimine katkı sağlayabilir.

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Çocuk ve Ergen Psikiyatrisine Yapay Zekayı Entegre Etmek: Etik ve Pratik Düşünceler

Hande Günal Okumuş
Uşak Eğitim ve Araştırma Hastanesi Çocuk ve Ergen Ruh Sağlığı ve Hastalıkları Kliniği

Yapay zeka terimi resmi anlamında ilk kez 1956 yılında ortaya konmuş olup temelde insan zekasına özgü olan yapma ve karar verme gibi yüksek bilişsel fonksiyonları veya otonom davranışları sergilemesi beklenen yapay bir işletim sistemidir. Günümüzde ekonomi, sağlık ve teknoloji gibi hayatın birçok alanında yapay zeka uygulamalarına rastlanmaktadır. Klinik psikoloji ve psikiyatride yapay zeka sistemlerinin, tanı doğruluğunun artırılması, ruh sağlığı sorunlarının erken tespiti ve bireyselleştirilmiş tedavi planlarının oluşturulması gibi alanlarda önemli katkılar sunduğu ve bu nedenle giderek daha fazla önem kazandığı görülmektedir (1). Diğer taraftan özellikle psikiyatri alanında yapay zekanın sorumlu ve etik bir şekilde kullanımı hususunda önemli endişeler bulunmaktadır. Tıp bilimi, sunduğu yenilikleri insan onuru ve haklarını merkeze alarak değerlendirmeli ve insanlık ile gelecek nesiller adına en uygun olan uygulamaları hayata geçirmelidir. Ancak, bilimsel ve teknolojik ilerlemelerin sunduğu tüm yeniliklerin hızla uygulanması gerektiği yönündeki yaygın anlayış ve bu yeni alanlarda yerleşik kuralların eksikliği, her olanaklı yeniliğin uygulanması gerektiği varsayımına zemin hazırlamaktadır (2). Henüz güvenilir olup olmadığı bilinmeyen teknolojilerin geliştirilmesi ve kullanılması sonucunda çok çeşitli biyoetik ikilemler ortaya çıkmaktadır. Bunlar, gizlilik, veri güvenliği, şeffaflık, hesap verilebilirlik, ilgili teknolojilere eşit ve adil erişimin nasıl sağlanacağı, örselenebilir kişi ve grupların nasıl korunacağı veya insan faktörünün azaltılması gibi konular olarak ele alınabilir. Söz konusu bilgi iletişim teknolojilerinin özellikle nöroloji ve psikiyatri alanlarında kullanımı konusu ise diğer alanlara kıyasla daha fazla etik sorun alanı içermektedir (3). Bu sunumda, çocuk ve ergen ruh sağlığı alanındaki yapay zeka uygulamalarının getirdiği etik ve pratik sorunlara değinilmeye çalışılacaktır.

Kaynaklar

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Annelik Duvarının Kadının Annelik Sürecine Etkileri

Kumru Şenyaşar Meterelliyoz

Bakırköy Prof. Dr. Mazhar Osman Ruh Sağlığı ve Sinir Hastalıkları Eğitim ve Araştırma Hastanesi

Toplumsal ve çalışma hayatındaki cinsiyet eşitsizliği kadınların annelik sürecini etkilediği ve toplumların doğurganlık hızında düşüşe sebep olduğu belirtilmektedir. Kadınlar doğum ve sonrası dönemde hayatının nasıl değişeceğini öngörerek ve toplumsal eşitliği artırabilmek amacıyla bilinçli olarak doğurganlığı azaltmayı seçtikleri gösterilmiştir. Yapılan çalışmalarda üniversite mezunu kadınların kariyer ilerlemesine öncelik verdiği, anneliği otuzlu yaşlarına kadar erteledikleri gösterilmiştir. Japonya'da yapılan çalışmada kadın cerrahların %38'i anne olduktan sonra çocuklarına bakım verebilmek amacıyla çalışma planlarını değiştirdiği, %11'inin de işinden istifa ettiği görülmüştür. İş-aile-yaşam üçgeninde kadınların tüm rollerde aynı anda başarılı olabilmek amacıyla yoğun bir baskı altında hissettikleri gösterilmiştir. Gelişmiş ülkelerde bile çocuk bakımı konusundaki politikalar değişen sosyal ve toplumsal yapıya uyum sağlayamamaktadır. Amerika, İngiltere ve Kanada gibi ülkelerde bile çocuk bakımı bireysel sorumluluklara bırakılmıştır. Kadınların iş hayatına dönebilmesini sağlayan güvenilir, erişebilir kreş imkânlarının yetersiz kalmaktadır. ABD'de yapılan çalışmada çocuğu olan cerrahlar incelendiğinde; kadın cerrahların çocuk bakımı ve ev işlerinde erkek cerrahlara göre daha büyük bir pay üstlendiğini bildirdi. Annelik, ev işleri ve iş hayatının getirdiği zorluklar olsa bile yapılan çalışmalar anneliğin kadınların işe dönme motivasyonun ve iş hayatındaki yeteneğini azaltmadığını göstermektedir. İş hayatında tanımlanan ve yıllardır cinsiyet eşitsizliği için çalışılan cam tavan sendromunun yanı sıra William tarafından annelik duvarı tanımlanmıştır. Çocuk sahibi olmanın kadının kariyerini önemli ölçüde etkilediği ve işyerinde önemli dezavantajlara maruz kaldıkları gösterilmiştir. Çocuk sahibi olan kadınların hayatının aynı döneminde olan erkeklere göre daha az kadrolu çalıştıkları, yöneticilik pozisyonundan çok yardımcı pozisyonlarda görevlendirildikleri ve çok daha az kazandıkları gösterilmiştir. İşe alımlarda hamilelik ve hamilelik planlarının kadınlar için dezavantaj oluşturabildiği, çocuk sahibi olan kadınların iş hayatlarında çok yoğun, fazla çalışmak ve terfi almak istemeyen kişiler olarak görüldüğü belirtilmektedir.

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CBT Practices in Neurodevelopmental Disorders
CBT Interventions in the Treatment of ADHD in Adulthood

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The prevalence of ADHD in adulthood is estimated to be 1% to 5%. In general, ADHD symptoms in adulthood are similar to those in children, with problems in distractibility, hyperactivity and impulsivity. Adult ADHD may be associated with impairments in employment, education, economic and social functioning. Although pharmacotherapy is the treatment modality for adult ADHD, some individuals may not tolerate medication or may not respond adequately to medication. Therefore, psychosocial interventions along with medication are important for the optimal treatment of adult ADHD. CBT techniques are effective in the treatment of adult ADHD and are associated with improvement in symptoms and increased functioning. In CBT for adult ADHD, cognitive components include thoughts and beliefs that may exacerbate ADHD symptoms. For example, when faced with a situation that feels overwhelming, a person may turn their attention elsewhere or think things like "I can't do this", "I don't want to do this" or "I will do this later". These thoughts contribute to negative emotions that can prevent successful completion of the task. Part of the treatment involves restructuring maladaptive thoughts. Behavioral components are behaviors that can exacerbate ADHD symptoms. Existing behaviors can include things like avoiding doing what needs to be done, not maintaining an organizational system, etc. CBT aims to recognize dysfunctional behaviors and help the person identify and implement more effective behaviors that target a problem area. Repeated practice of both cognitive and behavioral strategies at home is essential to create long-lasting changes.

The treatment program includes three basic modules:

1. Psychoeducation/organization and planning
2. Coping with distraction
3. Cognitive restructuring

The first part of the treatment involves organization and planning skills. This includes skills such as the following:

- Learning to effectively and consistently use a calendar
- Learning to effectively and consistently use a task list
- Working on effective problem- solving skills, including breaking down tasks into steps and choosing a best solution for a problem when no solution is ideal
- Developing a triage system for mail and papers
- Developing organizational systems for papers, electronic files, and other items

The second part of treatment involves managing distractibility. Skills include the following:

- Determining a reasonable length of time that one can expect to focus on a boring or difficult task and breaking tasks down into chunks that match this length of time
- Using a timer, cues, and other techniques (e.g., distractibility delay)

The third part of treatment involves learning to think about problems and stressors in the most adaptive way possible. Skills include the following:

- Positive "self-coaching"
- Learning how to identify and dispute negative, overly positive, and/ or unhelpful thoughts
- Learning how to look at situations rationally, and therefore make rational choices about the best possible solutions

In addition to these 3 main modules, procrastination and information sessions with family member/spouse/partner can be planned. In the effective treatment of adult ADHD, it is important to target improvements in areas of functioning by considering these approaches.

SPEECH SUMMARIES

Layered Model with Data: Research Findings and Clinical Applications

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Early Maladaptive Schemas (EMS), as outlined in schema theory, develop during childhood and adolescence. These schemas form repetitive, personality-like patterns stemming from unmet emotional needs in early life. Schema theory identifies 18 core schemas, including emotional deprivation, defectiveness/shame, mistrust/abuse, abandonment/instability, social isolation/alienation, failure, self-sacrifice, dependency/incompetence, entitlement, unrelenting standards, vulnerability, enmeshment, subjugation, emotional inhibition, insufficient self-control, negativity/pessimism, approval-seeking, and self-punitiveness.

In schema therapy, these EMS are central to understanding the client's psychological patterns. While research has consistently supported the existence of these 18 schemas, there has been less clarity regarding their higher-order structure. Clinical practice further highlights that not all schemas hold the same importance or urgency in treatment. Our recent study, which involved data from 3,310 psychotherapy patients, has clarified the hierarchical structure of schemas.

Additionally, our exploration of coping mechanisms and modes revealed notable parallels with the polyvagal theory's description of surrender, fight/flight, and social engagement systems. This finding suggests a close relationship between schemas, coping responses, and physiological modes of operation.

By synthesizing these insights, we developed the Layered Model, which combined schema and mode concepts into a unified framework. In this model, schemas are not isolated constructs but part of a dynamic, layered system involving vulnerability, reflexive responses, control mechanisms, and secondary (reflective) responses. This layered perspective allows for a more nuanced understanding of the interaction between schemas and coping mechanisms.

The layered model theory proposes a hierarchy of schemas based on unmet needs, where specific core schemas guide the evaluation and interpretation of other schemas. This integrated model will provide new depth in schema therapy and offer enhanced clinical tools for addressing complex emotional and behavioral patterns.

"Generic Cognitive Model" and the Layered Model: Analysis from a CBT Perspective

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Private Practice, Ankara

The generic cognitive model (GCM) was proposed by Beck to clarify some concepts that are difficult to explain with the traditional cognitive model. It has several important innovations to the cognitive model. Continuity between adaptation and maladaptation, the concept of schema activation, dual processing, protoschemas, primal schemas are some of these newly added concepts (1). It also offers new explanations for some clinical conditions (e.g. endogenous depression and mania) that are difficult to explain with the traditional model.

According to the GCM, triggering events are initially processed by protoschemas through the automatic system. Protoschemas evaluate data from the external environment and subjective experiences that may be vital. Protoschemas classify triggering events according to their importance and activate emotional and behavioral systems. The final stage of processing is carried out by the reflective system. The reflective system involves more complex schemas than the automatic system, subjecting the situation to a more detailed evaluation process. Supported by attentional processes, the reflective system refines or corrects the meaning or product of the protoschemas.

When a match is made between a triggering event and a protoschema, schema activation begins and beliefs are activated on the basis of the schema. Emotional, motivational and behavioral systems are activated and act in accordance with the schema. GCM also develops and introduces the concept of modes. Modes refer to a network of cognitive, emotional, motivational and behavioral components. Modes represent beliefs and expectations embedded in the schema. Together, these components function as an integrated organization.

The layered model suggests a hierarchical structure among early maladaptive schemas (EMS). It suggests that some schemas are foundational, while others are involved in making sense of and organizing triggers. This model presents the concepts of schema and mode in a unified framework.

In this way, it emphasizes the interaction between schemas and coping mechanisms. Together with the concept of protoschema, primal schemas and modes, the GCM can be considered to be similar to the layered model we have proposed. Investigating the conceptual overlap and divergence of these two models may add richness to the cognitive model.

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Treatment of Borderline Personality Problems with Metacognitive Therapy

Hans Nordahl

The workshop will introduce the MCT model and treatment principles for borderline personality problems, covering 6 steps. The MCT model describes the cognitive attentional syndrome and maladaptive coping strategies which are typical for these patients. Rather than changing beliefs about themselves and their relationships, the treatment emphasise working on increasing the patient's self-regulation by learning to disengage from distressing thoughts and angry ruminations. The workshop will illustrate the steps used to treat borderline personality problems and provide some exercises and demonstrations of techniques, which are found useful to engage the patient in the therapy!

Psikoterapide Terapötik İlişki

Hakan Türkçapar
Ankara Sosyal Bilimler Üniversitesi

Psikoterapi ekollerinin ve psikoterapi süreci ile ilgilenen araştırmacıların en sık cevap aradıkları sorulardan bir tanesi; psikoterapinin etkisinin kaynağıdır. Psikoterapi' nin nasıl işe yaradığına ilişkin sorulan bu soruya ilişkin çok çeşitli cevaplar verilmekle beraber günümüzde bu soruyla ilgili tartışma halen devam etmektedir. Terapinin etkisiyle ilgili çalışmalara bakıldığında araştırmacıların etkililiğin ortak özelliklere (empati, sahicilik, ilgi ve sıcaklık gibi) bağlı olduğunu düşünenler ve özgül özelliklere olduğunu düşünenler olarak iki grupta toplandığını görmek mümkündür. Bir grup araştırmacı tüm psikoterapi türlerinde ortak bazı etkenlerin olduğunu ve değişimin esasını bu etkenlerin oluşturduğunu savunurken diğer grup, psikoterapide esas olanın o terapiye özgü özellikler olduğunu ve terapi türlerinin buna göre etkinlik açısından farklı olduğunu savunmaktadır. Terapideki etkinin ortak etkenlere bağlı olup terapilerin etki açısından birbirinden ayrılmadığını savunanlar Alice Harikalar diyarında kitabında anlatılan "herkes kazandı, herkes birinci" hikayesinden yola çıkarak bu durumu ifade eden "Dodo Kuşu kararı" deyimini de literatüre kazandırmışlardır (Luborsky ve ark., 2002).

Ortak etken varsayımına karşı çıkanlar ise psikoterapilerin etkileri açısından eşit olmadığını ve bütün iyileşmenin ortak etkenlere bağlı olmadığını savunmuşlardır. Tüm psikoterapiler ilişki temellidir bu bağlamda psikoterapinin etkisinde iyi ilişki mutlak önem taşıyan bir anlamda olmazsa olmaz ögedir. Psikoterapi ilişki üstünden yürüdüğü için bu ilişki kurulmadan terapi yürütülemez, iyi ilişki terapi için gerekli şarttır. Bu gerekli şart karşılandıktan sonra bunun üzerine o psikoterapiye özgü yöntemler devreye girer.

Toplam etki de ilişki ve kullanılan payın ne olduğu konusunda pek çok meta analiz yapılsa da bu meta analizlerin desenleri nedeniyle tam bir sonuç vermeyeceği kesin sonuç ancak bu durumu anlamaya dönük kontrollü etkinlik çalışmalarıyla açığa çıkarılmasını bekleyebiliriz.

Bilişsel Davranışçı Terapide Terapötik İlişkinin Önemi

Selin Tutku Tabur

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Bilişsel Davranışçı Terapi (BDT): Doğuşundan itibaren deneyci bir yaklaşıma sahip olduğu ve bilişsel değişikliğe önem verdiği için terapötik ilişki üzerinde çok fazla durmadığı düşünülmüştür. Rasyonel Duygusal Davranışçı Terapi (REBT)'nin kurucusu olarak Albert Ellis, terapötik ilişkiye o güne dek egemen olan yaklaşımlardan yaklaşımlarından farklı bir perspektifle yaklaşmıştır. O terapötik ilişkinin amacının danışanın işlevsiz inançlarını ve düşünce kalıplarını değiştirmek için bir çerçeve sunmak olduğunu savunur. Terapötik ilişki; danışanın güvenli bir ortamda kendini ifade edebilmesi ve irrasyonel inançlarını sorgulayabilmesi için gereklidir. Terapistin danışanı koşulsuz kabul etmesinin gerekliliğine vurgu yaparken, empatinin olmasını onaylar ancak aşırı empatinin de değişime engel olabileceğini söyler. Bu doğrultuda Ellis'in terapötik ilişkiye yaklaşımı, uygun dozda empati ve sıcaklığın yanı sıra yönlendirici, yapılandırılmış ve işlevsel bir odak içerir. BDT'nin kurucularından Aaron Beck'e göreyse; terapötik ilişki terapinin gerekli unsurlardan biridir, ancak tek başına yeterli değildir. Terapinin başarılı olması için yapısal ve hedefe yönelik müdahaleler gereklidir. Yani terapötik ilişki; gerekli şarttır ancak yeterli şart değildir. BDT'ye göre terapötik ilişkinin kurulmasını sağlayacak en önemli etken terapistin terapi sürecini danışana yararlı olabilecek şekilde sürdürebilmesidir. Terapötik ilişkinin temel gerekliliklerinden sahicilik ve sahiplenici olmayan bir sıcaklık, BDT'nin de temelidir. BDT, danışana ve onun duygu-düşüncelerine önem verir. Danışanın her türlü düşüncesinin ve davranışının bugünden veya geçmişinden gelen bir gerekçesi olduğunu bilir, anlamaya çalışır ve değer verir. BDT terapisti öncelikle empati yapar ve hastanın düşşünce duygu istek ve niyetini valide eder, ardından da hastanın istek ve hedeflerine dönük alternatif düşünce ve davranışları onunla birlikte araştırır. Bu danışanı terapi sürecine aktif bir şekilde katılmaya teşvik eder. Terapistler danışanları hakkında ahlaki bir yargıya varmamayı olmazsa olmaz bir koşul olarak görürler. BDT terapistlerinin yetkinliğini değerlendirirken de terapötik ilişkiyi birinci öncelikli olarak dikkate alır. Kullanılan Bilişsel Terapist Değerlendirme Ölçeği (CTRS)'in ilk 5 maddesi ilişkiye ayrılmıştır. Terapi ilişkisinde psikodinamik literatürde en çok üzerinde durulan aktarım ve karşı aktarım kavramlarını ise BDT, bilişsel kuramdaki şema kavramıyla ele alır. BDT'nin yapısı, olumsuz bir aktarım ve karşı aktarım gelişmesini olabildiğince azaltacak birçok özelliğe sahiptir. Özet olarak;

- BDT, terapist-danışan ilişkisini değişim için tek araç olarak görmez;
- İyi bir terapötik ilişki, değişim için gerekli ancak yeterli bir koşul değildir;
- İlişkinin kalitesi terapiye yardımcı olabilir ya da terapiyi engelleyebilir.
- Terapiye müdahale etmediği sürece ilişki doğrudan ele alınmaz.
- "Aktarım size dokunmadıkça ona dokunmayın."

3. Dalga BDT'lerde Terapötik İlişkinin Önemi ve Kullanımı

Seher Cömertoğlu Yalçın
Cansağlığı Vakfı

Davranışçılık, zaman içerisinde evrilerek üç ana dalgaya ayrılmıştır. İlk dalga, 1940 ile 1960 yılları arasında ortaya çıkmış olup, bu dönemde davranışın nasıl şekillendiği ve öğrenildiği üzerine yoğunlaşılmıştır. Bu dönemin temel yöntemleri arasında klasik koşullanma, edimsel koşullanma, maruz bırakma ve tepki önleme teknikleri yer almıştır.

1960 ile 1980 yılları arasında, davranışçılığın ikinci dalgası ortaya çıkmıştır. Bu dönemde artık sadece davranışlar değil, bilişsel süreçlerin de davranışı etkilediği düşünülmeye başlanmıştır. Bu yaklaşımda, bireyin zihinsel süreçlerini anlama ve değiştirme üzerine odaklanılmıştır. Bilişsel yeniden çerçeveleme ve sokratik sorgulama gibi teknikler, bu dönemin öne çıkan araçları olmuştur.

1980 yılından itibaren ise davranışçılığın üçüncü dalgası olarak adlandırılan yeni bir dönem başlamıştır. Bu dönemde, başta Kabul ve Kararlılık Terapisi (ACT), Diyalektik Davranış Terapisi (DBT), Kendindelik Temelli Bilişsel Terapi (MBCT) ve Fonksiyonel Analitik Terapi (FAP) gibi terapiler ortaya çıkmıştır. Üçüncü dalga terapiler, bireyin kabul ve farkındalık kavramlarını kullanarak yaşadığı zorluklarla başa çıkmasını amaçlar. Kendilik, kabul ve bilişsel ayrışma gibi unsurlar, bu dalganın temel taşları arasında yer almaktadır.

Terapötik ilişki bağlamında kabul, danışanın söylediklerini ve yaptıklarını tam anlamıyla dinlemek, bu deneyimleri keşfetmek ve anlamak, danışanın getirdiği tüm duygu ve düşüncelere açık olmak, onun deneyimlerine bir bütün olarak yer açmak anlamına gelir. Üçüncü dalga davranışçı terapilerin önemli özellikleri arasında transdiagnostik yaklaşım, yaşantısal olma, sendromdan ziyade insan acısına yönelme ve terapisti de sürece dahil etme sayılabilir. Bu terapiler, bağlamı merkeze alır ve birey ile çevresi arasındaki dinamikleri anlamaya çalışır. Danışanın bağlamının anlaşılması, terapötik ilişkiyi güçlendiren bir unsurdur.

Bu yaklaşımlar, psikoterapi odasını "acı çeken iki insanın karşılaştığı bir alan" olarak görür, böylece danışan ve terapist arasında hiyerarşik bir ilişki kurulmaz. İyi bir terapötik ilişki, terapistin danışanı ve çevresini fark etmesi, bağlama ve ihtiyaca göre esnek davranabilmesiyle mümkündür. Üçüncü dalga terapilerdeki ilişki, "gerçek" bir ilişki olma özelliği taşır. Terapist, bağlama ve işlevlere dikkat ederek seans sürecinde zaman zaman danışanla kendi deneyimlerini paylaşabilir, bu da ilişkinin doğrudan ve samimi olmasına katkı sağlar.

Bu kapsamda, üçüncü dalga BDT'lerde terapötik ilişki, yalnızca teknik bir unsur değil, aynı zamanda terapistin danışanla eşit bir zeminde ve gerçek bir ilişki içerisinde olmasına olanak tanıyan önemli bir faktördür.

Çocuk ve Ergenlerde Kabul ve Kararlılık Terapisi

Fatma Benk Durmuş
29 Mayıs Üniveristesi

Üçüncü dalga psikoterapilerden biri olan kabul ve kararlılık terapisinde (KKT), bilinçli bir insan olarak şimdiki anla tam olarak temas kurma ve seçilen değerlerin hizmetinde davranışı sürdürme veya değiştirme süreci olarak tanımlanan ve mental sağlık ve dayanıklılık için önemi gittikçe anlaşılan psikolojik esnekliği geliştirmeye çalışılmaktadır. KKT, kişisel deneyimlerin veya olayların biçimini veya sıklığını değiştirmeyi değil, bunların davranışsal etkilerini azaltmak ve değer merkezli eylemlere giden yolu açmak için bireysel deneyimlerin işlevini değiştirmeyi amaçlamaktadır. KKT'nin pek çok terapi yönteminden farkı semptomların azaltılmasından ziyade olumsuz düşünce, duygu veya fiziksel hislere sahipken de etkili bir şekilde değer temelli davranışların geliştirilmesine odaklanmasıdır.

Çocuk ve ergenlerde ruhsal bozuklukların önlenmesi, psikolojik esnekliği arttırarak stresle baş etme becerilerinin geliştirilmesi ve var olan psikiyatrik bozukluğun tedavisinde KKT'nin etkili olduğuna dair kanıtlar giderek artan çalışmalarda gösterilmektedir.

Bazı çalışmalar, çocukların ve ergenlerin yetişkinlerden farklı olarak uzun süredir oluşturdukları köklü deneyimsel kaçınma örüntüsüne sahip olmadıklarını ortaya koymaktadır. Yine çocukluktan erişkinliğe geçiş periyodu olan ergenlik dönemi bireylerin psikolojik esneklik ve yaşam değerlerini geliştirmeleri için bir fırsat olarak görülmektedir. Bu nedenle, KKT'nin çocuk ve ergenlerde uygulanması, daha sonra ortaya çıkabilecek negatif davranışları, deneyimsel kaçınma ve bilişsel birleşme gibi psikolojik katılığı önleyebilecek öneme sahiptir.

KKT, çocuk ve ergenlerin farklı durumlara tepki olarak düşüncelerini ve davranışlarını uyarlama yeteneğini geliştirmelerine yardımcı olmakta, zor duyguları ve deneyimleri bastırmak veya kaçınmak yerine onlara kabul geliştirmeye yardımcı olmaktadır. KKT ile çocuk ve ergenler duygularını güvenli ve yargılayıcı olmayan bir ortamda tanımaya ve ifade etmeye teşvik edilir, bu da duygusal farkındalığı ve öz şefkati arttırmaktadır. KKT, çocuk ve ergenlerin kendilerine yardımcı olmayan düşüncelerden ve inançlardan uzaklaştırmalarına yardımcı olmak için defüzyon teknikleri öğretir. Çocuk ve ergenlerin düşüncelerine kapılmadan onları gözlemlemeyi öğrenerek, olumsuz düşünce kalıplarının etkisini azaltarak zihinsel süreçleri üzerinde bir kontrol duygusu kazanmalarını hedeflemektedir.

Bu sunumda, çocuk ve ergenlerde KKT teknikleri, erişkin uygulamalarından farkları ve klinik pratikte kullanım alanları güncel literatür ışığında ele alınacaktır.

Schema Therapy Approach in Undiagnosed Clients

Fatih Yığman
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Schema Therapy is a therapy method designed for psychological disorders that are difficult to change and have clear roots in childhood and adolescence. It originates from cognitive-behavioral therapies and differs from them in that it places more emphasis on experiential interventions and the therapeutic relationship.

According to schema theory, early maladaptive schemas develop during childhood or adolescence. They are considered as recurring patterns throughout the person's life (1). It can be said that schemas develop through interactions between temperament and early childhood experiences and reveal personality-like models in the long term.

Recent studies classify 18 early maladaptive schemas (EMS) into 4 main domains, each representing unmet needs. These domains are defined as "Disconnection & Rejection,""Impaired Autonomy & Performance," "Excessive Responsibility & Standards," and "Impaired Limits" (2).

Undiagnosed clients are those who experience mental difficulties but whose complaints do not meet the criteria for any "disorder". With the increase in the knowledge of mental health professionals, it can be said that many clients can be considered in this group. Reasons for application include complaints such as coping with life stress and difficulties, relationship problems, emotional difficulties, decision-making difficulties, self-confidence problems, trauma or negative experiences from the past, search for identity and meaning. These complaints are often related to our personality traits and are persistent.

In the schema therapy approach, while evaluating the current problems of undiagnosed clients, more attention is paid to whether these problems have the characteristics of a pattern. When recurrent problems are detected, their relationship with our personality traits (schemas) is tried to be determined. If these problems point to schemas, in addition to cognitive and behavioral techniques, experiential techniques are used with the client.

Schemas act as a lens in the way we perceive life. When we evaluate other people, ourselves and events, we make an evaluation influenced by our schemas. For this reason, people's schemas can be reflected in many areas of their lives. As a reflection of our personality patterns, it can be said that schema therapy can play an effective role in changing the complaints of undiagnosed clients.

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CBT Applications in Adults Diagnosed with Autism

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The prevalence of autism spectrum disorder is estimated at 1.8%. Although it is primarily studied as a childhood disorder, as with most neurodevelopmental disorders, 85% of individuals diagnosed with autism in childhood also meet the criteria for autism in adulthood. Although only 2% of autism-related studies focus on adults, adults diagnosed with autism experience many mental disorders, including depression and anxiety disorders. Although research is limited in the presence of additional diagnoses, psychotherapy methods are promising. The focus of the success of specific interventions and techniques in therapy is on nonspecific elements such as a good therapeutic relationship and the development of empathy capacity. Some clients benefit greatly from adapting to standard therapeutic approaches; this benefit can be general, such as changes in speech mode and speed, or it can be quite individual and specific, such as adaptation to certain sensory and information processing patterns. Adaptations should be made in therapy for the neurodevelopmental diversity in these individuals. Flexible session duration, realistic goals, including a relative in therapy, clearly defining homework, frequent use of role plays during sessions, and supporting behaviors aimed at reducing psychological distress caused by autism-specific differences. Cognitive interventions in therapy are aimed at examining evidence, functionality of thought, identifying and testing cognitive rigidity that causes intolerance to uncertainty, and negative thinking bias. Behavioral interventions are increasing the ability to understand emotions, increasing coping capacity, eliminating behaviors that maintain psychological distress, and supporting autism-specific behaviors that maintain psychological well-being. Regardless of the reason for referring or starting therapy, increasing psychological resilience against stressful situations is one of the most important goals of therapy.

Interpersonal Developmental Case Formulation in Cognitive Behavioral Analysis System of Psychotherapy (CBASP)

Massimo Tarsia

The workshop will present a framework for the development of a clinical case formulation in Cognitive Behavioral Analysis System of Psychotherapy (CBASP). CBASP is an evidence-based psychotherapy underpinned by contemporary developmental, interpersonal, and learning theories.

The workshop will provide a brief outline of the CBASP model before introducing the elements that construct the case formulation. Each component is grounded in the person's developmental history. A particular emphasis is given to learning from key relationships in the individual's interpersonal environment and the resulting patient's relational style in therapy. The CBASP case formulation offers a framework for conceptualising the origin of a person's presenting problems from a trauma-informed, interpersonal developmental perspective.

It provides a focus for personalised therapeutic goals and mechanisms of change based on the patient's developmental needs. It also informs the therapist on how to adopt an optimal relational stance in order to handle difficulties that may arise during the course of treatment. The outcome is a conceptual and process-based integrative map that guides the therapist's intervention.

Clinical and Cognitive Properties in Erectile Dysfunction

Canan Bayram Efe

Private Physician

Erectile dysfunction (ED) is defined as a disorder in initiating and maintaining an erection sufficient for sexual activity. The DSM-5 diagnostic criteria of the American Psychiatric Association is the inability to achieve and maintain an erection or inadequate erection until sexual activity is concluded in all or almost all sexual intercourse for at least 6 months. This disorder should cause significant distress or difficulties in interpersonal relationships. According to a study conducted in Turkey, ED is seen in 69.2% of people over the age of 40. The causes are divided into 2 as organic and psychological origin. Diabetes, hypertension, hyperlipidaemia, metabolic syndrome, some neurological diseases, endocrinological diseases, drug use are the main organic causes. Psychogenic causes include depression, anxiety disorders, alcohol and substance abuse, psychotic disorders and personality disorders. When ED is diagnosed, organic psychogenic differentiation must be made. Psychogenic causes of erectile dysfunction are classified as preparatory, initiating and sustaining. Lack of sexual knowledge, sexual myths, personality traits, traumatic experiences, lifestyle are some of the predisposing factors for erectile dysfunction. Physical diseases, mental diseases, drug use, unrealistic performance expectations, ageing, relationship problems between partners can be considered as initiating factors. Diseases, sexual misinformation and myths, performance anxiety, not seeking treatment, negative automatic thoughts can be listed as maintaining factors. ED treatment is organised according to the cause. Drug treatments and psychotherapies are treatment options. Cognitive and behavioural interventions are especially important in sexual therapies. The treatment is arranged with psychoeducation sessions in which sexual anatomy, physiology and sexual functions are explained to sexual knowledge deficiencies, sessions in which interventions are made by discussing myths such as men are always ready for sexuality, sexuality cannot be experienced without sexual intercourse, men do not have sexual problems, and psychotherapy sessions in which behavioural assignments such as sensate focus are planned. A regular and reinforcing partner contributes positively to the treatment.

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CBT Strategies for Erectile Dysfunction

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The most important step in the treatment of erectile dysfunction is to get the individual psychological, relational, and sexual history information as in other sexual dysfunctions. This information enables the determination of the factors that cause the emergence of sexual problems. The treatment strategies to be applied will target these causes. Firstly, the case formulation is done and then the therapist gives feedback to the couple, explains the CBT rationale, and discusses the treatment plan. The main intervention techniques applied in the treatment process are: 1. Sensate focus exercises 2. stimulus control 3. psychosexual skills training 4. cognitive restructuring. Sensate focus exercises desensitise the couple to anxiety and negative mood during sexual activity, reduce performance anxiety, and allow them to focus attention on sexual pleasure, not performance. Gradual exposure is used. Stimulus control is the procedure of combining sexual acts with a pleasant and comfortable environment. In psychosexual skills training, ideal scenarios that the couple has never tried before due to feelings of embarrassment, discomfort, miscommunication, guilt, etc. are transformed into more flexible and less restrictive sexual scenarios and sexual behaviors involving sexual stimuli and sexual behaviors. Pelvic muscle training is also an important part of psychosexual skills training. Psychosexual skills training ensures the understanding that the sexual problem is the couple's problem, builds mutual trust, and balances the couple's sexual life. Reducing embarrassment, providing sexual education, and drawing up a therapeutic plan counteracts the man's (and his partner's) hopelessness. Identifying the cognitive, behavioral, and emotional aspects of sexual and relational problems reveals barriers to sexual pleasure. Understanding the interconnections between cognitions and emotions and their behavioral interaction patterns can identify various intervention points. Techniques that can be used to address dysfunctional beliefs and sexual beliefs include sexual education, evaluation of the advantages and disadvantages of sexual beliefs, evidence review, behavioral experiments, and alternative thought development. The first step for sexual education to provide awareness of distorted and maladaptive beliefs is to provide basic information about the psychophysiological process of sexual response. Sexual myths can thus be overcome. Given the strong influence that negative cognitions have on the individual's emotional well-being (e.g., anxiety, depression) and behavior (e.g., excessive reassurance-seeking, and withdrawal from the partner), assessing and modifying them is an important component of CBT.

Evaluation and Interventions in Erectile Dysfunction in Partner Relationships

Didem Sücüllüoğlu Dikici
Private Physician

Erectile dysfunction is defined as the inability to achieve or maintain penile erection sufficient for sexual intercourse. It is among the most commonly encountered sexual dysfunctions. It is often not linked to a single cause. In addition to physical factors such as hormonal, neurological, vascular diseases, and medication use, psychological and interpersonal factors like sexual myths, lack of sexual knowledge, pressures within the family, childhood traumatic experiences, issues in the dynamics of the couple's relationship, conflicts, and communication problems can also cause erectile dysfunction. Even if there are organic causes for the emergence of sexual problems, the psychological factors that are influenced by them can contribute to the persistence of the issue.

Among sexual dysfunctions, erectile dysfunction has a more frequent organic etiology, but psychiatric disorders and partner relationship issues are also very common (40%). Relationship problems can be both an initiating and maintaining cause. Therefore, even if erectile dysfunction has an organic cause, it should be approached holistically, considering that every organic issue will likely have psychological components.

A good and healthy sexual relationship defines a process where harmony and satisfaction are experienced between partners, and both physical and mental health are prioritized. In this process, it is important for partners to know each other's expectations, not to be coercive about sexual desires, and to respect each other's thoughts and desires regarding sexuality.

How each partner perceives the sexual problem and the impact of this problem on the relationship are evaluated. For couples with significant areas of conflict in their relationship, couples therapy may be needed before or alongside sexual therapy.

This text discusses the effects of conflict resolution skills, lack of intimacy, and general relationship distress on couples experiencing sexual dysfunction and how these issues can be addressed.

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Memory Consolidation and Reconsolidation Processes in Therapy through the Layered Model

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Private Physician

This presentation explores memory consolidation and reconsolidation processes within the framework of the layered model in schema therapy. Memory consolidation refers to the process by which individuals solidify their past experiences into long-term memory, which is especially crucial in therapeutic processes involving traumatic memories. Reconsolidation, on the other hand, involves the reactivation of these past memories and their updating with new information and emotional contexts. In therapy, reconsolidation allows the restructuring of an individual's dysfunctional cognitive and emotional schemas.

The layered model deepens the impact of therapeutic interventions, supporting these restructuring processes. This model provides a multi-layered approach, enabling clients to work at cognitive, emotional, and behavioral levels. Throughout the therapeutic process, memory consolidation and reconsolidation play a key role in modifying the dysfunctional schemas developed during early life and in building healthy coping mechanisms.

The presentation will detail how memory consolidation and reconsolidation are integrated into therapy, their role in restructuring the client's schemas, and their contribution to long-term recovery. Additionally, the advantages of schema therapy in addressing these processes and its practical applications in clinical settings will be discussed.

Finally, the presentation will highlight the effects of schema therapy techniques on reprocessing traumatic memories, enhancing emotional regulation skills, and replacing dysfunctional schema structures with healthy ones.

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PANEL-15 Transdiagnostic Cognitive Behaviral Group Therapies

Fatma Ezgi Görgülüer

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Group therapies began in the 1900s as providing healthy living advice to tuberculosis patients. Later, their potential benefits for mental disorders were recognized, leading psychoanalytic theorists of the time to experiment with them. Especially Irvin D. Yalom worked on this way and provided benefit for many theoretical and structural studies related to group psychotherapy. By the late 20th century, group psychotherapy began to focus on more specific groups. Interest in group therapies increased by the time, because of their cost and time efficiency and the lack of significant differences in effectiveness compared to individual and group-format psychotherapies. Additionally, group learning offers advantages such as the feeling of not being alone, optimism about recovery, modeling and opportunities to improve interpersonal relationships.

Cognitive Behavioral Group Therapy (CBGT) is recognized as the most prominent approach in group psychoteraphies. CBGT bases the changes in group members on cognitive-behavioral processes. During therapy, Socratic questioning and guided discovery are used.

The existence of patients who show sub-threshold symptoms or frequently receive similar diagnoses but do not fit into existing diagnostic classification systems has suggested the possibility of underlying similar psychopathologies. This has led to the emergence of a transdiagnostic approach. CBGT combines the advantages of both group and transdiagnostic approach with established protocols.

Transdiagnostic Metacognitive Group Therapy

Merve Çelik Korkmaz
Dışkapı Yıldırım Beyazıt Training and Research Hospital

Transdiagnostic approach suggests that common psychopathological processes underlie various mental disorders. The presence of subthreshold symptoms in clients seeking help from mental health professionals, high rates of comorbidity, changes of diagnosis over time and clinical presentations among individuals with the same diagnosis all support the idea of shared underlying common psychopathological processes. Metacognitive theory suggests that irrational beliefs and schemas, which are the cause of psychopathologies, are influenced by metacognitions. Unlike traditional cognitive behavioural therapy, metacognitive therapy recommends that changing metacognitions are essential rather than questioning validity of beliefs and cognitions. The model of Self-Regulatory Executive Function (S-REF) suggests that mental disorders are controlled top-down. It is also suggested that problems in Self-Regulatory Executive Function (S-REF) model are due to the Cognitive Attentional Syndrome (CAS), which is considered primary cause of psychiatric disorders. In metacognitive therapy, several strategies for preventing CAS are employed. This part of the panel, we will be discussed about 8-session transdiagnostic metacognitive group therapy program and clinical experiences will be shared.

Diagnosis-Specific and Transdiagnostic Cognitive Behavoral Group Therapies
Cognitive Behavioral Group Therapy for Clients Diagnosed with Panic Disorder

Erkil Çetinel

Sağlık Bilimleri Üniversitesi Ankara Etlik Şehir Hastanesi, Turkey

Panic Disorder is a psychopathology that includes catastrophic cognitions in which the person believes that their bodily sensations will lead to catastrophic consequences, behaviors of avoiding symptoms and situations that they think will cause symptoms, and behaviors of seeking security to create the feeling of being safe against the symptoms that occur, leading to a decrease in the person's functionality. For our clients who apply to our clinic with a diagnosis of panic disorder, we will provide cognitive behavioral group therapies consisting of groups of maximum 8 people, consisting of 5 sessions, where the consequences of avoidance and safety-seeking behaviors are discussed and catastrophic cognitions are addressed. We aim to reinforce what the clients have learned by providing mutual interaction in the group. We aim to adapt the first experiential experiments conducted in a group environment to the client while adapting them to his own life, while also allowing him to experience different difficulties experienced by other clients that he has not experienced until then. In this part of the panel, we will discuss cognitive behavioral group therapy for panic disorder.

Diagnosis-Specific and Transdiagnostic Cognitive Behavoral Group Therapies
Cognitive Behavioral Group Therapy for Tinnitus Patients

Gökçe Saygı Uysal
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Tinnitus is defined as "the conscious awareness of a tonal or complex noise without an identifiable external acoustic source" and is associated with emotional distress, cognitive impairment, and/or autonomic arousal, which can lead to behavioral changes and functional disabilities. The impact of tinnitus on daily life is also related to individuals' past psychological experiences, and stress related to tinnitus may contribute to the chronicity of the condition. Additionally, it may be associated with other functional auditory disorders (e.g., hyperacusis), anxiety and depression cycles, difficulties with sleep or concentration, cognitive challenges, or mood swings.

While patients may attribute their emotional distress to tinnitus, pre-existing psychological issues can lead to the tinnitus-related sound being perceived as more threatening. It is noted that in the presence of tinnitus, the limbic system and networks related to attention are more active, which might explain the relationship between persistent tinnitus and mental fatigue.

In etiology, cochlear dysfunction triggering abnormal central neuroplastic responses, neural 'firing' disorders leading to altered activity in limbic, autonomic, and reticular systems, damage and loss of outer and inner hair cells or stereocilia in the cochlea, synaptopathy between inner hair cells and spiral ganglion, and basilar membrane damage are highlighted. Additionally, non-auditory pathways (intracochlear glutamate metabolism, prefrontal cortex, cerebellum) have also been reported to play a role in the development of tinnitus.

Tinnitus treatment includes medications (ginkgo biloba, antidepressants, anxiolytics, and sedatives), auditory methods (tinnitus retraining therapy, sound therapy), psychological strategies (counseling and cognitive behavioral therapy), and other methods (biofeedback, breathing exercises, and electromagnetic stimulation). Short-term psychoeducational counseling is also suggested as a valid alternative to different tinnitus treatment programs.

Cognitive Behavioral Therapy (CBT) is a type of psychotherapy used for a wide range of psychiatric conditions, including anxiety, depression, and distress associated with tinnitus. CBT aims to modulate negative thoughts associated with maladaptive behavior through reframing and uses techniques like the development of positive coping skills, distraction, and relaxation.

To date, CBT is the most strongly recommended intervention for tinnitus in clinical practice guidelines, though its benefits may be limited to managing tinnitus-related distress. While CBT is effective in improving patients' negative interpretations of tinnitus, its impact on anxiety or health-related quality of life may be less pronounced than audiological care, and evidence of long-term outcomes is lacking. A 2020 Cochrane review found that compared to waiting or receiving no treatment for tinnitus, CBT significantly improved tinnitus severity (THI score) and, to a lesser extent, quality of life, anxiety, and depression measures.

In this section of panel we discuss about group therapy to tinnitus that applied 7 sessions to 5 patients.

Cognitive Behavioral Therapy for Misophonia

Ali Ercan Altinöz

Eskişehir Osmangazi University, Faculty of Medicine

Misophonia is a disorder characterized by extreme emotional reactions—typically anger, disgust, or anxiety—triggered by specific sounds, such as chewing, breathing, or tapping. Although relatively under-researched, Cognitive Behavioral Therapy (CBT) has shown promise as a treatment for misophonia by targeting the maladaptive thought patterns and behavioral responses that exacerbate the emotional distress associated with trigger sounds.

In CBT for misophonia, the goal is to help individuals identify and challenge negative automatic thoughts about the sounds, such as catastrophic thinking or perceived personal attacks. For example, patients often interpret these sounds as intentional or disrespectful, amplifying their emotional reaction. By reframing these thoughts and teaching patients more adaptive responses, CBT aims to reduce the emotional intensity of their reactions.

Exposure therapy is another critical component of CBT for misophonia. By gradually and systematically exposing patients to trigger sounds in controlled environments, they learn to tolerate the sounds without escalating their emotional responses. Relaxation techniques and mindfulness are also employed to help patients manage the physical symptoms of their emotional reactions, such as increased heart rate or muscle tension.

This presentation will explore the efficacy of CBT in treating misophonia, focusing on the reduction of distress and avoidance behaviors. Case studies and clinical trials have shown promising results, with many patients experiencing reduced symptoms and improved quality of life. Attendees will gain insight into the therapeutic techniques that can be employed to help patients manage their misophonia more effectively.

When in Doubt: A CBT Approach to Excessive Doubt

David A. Clark
University of New Brunswick, Canada

Doubt is a normal mental state known to all. Whenever we are confronted with the unknown consequences of a past action or decision, the uncertainty of decision-making, or troubling questions about long cherished beliefs and values, we doubt. Excessive doubt is an overlooked process that can be a significant contributor to anxiety, worry, and depression and, of course, obsessive-compulsive disorder (OCD). This keynote address examines the problem of excessive doubt, beginning with an analysis of the nature of doubt that highlights the distinction between healthy and unhealthy variants of the mental state. We then consider five psychological processes that undermine its adaptability and result in the excessive and distressing doubt often seen in the emotional disorders. The presentation concludes by offering several interventions for pathological forms of doubt. Although rarely targeted for treatment in standard CBT, for many individuals excessive doubt can blunt an effective response to treatment. It is recommended that CBT practitioners include individual's experience with doubt in their assessment, case formulation, and treatment plans.

Biblioterapinin Depresyon ve Anksiyete Bozukluklarında Etkisi

Alişan Burak Yaşar
İstanbul Gelişim Üniversitesi

Biblioterapi, bireylerin kendi hızlarında uygulayabileceği, minimum düzeyde profesyonel destek gerektiren bir yöntemdir. Çeşitli meta-analizler ve randomize kontrollü çalışmalar, bu yöntemin özellikle depresyon tedavisinde etkili olduğunu göstermektedir. Özellikle Feeling Good kitabı gibi eserlerin, depresif belirtileri azaltmada başarılı olduğu kanıtlanmıştır. Biblioterapi, erişim zorlukları yaşayan bireyler için etkili bir alternatif sunarken, bazı çalışmalar bu yöntemin uzun vadeli depresyon yönetiminde tek başına yeterli olmayabileceğini de ortaya koymaktadır. Buna rağmen aksi yönde görüşler de mevcuttur. Araştırmalar sür ektedir. Terapist rehberliği ile sunulduğunda daha güçlü sonuçlar elde edilebilir.

Bizim yaptığımız araştırmada, bilişsel davranışçı terapi temelli kendine yardım kitaplarının depresif belirtiler üzerindeki etkileri, plasebo kitap ve kitap önerilmeyen kontrol grubu ile karşılaştırılmıştır. Randomize kontrollü araştırmamızda, kitapların depresif semptomları azaltmada anlamlı bir etki yarattığı görülmüştür. Sonuçlar, biblioterapinin özellikle yetişkinlerde depresyon ve anksiyete bozukluklarında etkili ve uygun maliyetli bir müdahale olduğunu desteklemektedir.

Kaynak

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Cognitive Behavioural Therapy for Psychosis

Erkan Kuru
Private Physician

Schizophrenia is a mental disorder characterized by hallucinations, delusions, disorganized thinking and behavior, often as a result of cognitive impairments linked to neurobiological defects. More intensive forms of some cognitive errors that can be present in all individuals are seen. Due to the nature of the schizophrenia, individuals is often completely lacking in insight. While about half of the patients continue to use oral medication in the first year after discharge, this rate drops to 30% in the second year. This will trigger recurrent psychotic episodes. For these reasons, current schizophrenia treatment guidelines recommend psychotherapeutic approaches (psychoeducation, family interventions, cognitive-behavioural therapy and psychosocial rehabilitation) in addition to antipsychotic drug treatment.

Cognitive Behavioural Therapy (CBT) studies in pschosis started in 1952 when A. T. Beck examined the delusions of a chronic schizophrenia patient. In the normal population, a 5 per cent rate of delusion was found. Non-psychotic individuals are not disturbed because they perceive hallucinations as originating internally. However, psychotic patients perceive hallucinations as external, dangerous and uncontrollable. The CBT of schizophrenia is mainly based on the the vulnerability–stress model. The vulnerability–stress hypothesis of schizophrenia simply states that vulnerabilities and stresses combine to produce the symptoms characteristic of the disorder.

CBT, has specific treatment goals for individuals with psychosis. These goals include reducing distress, improving insight into psychotic experiences, improving coping skills, reducing the disstres associated with hallucinations and delusions, and maintaining progress. The therapy process involves various steps, beginning with assessment and setting treatment goals, followed by psychoeducation to provide information about the disorder and reduce stigma. Skill development focuses on problem solving and coping strategies for symptoms, while interventions target specific symptoms such as delusions and auditory hallucinations. Finally, relapse prevention involves creating a self-management plan. It's important to note that the aim of CBT is not to cure psychosis, but to alleviate distress and improve coping mechanisms. Therefore, CBT can also be used in delusions resistant to antipsychotic treatment. Individuals with psychotic disorders, even if they believe that they do not have any disorder, will generally have improved treatment compliance and medication adherence when the clinician provides a motivation that is important to their lives.

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Psikotik Bozukluklarda Kabul ve Kararlılık Terapisi

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Psikoz; emosyon, algı, düşünce ve davranış bozukluklarını içeren birtakım semptomları tanımlayan geniş bir terimdir. Psikotik semptomlar başta şizofreni olmak üzere birçok psikiyatrik bozuklukta görülebilir. Psikotik bozukluklara sahip bireylerde düzenli ilaç kullanımına rağmen semptomlarda sınırlı bir iyileşme olması ve işlevsellikte belirgin bir düzelme olmaması ve ilaçların faydalarının yanı sıra önemli yan etkilerinin bulunması psikotik bozukluklarda etkili psikoterapötik müdahalelere ihtiyacı belirginleştirmiştir. Son yıllarda psikoz tedavisinde psikoterapinin etkililiğine ilişkin çalışmalar artmakta, güncel kılavuzlar psikoz tedavisinde farmakolojik tedavilerle birlikte psikososyal müdahaleleri de önermekte psikoza yönelik psikolojik müdahaleler arasında bilişsel davranışçı terapiler (BDT) altın standart olarak kabul edilmektedir.

Kabul ve Kararlılık Terapisi (ACT), davranış değişim stratejileri ile psikolojik esneklik sağlamak için çeşitli şekillerde harmanlanmış kabul ve farkındalık stratejilerini kullanan kanıta dayalı psikolojik müdahale yöntemleri bütünüdür. Üçüncü dalga bilişsel davranışçı terapiler arasında değerlendirilen bu terapi seksenlerin sonunda Hayes ve Strosahl tarafından geliştirilmiş, psikotik bozukluklar dahil birçok psikiyatrik bozuklukta etkili olduğu klinik çalışmalarla gösterilmiştir. Psikolojik esnekliği merkeze alan bu yaklaşım, psikotik semptomları azaltmak ya da kontrol etmek yerine kişinin bu semptomlarla ilişkisini değiştirmeyi amaçlar. Psikoz psikopatolojisinde etkili olduğu bilinen yaşantısal kaçınma, bilişsel birleşme ve perspektif alma süreçlerini hedefleyerek kişinin daha esnek bir kendilik algısı oluşturmasına ve istenmeyen içsel yaşantıların varlığında anlamlı, dolu dolu bir hayat sürdürmesine yardımcı olur. Psikotik bozukluklarda Kabul ve Kararlılık Terapisi (ACTp)'ne ilişkin yapılan çalışmalar ACTp'in psikotik belirtilerde ve hastane yatışlarında azalma ve duygudurum belirtilerinde iyileşme ile ilişkili olduğunu ortaya koymuş olup, halihazırda ACTp orta düzeyde kanıt düzeyine sahiptir. Bu oturumda katılımcıların Kabul ve Kararlılık Terapisi (ACT) 'nin temel ilkeleri ve psikoza yaklaşımı hakkında genel bir bilgi sahibi olması, ACTp'un hangi açılardan farklılaştığını öğrenmesi hedeflenmektedir.

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CBT Interventions in the Treatment of ADHD in Adolescence

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Neurodevelopmental disorders typically manifest in early childhood, often due to unidentified etiologies. These disorders are characterized by impairments in personal, academic, social, and occupational functioning. The co-occurrence of multiple neurodevelopmental disorders is common, and the severity and distribution of symptoms can vary significantly. Intervention programs should be planned to the psychopathological profile and current needs of the individual.

Attention-deficit/hyperactivity disorder (ADHD) is a neurodevelopmental disorder characterized by symptoms of inattention, hyperactivity, and impulsivity. The prevalence of ADHD in adolescents is reported to be 5-10%. According to research, 50-80% of individuals diagnosed with ADHD in childhood continue to exhibit symptoms during adolescence and adulthood. Psychosocial interventions are increasingly being used in addition to pharmacological treatments for managing ADHD.

Research has shown that cognitive behavioral therapy is an effective psychosocial intervention for adolescents with ADHD. Symptoms such as distractibility, disorganization, difficulty completing tasks, and impulsivity can prevent individuals with ADHD from learning and using effective coping skills. The lack of these skills can lead to underachievement and failures. Underachievement and failures can result in negative thoughts and beliefs. These negative thoughts and beliefs can contribute to mood problems and increase avoidance and distractibility. Cognitive behavioral therapy practices for adolescents with ADHD include psychoeducation about ADHD, development organizational and planning skills, management of distraction, cognitive restructuring related to negative thoughts and beliefs, and strategies for managing procrastination. Parent sessions, whether involving adolescents or not, facilitate the review of parental behaviors, reinforcement of the adolescent's skills, and the inclusion of parents in the therapy process. It is important that the strategies and skills learned during therapy continue to be practiced regularly in order to maintain gains.

Case Formulation in Panic Disorder

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Cognitive behavioral therapy is implemented based on case formulations that aim to represent the predisposing, triggering, and maintenance factors involved in individual disorders. Case formulation provides the therapist with a guide to what to modify in therapy, and consequently, the most useful approaches will be those that reveal the factors involved in the etiology and maintenance of anxiety disorders. Panic attack is a distinct period or episode of intense fear or discomfort that builds suddenly, peaks briefly, and is characterized by unwanted and inexplicable physical sensations and frightening cognitions. After repeated panic attacks the core fear may crystallize as a fear of having another panic attack. The fear or worry of having a panic attack persists over weeks or months and often leads to behavioral changes involving avoidance of places or activities thought to increase the risk of panic attacks. The catastrophic thinking most common in panic is fear of dying, losing control, and fear of having more frequent, intense, and uncontrolled panic attacks. At the very heart of the cognitive behavior treatment of panic is the assertion that it's the catastrophic misinterpretation of bodily sensations that is the core problem in repeated panic attacks. Daily self-monitoring and direct behavioral observation are important assessment strategies that should be a regular feature of any assessment and case formulation of panic disorder. Both strategies are critical for determining the nature of immediate fear activation. A cognitive case conceptualization of a panic attack must begin with a thorough assessment of the situations, experiences, and cues that trigger anxiety. It is important to know the intensity of anxiety felt in each situation since the therapist should have a range of situations or triggers that elicit mild to severe anxiety states. The therapist must determine how often the person experiences an anxiety-provoking situation and the duration of his or her exposure to the situation. The cognitive therapist should also obtain information on the extent to each situation is associated with escape or avoidance. The therapist obtains an accurate assessment of the client's first apprehensive thoughts in a variety of anxiety-provoking situations to determine the underlying threat schema responsible for the anxious state. The nature, function, and interpretation of physiological hyperarousal and other bodily sensations must be defined as part of any case formulation for anxiety. An important part of any cognitive assessment of anxiety is to identify these fear-inhibiting responses. Yet, their detection can be difficult because they are so automatic, with the individual having little conscious awareness of their presence. It is important to identify the primary intentional safety-seeking behaviors. Assessing the nature, frequency, and function of worry and other cognitive control responses is another aspect of the case formulation of the persistence of panic attacks. The primary focus of case conceptualization and change is the content of catastrophic misinterpretation and the factors that contribute to the maintenance of belief in the validity of such appraisals. The cognitive approach has proven to be highly effective in panic disorder.

Cognitive Behavioral Therapy for a Case of Generalized Anxiety Disorder

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The case is 21 years old, female patient. She is a 3rd year of university student. Current problems are worried about exams and the future, difficulty of relaxing herself, feeling constant pain, muscle tension, teeth clenching and jaw pain, difficulty falling asleep, difficulty concentrating, heart palpitations, nausea, trembling hands during times of increased stress (pre-exams). Also avoidance of social activities, avoidance of studying, decline in academic performance. First, she started to worry about her exams and over time, physical symptoms were added to her anxiety. She had difficulty concentrating while studying and during the exam and she would think "it is impossible to study, I will not be able to complete my subjects, I will fail" and she would stop studying. She felt inadequate to find a job and build a career, and thought things would get worse. She states that when she goes to bed, her negative thoughts do not stop. In time, she also started to avoid social situations. "Even when I go out with my friends, I always feel restless and I don't want them to notice my restless state," she says. Now she has difficulty in doing even simple daily tasks and feels tired and exhausted at once. The point of beck anxiety scale is 30, hamilton anxiety scale is 25, beck depression scale is 11. As a result of psychiatric examination and tests, the patient was diagnosed with DSM-5 Generalized Anxiety Disorder. We can determine treatment goals as reducing physical symptoms of anxiety and worries, reducing the negative automatic thoughts, eliminating the avoidance of social situations, increasing the academic performance, becoming interested in hobbies again. Automatic thoughts are "I will fail", "Bad things will happen to me", "I won't be able to cope with them." Maladaptive assumptions are "I have to control my anxiety in any time.", "I should not be anxious". Core beliefs are " I am weak, I am a helpless person." Cognitive behavioral therapy steps are psychoeducation (GAD, CBT and physiology of anxiety), examination of cognitive distortions (catastrophizing), working with the core belief of 'I am inadequate', overcoming avoidance (avoiding studying; avoiding friendships), practicing problem solving skills and alternative strategies and relaxation training. After psychoeducation and teaching ABC formulation we apply worry time in the 3rd-5th sessions. We limit worry with a specific time and place. It should be applied for 30 minutes at home after work. The goal is to make the worry times more controlled and solution-focused. While working with the cognitive distortion of catastrophizing (I will get bad grades on exams, I will have difficulty to finish school) we can use cost- benefit analysis, weighing the evidence for and against a thought, vertical descent, pie technique and double standards tecniques. Relaxation is a skill through which the patient can learn to gain more control over their bodily responses. It can be applied through relaxation techniques involving 12 muscle groups, 8 muscle groups, or breathing exercises. We can work with core beliefs and maladaptive assumptions in the further sessions.

SPEECH SUMMARIES

Bir Mobil Telefon Uygulaması Kültürel Uyarlama Süreci

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Koronavirüs salgını (COVID-19) hâlihazırda psikolojik zorluk deneyimleyen kişilerin mevcut belirtilerini şiddetlendiren ya da pandemi öncesi belirti göstermeyen kişilerin bir takım psikolojik sıkıntılar yaşamasını tetikleyen bir yaşam olayı olarak kişilerin psikolojik desteğe olan ihtiyacını arttırmıştır. Bu ihtiyacın karşısında ise gerek bireysel gerekse toplumsal düzeyde uygulanan önlemler kapsamında klinik ortamda gerçekleştirilen, geleneksel yüz yüze destek imkânını ise neredeyse tümüyle ortadan kaldırmıştır. Geleneksel psikolojik destek yöntemlerine alternatif arayışı sonucunda mobil telefon teknolojilerinin günlük hayatın her alanına girmesi bu teknolojilerin psikolojik sağaltıma yardımcı kullanımını da mümkün kılmıştır. Mevcut panelde yer alan bu sunumda Bilişsel Davranışçı Terapi ilkelerine göre oluşturulmuş obsesif-kompulsif belirtileri ve COVID-19 ile ilişkili psikolojik zorlukları hedef alan mobil uygulamaların Türkiye örneklemine uyarlama süreci ele alınacaktır.

Internet-Based Interventions for University Students and a Transdiagnostic Example

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Psychological problems are quite common among university students, but help-seeking behavior is limited and access to qualified sources of help is often inadequate. This makes it difficult for students to cope with their psychological problems. At this point, tarnsdiagnostic CBT and internet-based interventions offer effective solutions.

Transdiagnostic CBT interventions aim to provide more inclusive, flexible and adaptive support by targeting common mechanisms across different psychological disorders. These approaches enable more efficient use of resources and reach a wider audience. Internet-based interventions, which are a widely used tool in the field of mental health with the development of technology, can be defined as the delivery of psychotherapeutic interventions with scientifically validated efficacy in order to prevent and treat psychological problems/disorders or to increase the well-being and coping skills of users, through online web pages, mobile applications or computer software in a way that the user can use with a guide, usually a mental health professional, or completely on their own. Internet-based interventions stand out with the advantages of accessibility, low cost and anonymity. The ability of users to progress at their own pace and access psychotherapeutic interventions online contributes to the effectiveness and sustainability of such approaches.

The aim of this study is to introduce UNIPDES, an internet-based transdiagnostic intervention program to help university students cope with their psychological symptoms. UNIPDES aims to increase university students' well-being and reduce the prevalence of psychological problems. The method of the study was designed with a study group consisting of students selected from five different universities. The study is a randomized controlled experimental research. Participants are selected according to set criteria and evaluated at three different times: pre-test, post-test and follow-up after the program is completed. The effectiveness of the program is measured through forms and questionnaires filled in by the users themselves.

The UNIPDES program consists of six modules: goal setting, psychoeducation, recognizing emotions, changing behaviors, recognizing thoughts and planning for the future. Each module is supported by interactive forms and animations, aiming to provide an experience tailored to the personal needs of the users.

This project is being carried out with the support of TUBITAK within the scope of 3501 Career Development Program, 123K895 numbered named Unipdes - Internet-Based Euthetical Intervention Program for Psychological Symptoms of University Students: Development, Usability and Effectiveness Evaluation.

Cognitive Behavioral Therapy-Based Weight Control Mobile Application: Bi'Kilo

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In recent years, mHealth applications have emerged as an innovative approach to overcoming barriers to treatment accessibility, especially in the realm of weight management. These applications offer cost-effective and scalable solutions, providing users with tools to manage their health and psychological well-being. One such application, Bi'Kilo, is a Cognitive Behavioral Therapy (CBT)-based mobile platform aimed at supporting weight control in individuals struggling with overweight and obesity. This presentation will introduce the Bi'Kilo application and discuss the results of a pilot study that tested its effectiveness across several key areas related to obesity.

The project, supported by TUBITAK 1001 - The Scientific and Technological Research Projects Funding Program (project number 122S049), aimed to explore the psychological and behavioral facets of overweight and obesity by offering an innovative tool grounded in CBT principles. Bi'Kilo combines psychoeducation, self-monitoring, and interactive features to promote healthier eating habits, mindful eating, and sustainable lifestyle changes.

Bi'Kilo's Features and Structure

The Bi'Kilo application includes various CBT-based components, such as animated video content for psychoeducation, self-monitoring tools, and exercises designed to reinforce learned behaviors. Key features include the "Eating Records" to track food intake, "Mindful Eating" exercises, and "Thought Cards," which guide users in challenging maladaptive thought patterns related to eating. Psychoeducation focuses on healthy eating, portion control, and lifestyle modifications, while the interactive features encourage users to apply these skills in real-life contexts.

Participants in the study were randomized into two groups: the study group had access to all components of Bi'Kilo, while the control group could only access the psychoeducation content. Anthropometric (weight, BMI, waist-to-hip ratio, body fat percentage, visceral adiposity index) and biochemical measurements (glucose, insulin, HOMA-IR, leptin, ghrelin) were collected. In addition, psychometric assessments related to eating behaviors and attitudes (EEQ, mYFAS 2.0, MEQ) and cognitive tests (CANTAB-CGT, RVP, SWM, SST, MOT) were conducted at baseline, 6 weeks, and 10 weeks.

Findings of the Pilot Study

The study began with 77 participants, of whom 38 completed at least two rounds of measurements. The average participant age was 40.3, with 57.9% of the study group identifying as female. There were no significant demographic differences between the study and control groups in terms of age, gender, BMI, or relationship status.

During the follow-up period, the study group demonstrated significant improvements in BMI, weight, and specific aspects of mindful eating, including the **MEQ-Awareness** and **MEQ-Mindfulness** subscales. These changes were observed when comparing the study group to the control group. However, no significant differences emerged between the groups concerning biochemical parameters or cognitive tests.

One of the most notable findings was a significant reduction in emotional eating among participants in the study group compared to the control group. This finding is significant as emotional eating is a common challenge for individuals with obesity, and its reduction can contribute to long-term success in weight management.

Conclusion and Future Directions

Bi'Kilo represents the first CBT-based weight control mobile application developed in Turkey, and its effectiveness was evaluated through a randomized controlled pilot study. The findings suggest that Bi'Kilo is effective in promoting weight loss, reducing emotional eating, and increasing mindfulness around eating behaviors. While no significant changes were observed in biochemical measurements or cognitive functions, the study provides a promising foundation for further research.

Given the increasing prevalence of obesity and the need for accessible, scalable interventions, Bi'Kilo's development marks an essential step in leveraging digital tools for health behavior change. Future studies with larger sample sizes will be crucial to validate its effectiveness further and explore additional outcomes related to cognitive and metabolic health. The authors thank TUBITAK for their support.

Metacognitive (Metacognitive) Training, a New Cognitive Behavioural Method Developed

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Psychotic disorders are psychiatric disorders whose main symptoms are delusions and hallucinations, which seriously affect the life and functionality of the individual. Until recently, it was thought that medication could be the only method in terms of treatment, but in recent years, the idea that psychosocial treatments can make important contributions in addition to medication has come to the fore. In this direction, in addition to the known and used CBT approaches, Metacognitive (Metacognitive) Training, a new cognitive behavioural method developed in recent years, effectively complements the treatment of psychotic disorders. The Metacognitive (Metacognitive) Training programme (MBT) is based on the psychosis model of cognitive behavioural theory and its unique feature is that it focuses on the metacognitive domain in practice. Cognitive behavioural therapy methods used in the psychosocial treatment of schizophrenia base their applications on explanations at the level of perception, cognition and schema regarding the formation of psychosis. Developed in 2005 by Steffen Moritz and Todd S. Woodward, Metacognitive (Metacognitive) Training is a new method developed for the treatment of positive symptoms in psychosis, especially delusions. This training has been supported by research that psychotic individuals can contribute to gain insight. Metacognitive training is suitable for inpatient groups and outpatients. It can be applied in both individual and group format. Since the aim of the training is to enable the patient to see the negative consequences of cognitive biases, a large number of examples are used with the prepared materials.

In conclusion, it is expected that the role of metacognitive training in the treatment of psychotic disorders will increase in the future. Especially its integration into the treatment approaches provides a great advantage. The benefits and limitations of using metacognitive training together with cognitive-behavioural therapies and pharmacotherapy should be reviewed.

Intolerance of Uncertainty

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The concept of intolerance of uncertainty (IU) was initially developed on the basis of anxiety-related psychopathologies. It was later shown to be effective in many other mental disorders and was proposed as a transdiagnostic factor.

IU emerges as negative beliefs and reactions to unpredictable situations (1). IU is conceptualized under four subheadings; desire for predictability, paralysis of uncertainty, distress in the face of uncertainty and rigid uncertainty beliefs. Emotional distress in response to uncertainty represents the affective aspect. Dysfunctional beliefs about uncertainty are linked to both cognitive and metacognitive thought processes. From this perspective, IU emerges as a concept that evaluates metacognitive beliefs, cognitions, emotions and behaviors (2).

Research on IU has approached the subject from two main perspectives. The first one is prospective IU and inhibitory IU. Prospective IU refers to cognitive appraisals and is related to future uncertainties. In this sense, it can be said that the concept has a cognitive component. On the other hand, inhibitory IU is the behavioral part of the construct and defines attitudes such as avoidance behavior related to uncertainty (3).

The other stage of research can be defined as trait IU, which is related to personal characteristics, and situation-specific IU, which is more specific to the condition. The concept of trait IU is at the forefront in conditions such as obsessive-compulsive disorder and generalized anxiety disorder. Mental disorders such as social anxiety disorder and panic disorder are more closely associated with situation-specific IU.

From a cognitive behavioral perspective, negative beliefs about uncertainty initiate biased information processing after triggering events. They also causes attention to be more focused on issues related to uncertainty. Emotionally, anxiety and distress arise. On the behavioral side, people tend to engage in safety-providing behaviors and avoidance behaviors. While these behavioral strategies provide short-term relief, in the long term they work as negative reinforcers on uncertainty beliefs.

Initially developed through research on generalized anxiety disorder, IU was later found to be associated with many mental disorders such as social anxiety disorder, obsessive-compulsive disorder, post-traumatic stress symptoms and disorder, depression, agoraphobia and panic disorder, and eating disorders.

In conclusion, IU has an important place as a transdiagnostic factor in the evaluation and treatment of mental disorders. It can be said that treatment protocols that target IU cognitively and include behavioral practices will have an important place in psychotherapy processes.

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Anxiety Sensitivity

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Anxiety sensitivity has been defined as a trait that reflects the tendency to fear the consequences of anxiety. Anxiety sensitivity has been classified into three sub-dimensions: physical, social and cognitive (1). The concept of anxiety sensitivity was initially considered to be one-dimensional, but as a result of factor analyzes, it was considered as a concept with three sub-dimensions (2). Physical sub-type of anxiety sensitivity, which is one of these three sub-factors, has been described as being concerned about the consequences of the physical symptoms of anxiety (2). While cognitive anxiety sensitivity, which is another sub-factor, has been described as the state of being worried about the loss of cognitive control due to anxiety, the last sub-factor, social anxiety sensitivity, has been conceptualized as worrying about the unfavorable social consequences of observing anxiety symptoms by others (8). Previous studies have revealed that anxiety sensitivity is a transdiagnostic factor by associating it with numerous mental illnesses (3, 4).

This is thought that individuals with high anxiety sensitivity may be more likely to interpret events as catastrophic and increase their anxiety and depression scores, since anxiety sensitivity is related to the anxiety caused by experiencing their symptoms. Considering all these findings, specific interventions for anxiety sensitivity would help treat symptoms regardless of the diagnosis. Previous studies show that mindfulness-based exercises, meditation and physical activity can improve symptoms of anxiety and sensitization (5). Cognitive behavioral therapy interventions to reduce increased anxiety sensitivity (e.g., interoceptive exposure interventions) are thought to be effective in reducing anxiety scores (6).

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SPEECH SUMMARIES

Repetitive Negative Thinking

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Repetitive negative thinking (RNT) is a transdiagnostic process that involves the person dwelling on feelings of sadness (rumination), worrying about the future, and post-event evaluations following stressful events. RNT is repetitive negative thought that is passive, self-focused, and difficult to control. The main features of RNT are repetitive, negative, intrusive, unshakable, uncontrollable, abstract and passive. RNT can be associated with emotions such as depression, anxiety, guilt, resentment, and shame. It particularly highlights thinking about unmet goals and the difficulties in coping with the emotional burden caused by this. Each of the underlying theories (metacognitive model, self-regulation model, integrative theoretical model) has different focal points. The metacognitive model focuses on positive and negative metacognitions as the main triggers and maintainers of rumination or worry, while the self-regulation model emphasizes goal salience and cognitive control. Based on self-regulatory and metacognitive models of rumination, Tamm, Koster, and Hoorelbeke (2024) modeled the interrelationships between rumination, depression, effortful control, promotion focus, promotion goal failure, perfectionism, (lack of) cognitive confidence, cognitive self-consciousness, need for control of thoughts, and positive and negative beliefs about rumination. Rumination was directly related to positive beliefs about rumination, cognitive self-consciousness, effort control, negative beliefs about uncontrollability, perfectionism, lack of cognitive confidence and depression. Positive beliefs about worry are directly linked to worry, and negative beliefs about worry also influence anxiety, the need for control, and cognitive self-consciousness.

Perfectionism

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Perfectionism is a transdiagnostic factor for psychological disorders. Clinical perfectionism is self-esteem underpinned by striving to achieve standards despite negative consequences (Shafran, Cooper, & Fairburn, 2002). Perfectionistic concerns have a positive relationship with psychopathology, such as depression, anxiety, and obsessive-compulsive disorder (OCD) (Limburg, Watson, Hagger, & Egan, 2017). Perfectionism can be measured with the Multidimensional Perfectionism Scales. Factor analyses have shown a consistent two-factor model of perfectionistic strivings, striving towards standards and perfectionistic concerns, worrying over mistakes, and believing others expect perfection (Smith & Saklofske, 2017). The definition of clinical perfectionism has a significant role in treatment with cognitive behavioral therapy (CBT) for perfectionism, which has been found to be efficient psychotherapy in diminishing symptoms of depression, anxiety, and eating disorders (Galloway, Watson, Greene, Shafran, & Egan, 2022). Understanding perfectionism could be helpful to intervene with perfectionistic concerns in psychopathology, without necessarily reducing striving to meet standards as a transdiagnostic process.

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Culturally Sensitive Cognitive Behavioural Therapy: Applications in the Migration Context

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Culturally sensitive psychotherapy is an approach that takes into account an individual's cultural background, values, and experiences during the therapeutic process. Integrating different cultural perspectives with Cognitive-Behavioural Therapy requires therapists to learn about the common experiences of individuals with various cultural backgrounds because common experiences do not encompass the full spectrum of experiences within any group. Therapists should also be open to each patient's individual experiences and life contexts.

A culturally sensitive approach to Cognitive Behavioural Therapy begins before therapists establish a therapeutic relationship with their patients. The first step at this stage is recognizing areas where therapists may have biases due to inexperience or a lack of knowledge. In situations where there is a lack of knowledge or experience about a specific group, we often unconsciously use dominant cultural messages to generalize and draw conclusions about specific group members. However, once we become aware of these biases, we can actively work to replace our false beliefs and assumptions with reality-based information. This work is personal and cannot be accomplished with just a few cross-cultural encounters. It is a lifelong process that can be developed through various activities that explore the cultural influences on a person's beliefs, behaviours, and identity. For example, acquiring cultural knowledge from culture-specific sources (e.g., news published by ethnic and other minority communities), participating in cultural celebrations and other public events, seeking guidance from someone knowledgeable about and belonging to a minority culture, reading multicultural counselling research in the literature, communicating with different professional groups from diverse cultures, and developing relationships with people from various cultures. Learning through these channels facilitates the development of cognitive schemas or templates that help acquire and internalize culture-specific information. It is the responsibility of the therapist to develop this cultural schema. Therefore, it is not expected that clients should teach the therapist about the broader social and cultural meanings of their identities. However, the therapist should obtain knowledge from patients that includes the unique personal experiences of their culture.

Migration is one of the fundamental determinants of a multicultural life. Communication difficulties stemming from language and cultural differences, negative experiences before, during, and after migration, traditional beliefs, culturally distinctive coping models, family socioeconomic status, and negative family dynamics are the main reasons for the difficulties experienced by patients during the migration process. Therapists should systematically examine the entire process of migration, including social, professional, and family functionality, cultural background, socioeconomic status, and the comparison of pre-migration and post-migration situations. This will help in understanding and identifying the challenges of adapting to a new society.

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Treatment of Depression with Metacognitive Therapy

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Metacognitive Therapy (MCT) has emerged as a powerful approach to treating depression by targeting maladaptive thought processes rather than the content of thoughts. Unlike traditional Cognitive Behavioral Therapy (CBT), which focuses on altering negative beliefs and cognitive distortions, MCT primarily works by addressing metacognitive beliefs—the thoughts about one's thinking processes that sustain emotional distress.

Depression is often maintained by cycles of rumination, where patients repeatedly dwell on their problems, negative emotions, and self-critical thoughts. This repetitive negative thinking traps individuals in a cycle of mood deterioration. MCT intervenes by helping patients recognize that rumination is not an effective problem-solving strategy and teaching them to detach from these patterns.

The key components of MCT for depression include modifying beliefs about the uncontrollability and danger of thoughts, reducing extended worry or rumination, and promoting flexible attention. MCT helps patients break free from habitual thinking patterns by teaching them how to direct their attention away from distressing thoughts and toward more neutral or positive aspects of their experiences.

Studies have shown that MCT is highly effective in reducing symptoms of depression, with sustained long-term effects. The treatment typically requires fewer sessions compared to CBT and has been demonstrated to prevent relapse by encouraging patients to develop a healthier relationship with their thoughts. This presentation will highlight the mechanisms behind MCT's success, practical techniques employed in sessions, and case studies showcasing patient outcomes.

SPEECH SUMMARIES

Cognitive Behavioral Therapies in Autism Spectrum Disorder

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Autism Spectrum Disorder (ASD) is a neurodevelopmental condition that affects social communication, behavior, and flexibility in thinking. Cognitive Behavioral Therapy (CBT) has been adapted to meet the unique needs of individuals with ASD, particularly in treating comorbid conditions such as anxiety, depression, and obsessive-compulsive tendencies.

Children and adults with ASD often experience heightened anxiety due to difficulties in interpreting social cues, sensory sensitivities, and rigid thinking patterns. CBT, as modified for ASD, emphasizes the development of coping skills, emotional regulation, and flexibility in thinking. It uses structured, visual-based approaches to accommodate the processing style typical of many individuals on the spectrum.

This presentation will explore the core adaptations made to CBT for treating anxiety in individuals with ASD. For example, therapists use concrete, visual aids and highly structured sessions to improve communication. Social stories, role-playing, and gradual exposure to anxiety-provoking situations are also integral components of this tailored CBT approach. Parental involvement is often crucial, especially for younger individuals, to reinforce strategies in daily life.

Research has demonstrated that CBT can significantly reduce anxiety and improve social functioning in individuals with ASD. The focus on teaching practical coping mechanisms and challenging rigid thought patterns aligns with the cognitive-behavioral framework, making it an effective intervention. We will review clinical outcomes, key strategies, and discuss future directions for enhancing CBT's efficacy for individuals with ASD.

Cognitive Behavioral Therapy in Functional Dysphonia: A Case Report

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Functional dysphonia (FD) is a vocal disorder characterized by variable vocal sound, pitch, and intensity that cannot be explained by defined organic or neurological causes and in which vocal effort increases (1, 2). Psychiatric and psychological features may include anxiety in the foreground, increased attention to physical symptoms, difficulty in coping skills, inadequacies in self-definition, and difficulty in defining, expressing, and regulating emotions. At this point, cognitive behavioral therapy (CBT) stands out as a practical approach to treating FD. It successfully improves voice quality and addresses underlying psychological factors when integrated with traditional voice therapy. Studies show the positive effects of CBT in the short and long term (2–4).

The cognitive behavioral therapy process for FD starts with assessment. Physiological, psychological, and behavioral factors, life history, interpersonal relationships, and coping skills are addressed in the assessment process. The therapy process proceeds in an individualized manner. Psychoeducation for the application of CBT and the physiology of anxiety are studied in the initial sessions. Motivational interviewing, disease-oriented psychoeducation, and a strong psychotherapeutic relationship are essential for FD patients. In particular, the fact that FD is a "disease" and that psychotherapy is involved in its treatment due to its psychological causes is one of the points to be addressed in psychoeducation about the disease. In the following sessions, negative thoughts identification, cognitive restructuring, reshaping beliefs about voice use, and progressive muscle relaxation exercises are given. It aims to recognize automatic thoughts, recognize the characteristics of thoughts, and change the ones that are not in accordance with reality. Skills in recognizing and expressing their emotions are worked on with both cross-sectional formulations and behavioral experiments. In this process, a multidisciplinary approach, including psychotherapists and voice therapists, should be adopted to combine vocal hygiene training with cognitive techniques. In the following sessions, coping skills, behavioral patterns, communication skills, and social skills should be worked on, longitudinal formulation and schemas should be worked on, and self-definition should be redefined. For patients who are worried that they will experience hoarseness again, it is crucial to work on coping skills and tolerance of uncertainty. The new skills are reviewed in the finalization sessions, and how to use these skills in new situations is worked on.

Case Report

A 25-year-old female patient who was admitted to our outpatient clinic with hoarseness of voice for about one year was taking escitalopram 10 mg/day and pyridostigmine 60 mg/day. After a psychiatric examination and review of old medical records, the patient was diagnosed with FD. After the assessment interviews, 22 CBT sessions were administered over six months. During the CBT process, psychoeducation, cognitive restructuring, recognizing emotions, using them in communication, coping skills, and self-compassion were practiced. After the fourth session, her voice started to improve. The patient's medication was gradually discontinued. The patient kept both thought and hoarseness records. Voice changes were recorded during the session and evaluated together with the patient. As of the 14th session, schemas were started to be studied. Self-definition was made. The therapy process was finalized with the patient, who no longer experienced hoarseness and was able to use CBT techniques outside the session.

The use of CBT in the treatment of functional dysphonia will continue to play an essential role in improving patients' psychological resilience and quality of life while providing a holistic approach to voice disorders. In the future, studies on standardizing treatment protocols and developing customized approaches for different patient subgroups are thought to provide more effective treatment algorithms for this disease.

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"Çünkü Ben Bipolarım..." Bipolar Bozuklukta Benlik Algısı ve Etiketlere ACT Perspektifinden Yaklaşım
Etiketler Bize Ne Söyler? Davranışları Etkilemedeki Rolü

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Kabul ve Kararlılık Terapisi'nde (ACT) tanımlanan 3 benlik algısı vardır. Bunlar kavramsal benlik, fark eden benlik ve bağlamsal benliktir. Kavramsal benlik "Siz kimsiniz?" sorusuna verdiğimiz cevaplar olarak tanımlanabilir. Bu cevaplarda kişinin hayatındaki davranışlarını, tutumlarını etkileyen birtakım etiketler görürüz. Bu benlik kavramlarına/etiketlere katı bir şekilde bağlanmak ve sadece belirli bir kısmıyla hareket etmek kişilerin hayatını ve davranış repertuarını kısıtlamaktadır. Bu benlik kavramlarını fark etme süreci fark eden benlik; kavramları ve fark etme eyleminin de farkında olunduğu, sürekli, sabit ve değişmeyen, hepsinin hiyerarşik olarak üstünde, hepsini gözlemleyen noktaya ise bağlamsal benlik denmektedir.

Bipolar bozuklukta benlik kavramının nasıl etkilendiğine dair farklı görüşler bulunmaktadır. En sık karşılaşılan durumlardan birisi kişinin kendisi ile patolojiyi ayırt etmede yaşadığı zorluktur. Benlik algısı ile hastalık arasındaki sınırlar bulanıklaşabilir ve kişi kendisini tanısal bir etiketten ibaret görebilir. "Ben bipolarım" etiketi ile birleşme; kişinin sorunlarını, kişilik özelliklerini, düşünce süreçlerini, davranışlarını aşırı ve uygunsuz bir şekilde bipolar bozukluğa atfetmesine neden olabilir. "Ben bipolarım" gibi etiketlerin dışında görebildiğimiz "ben hastayım", "dengesizim", "yetersizim" gibi etiketler ile katı bir şekilde bağlanma kişinin tutumlarının nedeniymiş gibi görünebildiği gibi, kişilerin hayatlarında arzu ettikleri doğrultuda hareket almalarını kısıtlamaktadır. Bu etiketlere katı bir şekilde bağlandıkça kişilerin mesleki, kişiler arası ve gündelik hayatta işlevsellikleri bozulmaktadır.

Bir diğer görüş ise bipolar bozuklukta benlik algısının bipolar bozukluk dönemlerinden etkilenebilmesi ve değişkenlik göstermesidir. "Ben kimim?" veya "Nasıl biriyim?" sorularına verilen yanıtlar, duygudurum dönemine bağlı olarak büyük ölçüde değişebilir. Bir kişi manik dönemdeyken «Güçlüyüm», «Yaratıcıyım» gibi etiketlere sahipken aynı kişi depresif dönemde "acizim", "beceriksizim", "yetersizim" gibi etiketlere sahip olabilir. Bu da benlik kavramında sürekliliğin ve tutarlılığın olmaması ile sonuçlanır. Tutarlılık gelecekle ilgili tahminlerde bulunma, hedef belirleme, uzun vadeli davranış planlama ve bu davranışları sürdürme ile ilişkili bir kavramdır. Bipolar bozuklukta benlik algısında ortaya çıkabilen bu tutarsızlık kişiler arası ilişkiler, kariyer ve eğitim gibi uzun vadeli planlama gerektiren görevler gibi alanlarda zorluklar yaratabilir.

Bu oturumda;

1. Bipolar bozuklukla ve benlik algısı ile ilgili literatür bilgisinin paylaşımı,
2. Bu alandaki tecrübelerin aktarımı,
3. Terapi sürecinde yaşanan zorlukları ve bu zorlukları aşmanın yollarını çalışmak hedeflenmiştir.

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The Importance of Case Formulation in Cognitive Behavioral Therapies

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Case formulation is a critical component of Cognitive Behavioral Therapy (CBT), serving as a roadmap that guides the therapeutic process. It provides a comprehensive framework for understanding the patient's unique problems, the underlying cognitive and behavioral patterns contributing to their distress, and the most effective strategies for intervention. In essence, case formulation individualizes the therapeutic approach, ensuring that interventions are tailored to each patient's specific needs.

At its core, case formulation in CBT involves identifying and integrating information from several sources, including the patient's history, presenting symptoms, and the cognitive-behavioral patterns that maintain these symptoms. The therapist works collaboratively with the patient to explore how their thoughts, behaviors, and emotions are interconnected and how these elements contribute to their psychological difficulties.

A well-constructed case formulation typically includes a detailed understanding of the patient's core beliefs, automatic thoughts, and behavior patterns. It examines how these factors interact in a way that sustains their emotional distress, whether it be anxiety, depression, or other psychological issues. For example, in a patient with social anxiety, the case formulation might reveal how automatic negative thoughts about social rejection lead to avoidance behaviors, which in turn reinforce the belief that social situations are dangerous.

The case formulation process also enables therapists to select the most appropriate interventions. It informs the decision-making process, allowing therapists to prioritize specific techniques, such as cognitive restructuring, exposure, or behavioral activation, based on the patient's individual needs. Moreover, the dynamic nature of case formulation allows it to be revised as therapy progresses, ensuring that the approach remains flexible and responsive to the patient's evolving experiences.

In this presentation, we will delve into the significance of case formulation in CBT and how it enhances the effectiveness of therapy. We will explore its role in creating a shared understanding between the therapist and the patient, essential for building a solid therapeutic alliance. Case formulation not only helps in identifying key treatment targets but also fosters collaboration, as patients feel more engaged in the process when they understand how their thoughts and behaviors are being addressed.

A key aspect of case formulation is its ability to explain setbacks and relapses, providing a framework for patients to understand why certain behaviors persist despite their best efforts. By revisiting and refining the formulation throughout therapy, both therapist and patient can adapt their strategies to overcome new challenges, ultimately improving the long-term efficacy of treatment.

We will also examine real-life case studies to demonstrate how case formulation has been successfully applied across a variety of psychological disorders, including anxiety, depression, and obsessive-compulsive disorder. These examples will highlight how a well-crafted case formulation can serve as a powerful tool not only for guiding the therapeutic process but also for empowering patients to understand their patterns of thinking and behavior.

In conclusion, case formulation is indispensable in CBT as it transforms general therapeutic principles into a personalized action plan. It bridges the gap between theory and practice, ensuring that therapy is targeted and flexible. Through detailed case formulation, therapists can enhance patient outcomes, facilitate meaningful change, and foster long-term resilience. This presentation will provide attendees with a thorough understanding of how to construct effective case formulations and incorporate them into their therapeutic practice to optimize the results of CBT interventions.

Schema Therapy of Generalised Anxiety Disorder

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Generalised anxiety disorder (GAD) is a persistent and common disorder, in which the patient has unfocused worry and anxiety that is not connected to recent stressful events, although it can be aggravated by certain situations. Generalised anxiety disorder is characterised by feelings of threat, restlessness, irritability, sleep disturbance, and tension, and symptoms such as palpitations, dry mouth, and sweating. About 1%–5% of the general population report having generalised anxiety disorder. Less than half of people have full remission after 5 years. Despite these high prevalence rates and loss of function, generalised anxiety disorder is not sufficiently recognised. This seems to negatively affect the course of the disease.

Its chronic course and high risk to recurrence make GAD seem like a personality level rather than an acute mental disorder. For this reason, schema therapy, which is known to be effective in pathologies showing pattern characteristics, can be seen as a good option in treatment. Schema therapy is a therapy approach developed by Jeffrey Young integrating relational, cognitive, experiential and behavioral techniques. Early maladaptive schemas (EMS) which is one of the fundamental concepts of schema therapy. They are self-destructive emotional and cognitive patterns that begin in early childhood, develop during childhood/adolescence and elaborate and repeat throughout lifetime. Early maladaptive schemas (EMS) play an important role in substance use, depression, and anxiety disorders.

Vulnerability to harm, pessimism, abandonment, mistrust, self-sacrifice, punitiveness and unrelenting standards schemas are seen to be related to GAD. These schemas and the dysfunctional coping that occurs when these schemas are triggered need to be worked with. Cognitive and behavioural interventions can be made in these areas. Schema therapy also uses experiential techniques extensively in treatment. Especially imagery rescripting and chair techniques are important emotional/experiential techniques.

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"Daha Nasıl Anlatayım?" Psikoterapide Danışanın Metaforuyla Çalışmak

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Metafor, bir kavramı ya da durumu başka bir kavram ya da durumla benzetme yoluyla anlatan bir dilsel araçtır (1). Bu haliyle metafor insan dilinin kullanıldığı her ilişkide kendine yer bulmaktadır. Aslında gündelik konuşma dilinde metaforlara sıkça rastlarız.

İnsan dil ve bilişini açıklamak için oluşturulmuş "ilişkisel çerçeveleme teorisi" metaforların ne olduğu ve nasıl çalıştığı ile ilgili önemli açıklamalar sunmaktadır. Bu teoriye göre, insan zihni/dili fenomenleri birbiri ile ilişkilendirmekte ve bu şekilde fonksiyon göstermektedir. Bir deneyim yaşadığımızda, insan dili/zihni bu deneyimin parçalarını belirli şekillerde ilişkilendirilip, bir ilişkisel çerçeve oluşturmaktadır. Dil becerimiz fenomenleri birbileri ile ilişkilendirmemize imkan sağladığı gibi ilişkisel çerçeveleri de birbirleri ile ilişkilendirebilmemizi sağlar. Metaforlar bu şekilde kullanışlı hale gelir (2). Bir örnek verecek olursak; bir çok zorlukla baş etmeye çalışan ve bu süreçte ne yapacağını bilemeyen ancak çabalayıp duran bir danışan, yaşadığı durumu "fırtınalı ve dalgalı bir denizde gemisini yüzdüren kaptan gibiyim" şeklinde tarif edebilir. Burada kişi son zamanlarda yaşadığı durum ile (ve aslında bu deneyimlerine ait ilişkisel çerçevelerle) fırtınalı ve dalgalı bir denizde gemisini yüzdüren kaptanının yaşadığı durum (bu örnekteki parçalardan oluşan ilişkisel çerçeve) arasında benzerlik kurmaktadır. Böylelikle metafor üzerine yapılan bir değerlendirme/müdahale, kişinin kendi deneyimine de aktarılabilir (3).

Terapide metafor kullanımı, terapistin getireceği bir metafor üzerinden veya danışanın seansta kullandığı bir metafor üzerinden de gerçekleştirilebilir. Danışan, kendisinin kullandığı metaforu, deneyimi ile daha kolay ilişkilendirebilir. Bu da, iki ilişkisel çerçeve arasında kurulacak olan benzerlik ilişkisinin daha güçlü olmasınına sağlayabilir. Danışanın deneyimine gerçekten temas edebilmek için -özellikle danışanın sunduğu- metaforlar bize önemli kolaylık sağlamaktadır.

Seanslar metafor kullanımı kabul kararlılık terapisinde ön plana çıksa da terapide metafor kullanımı hehangi bir terapi ekollü ile sınırlı değildir. Danışan ile etkili bir iletişim için metaforik dili kullanmak çoğu zaman fayda sağlayacaktır. Yine de terapist seans içinde psikolojik esneklik becelerilerini sergilemeli, her davranışı gibi metafor kullanımını da işlevsel olup olmadığına göre değerlendirmelidir.

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