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IACP PRESIDENT'S MESSAGE STEFAN G. HOFMANN, PHD

It is my great pleasure and honor to serve as your next *International Association for Cognitive Psychotherapy* president. It will be difficult – if not impossible - to fill Lata McGinn's elegant shoes. Lata began too many excellent new initiatives to name here in detail. However, I want our members to be aware of Lata's long-lasting beneficial impact on our organization. On behalf of the board and our membership, I would like to thank Lata for her outstanding services.

CBT is on the rise. It is a highly cost-effective treatment that can be effectively trained. Therefore, many countries spend a large amount of money toward the further development, training, and dissemination of CBT. For example, CBT is now widely disseminated in the UK under the *Improving Access to Psychological Therapies* initiative, which began under the leadership of one of our former presidents, David M. Clark. Similarly, compelling economic evidence has contributed to shifts in health care policy in Australia, which also resulted in greater access to publicly funded CBT. A similar trend is now happening in the USA, with the *Patient Protection and Affordable Care Act* (ACA), also known as *Obama Care*. Mental health care will benefit much like general health care under this new law. This radical new change in will improve overall health care coverage by providing incentives to practitioners for providing high quality care, including CBT for psychiatric problems. It is expected that approximately 68 million Americans will finally have access to mental health care. This new law could mean a major boost for CBT in the US.

Considering the radical changes of mental health care delivery across the globe and the promotion of CBT, IACP is ideally positioned to become a key national and international player. With its firm empirical foundation and international representation, our organization is destined to be a leader for the dissemination and implementation of CBT.

Our contribution is not limited to organizing our popular international conventions (with the next one in 2017 being held in Cluij Napoa, in the heart of Transylvania, Romania and chaired by Daniel David). We are also exploring a number of other avenues, such as webinars, trainings, certifications, and local workshops. Most importantly, we are currently in close communications with our friends from the Academy of Cognitive Therapy to explore mutually beneficial ways to interact and join forces. I will keep our members updated on any new developments.

Of course, none of this is possible without the support of a dedicated and hard-working Board. Many individuals contribute

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ACT PRESIDENT'S MESSAGE
DENNIS GREENBERGER, PHD, ACT

It has been a special honor to serve as the President of the *Academy of Cognitive Therapy*. On December 31, 2014 my two year term will be complete. I wanted to take the opportunity of my final column to summarize significant Academy accomplishments during the last two years and share my vision of the bright future of the Academy.

First and foremost people continue to take remarkable pride in being an Academy Diplomate. Because of the rigorous application requirements including a peer review of a psychotherapy session and a case write up many people describe being a Diplomate as their highest professional achievement. Earlier this year the Academy passed an important milestone in granting Diplomate number 1000. We continue to grow and consistently have more Diplomates year over year. As clinicians increasingly recognize the personal meaning and professional significance of becoming a Diplomate. the Academy has been adding Diplomates from around the world. In the last two years we have significantly increased our ability to have applicants proceed through the application process in languages other than English. We now have the ability to rate session recordings and case write ups in English, Spanish, Portuguese, Russian, Japanese, Mandarin, Cantonese , Arabic, Turkish and Farsi. We currently have Diplomates in 44 countries and the Academy has a presence throughout the world. Our ability to rate applicants in more and more languages is sure to grow in the coming years and the ACT Diplomate will be further recognized as setting the standard of excellence in CBT. In addition to the growth in the number Diplomates the Academy has also grown in our granting of the Certified Trainer/Consultant designation and in our general membership. We have established a large tent geographically, by type of license, and by type of affiliation with the Academy.

In an exciting development the Academy has partnered with a number of governmental organizations including the State of Texas, the Veterans Administration, Ventura County, and the County of Los Angeles. Our ground breaking work with the County of Los Angeles deserves special mention. The County of Los Angeles and its network of providers is the largest provider of mental health services in the United States. Los Angeles County has chosen the Academy to provide CBT training for up to 2000 clinicians. These clinicians will be receiving didactic instruction and weekly consultation with an ACT Certified Trainer/Consultant. We are hoping that this training will bring CBT to a poor, underserved, multi-cultural population with severe mental disorders – a population that traditionally has not received state of the art psychotherapy services. The Academy was chosen, in part, for this project because of recognition that we set the standard of excellence in evaluating clinician competence and because our cadre of Diplomates and Trainer/Consultants gives us the ability to lead large scale training initiatives. Lynn McFarr deserves special recognition for bringing this opportunity to the Academy.

In order to provide a wider range of services the Academy is in the process of an organizational restructuring. From our beginning we have been exclusively an IRS designated 501 (c) (3). We are retaining our 501 (c) (3) status and, in addition, we are creating an IRS designated 501 (c) (6). This change is likely to be relatively seamless and almost invisible and will not result in any disruption in to any member of the Academy. By structuring ourselves in this way we will continue to have all of the advantages of the 501 (c) (3) but we will also have great freedom to engage in even more activities that are likely to benefit the CBT community.

I want to thank the Board of the Academy for choosing me to lead the organization for the last two years. The Board is a highly committed and multi-talented group and we are all lucky to have them volunteer their time and expertise in growing the Academy.
I have been on the Board for 12 years and I can honestly say that the future for the Academy has never been brighter. This is a very exciting time for CBT and for the Academy. The Academy is well established and on a solid foundation in so many ways. Our membership consists of leading clinicians, academics, and researchers that are at the cutting edge of this growing field. The Academy serves as an organization that allows us to come together, to learn from one another and to grow in the process. We will continue to grow throughout the world and we will continue to set the standard for excellence in CBT.

Thank you again for allowing me the honor of being the President of this very special organization for the last two years. I am confident that the Academy will be left in the very capable hands of President Elect, John Williams, MD, ACT's Executive Director Troy Thompson and the entire Board of Directors.

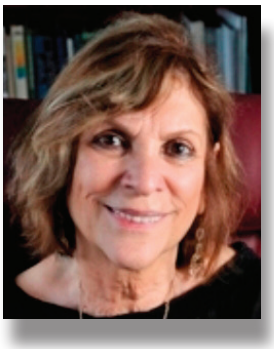
STANDING ON THE SHOULDERS OF GIANTS: AN INTRODUCTION TO EDNA B. FOA, PHD
SIMON A. REGO, PSYD, ABPP, ACT, MONTEFIORE MEDICAL CENTER, BRONX, NEW YORK

For those of you who are new to *Advances*, "Standing on the Shoulders of Giants" features a giant in the field writing about his or her influences in training. Past issues have featured contributions from such luminaries in our field as Art Nezu, David M. Clark, Christopher Fairburn, Philip Kendall, Jack Rachman, Aaron Beck, and most recently, Anne Marie Albano.

For this issue, I could not be more pleased to introduce you to the next featured giant: *Dr. Edna Foa*. Dr. Foa took a chance on me when she offered me a position at the Center and Treatment of Anxiety (CTSA) at the University of Pennsylvania back in 2001 - which I started just one week after defending my dissertation and just six days after 9/11. Although I ultimately only spent two years at the CTSA, the training and supervision I received there forever shaped the way I think - and practice - as a clinical psychologist. Thus, I am indebted to Dr. Foa for providing me with that opportunity, honored to have been able to keep in touch with her over the years, and I am thrilled that she kindly agreed to do this column.

On the off chance any of you are unfamiliar with her work, Dr. Foa is a Professor of Clinical Psychology in Psychiatry at the University of Pennsylvania and Director of the Center for the Treatment and Study of Anxiety. She devoted her academic career to study the psychopathology and treatment of anxiety disorders, primarily obsessive-compulsive disorder (OCD) and post-traumatic stress disorder (PTSD). Her research activities included the formulation of theoretical frameworks for understanding the mechanisms underlying these disorders, the development of targeted treatments for these disorders, and elucidating treatment mechanisms that can account for their efficacy. The treatment program she has developed for PTSD sufferers has received the highest evidence for its efficacy and has been widely disseminated in the US and around the world.

Dr. Foa has published 18 books and over 350 articles and book chapters. Her work has been recognized with numerous awards and honors, among them the *Distinguished Scientific Contributions to Clinical Psychology Award* from the American Psychological Association; the *Lifetime Achievement Award* presented by the International Society for Traumatic Stress Studies; the *Lifetime Achievement Award* presented by the Association for Behavior and Cognitive Therapies; the TIME 100 most influential people of the world; the 2011 *Lifetime Achievement in the Field of Trauma Psychology Award* from the American Psychological Association; and the Inaugural International Obsessive Compulsive Disorder Foundation Outstanding Career Achievement Award.



EDNA B. FOA, PH.D.
PROFESSOR OF CLINICAL PSYCHOLOGY IN PSYCHIATRY
UNIVERSITY OF PENNSYLVANIA

I was drawn to Psychology as an adolescent, when I discovered the writings of Sigmund Freud and became fascinated with Psychoanalysis. This interest led me to study psychology at Bar Ilan University where I received my B.A. in 1962. At Bar Ilan, my clinical psychology teachers were all psychoanalytical or psychodynamic oriented; none of them thought that psychotherapy could or should be studied empirically.

My first contact with behavior therapy and behavior modification occurred at the University of Illinois, where I received my M.A. in 1970 under the supervision of O. H. Mowerer. In the 60's, the Clinical program in the Department of Psychology at Urbana was one of the strongholds of Behavior Therapy and Modification. There, I first become acquainted with the work of Joseph Wolpe and with the integration of concepts from experimental psychology into psychopathology and treatment. This educational experience at the University of Illinois marked the beginning of my professional career.

After completing my Ph.D. in 1970 at the University of Missouri at Columbia, I was awarded an NIMH post-doctoral fellowship to work with Wolpe at Temple University, the Mecca of Behavior Therapy at the time. There I had the opportunity to meet leaders in the field, many of whom influenced my conceptual and empirical work. I was particularly fortunate to meet the leaders on cognitive behavior therapy. Of special importance for my career was the influence of Peter Lang. At the University of Illinois, I had been introduced not only to Behavior Modification and Behavior Therapy but also to the clinician-researcher model. And it is this model that is reflected in the development of my own career. In 1979 I founded the Center for the Treatment and Study of Anxiety, first at Temple University and then at the University of Pennsylvania. It is in this center, and together with my colleagues, that my research and clinical work has taken place.

I began developing treatments, focusing on OCD (Foa, Yadin, & Lichner, 2012) and PTSD (Foa, Hembree & Rothbaum, 2007) , conducting studies to assess the outcome and processes of these treatments (e.g., Foa et al., 2005, Simpson et al., 2013) as well as to elucidate the psychopathology of fear and anxiety. More recently, and continuing in the spirit of the clinician-researcher model, I have been much concerned with the dissemination of the effective treatments that my colleagues and I have developed.

My interest in the psychopathology and treatment of anxiety has produced emotional processing theory (Foa & Cahill, 2001; Foa & Kozak, 1985, 1986), which aimed to account for the processes involved in pathological anxiety and its treatment. Later work focused on testing hypothesis derived from the theory (e.g. Zalta, et al., 2013).

Throughout my career I was fortunate to have wonderful collaborators from other institutions and dozens of students, post-docs and junior colleges, many of whom have become leaders in the field. In order not to overlook some of these invaluable collaborators I will not mention any names. But their contributions are recognized in the numerous papers we

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RECENT ADVANCES OF COGNITIVE BEHAVIOR THERAPY IN KOREA

YOUNG HEE CHOI, M.D., PH.D.
METTAA INSTITUTE

Young Hee Choi is Director of the Mettaa Institute of Cognitive Behavior Therapy and Schema Therapy in Seoul and a Clinical Professor of Psychiatry at the Seoul Paik Hospital of Inje University. He is Certified as a Schema Therapist by the International Society for Schema Therapy and a Fellow of the Academy of Cognitive Therapy.

There have been many advances of CBT in Korea in the decade since I last submitted an article on the topic ("Cognitive behavior therapy (CBT) in Korea") with Jung Hye Kwon to this newsletter. CBT is no longer just a new therapy, but stands in the center of psychotherapies among Korean mental health professionals.

For example, the Korean Association of Cognitive and Behavior Therapy (KACBT), which was established in September 2001 with the goal of promoting dissemination, further development, and training of CBT in Korea, has been organizing symposia, workshops and lectures for the wider audience of mental health professionals and now exceeds 400 members. Jung Ho Chae is serving as the 7th president of KACBT at the moment, and the former presidents are Jae Woo Lee, Jung Hye Kwon, Young Hee Choi, Kyu Man Chae, Jung Bum Kim, and Byung Bae Min.

Its journal, Cognitive Behavior Therapy in Korea, tri-annually publishes original articles on application and implementation of CBT in Korea, serving as a major database of clinical experiences in CBT. The latest volume (14, 2) was published recently and the total number of articles published since its inception is estimated at 200.

Another promising development involved the founding of the ACBTA (Asian Cognitive Behavior Therapy Association) in 2011, when the KACBT hosted the 3rd Asian CBT Conference in Seoul, South Korea. The ACBTA represents all CBT therapists in each Asian country and has a seat under WCBCT (World Congress of Behavioral and Cognitive Therapy).

In addition, numerous CBT textbooks and manuals, published around the world (mostly from the USA), have been translated into Korean. There are also a large number of books on CBT that have been written by experienced Korean authors, not only for professionals but for lay persons as well.

Due to a variety of complex historical and political factors in Korea, however, CBT has suffered stunted growth as a mainstream therapy. For example, the medical law in Korea states that among mental health professionals, only psychiatrists can treat patients independently in psychiatric institutions, with other mental health professionals (e.g., clinical psychologists, social workers, and psychiatric nurses) working at these mental health institutions needing to be supervised by the psychiatrists. As a result, the practice of clinical psychologists and other mental health professionals has remained outside of psychiatric institutions. Recently, however, more collaboration between psychiatrists and clinical psychologists has occurred, making the future of CBT quite promising in Korea. In addition, because the training curriculum of psychiatrists in Korea has traditionally mostly consisted of psychodynamic approaches, few psychiatrists currently use CBT in their practice. However, there has been a big change in the field of psychiatry over the past 10 years, with psychiatrists now having various opportunities to learn CBT through various workshops, lectures and symposia.

For example, to meet the needs of further training and supervision, two CBT centers - the Mettaa Institute (by Young Hee Choi) and Maum Sarang Institute for CBT (by Byung Bae Min) - have been providing systematic training and workshops. In particular, the Mettaa Institute has invited many CBT experts (e.g., Arthur Freeman, Mark Reinecke, Jeffrey Young, Robert Liberman, Paul Salkovskis, Frank Dattilio, Christopher Fairburn, Isaac Marks, Travis Atkinson, David Kingdon, Judith Beck, Keith Dobson, and Irismar de Reis Oliveira) to Korea to provide workshops for Korean mental health professionals. In addition, Schema Therapy is now being introduced, with training offered by Young Hee Choi, who received certification from in it from the ISST (International Society of Schema Therapy). Also, beginning in 2011, the KACBT started to certify therapists using CBT in Korea, with 64 therapists having been certified to date. In addition, we have five ACT (Academy of Cognitive Therapy) certified therapists in Korea. They are: Young Hee Choi (Fellow), Jung Hae Kwon (Fellow), Jung Min Kim, Mingeul Kim, and Jihwan Choi. Nevertheless, unfortunately, there continue to be many therapists who declare themselves as CBT therapists who have not been trained or certified by proper supervisors or institutions.

Korea, as is the case with the rest of the world, has also embraced the so-called "3rd wave" of behavior therapy. For example, there are many workshops and lectures on ACT (Acceptance Commitment therapy), DBT (Dialectical Behavior Therapy), and MBCT (Mindfulness Based Cognitive Therapy). In addition, many books describing these therapies have been translated into Korean. Nevertheless, some therapists who are familiar with mindful meditation believe that they can practice mindfulness-based therapy without any training or supervision with some professionals even attempting to teach these approaches as if they have certified.

In conclusion, CBT is already an approved and is becoming an increasingly popular psychotherapy in Korea. In addition, Schema Therapy and various 3rd wave approaches have also been introduced

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NIGHTMARE THERAPY UPDATE

BARRY KRAKOW, M.D.

Barry Krakow is a board certified internist and sleep disorders specialist, who has studied and practiced for 25 years in the fields of internal medicine, emergency medicine, addiction medicine, and sleep medicine. Currently, he is medical director of two sleep facilities in Albuquerque, NM: Maimonides Sleep Arts & Sciences, Ltd, a community-based, sleep medical center and the Sleep & Human Health Institute, a non-profit sleep research institute. He has published nearly 100 peer-reviewed research papers, abstracts, book chapters and white papers with a special emphasis on sleep disorders in mental health patients. He has also authored three books on sleep disorders, Insomnia Cures, Turning Nightmares into Dreams, *and* Sound Sleep, Sound Mind.

Chronic nightmares are a distressing condition often taking on a life of its own beyond the original or triggering cause (e.g. traumatic exposure leading to PTSD). Both research and clinical advances now unequivocally demonstrate nightmares are a direct cause of sleep and waking impairment. Evidence continues to mount showing that direct nightmare treatment alleviates not only the bad dreams but also improves distress. In a crucial randomized controlled trial published in *JAMA* in 2001, we proved that a cognitive-imagery technique known as imagery rehearsal therapy (IRT) decreased both nightmare frequency in sexual assault survivors with PTSD and their posttraumatic stress symptoms (Krakow et al., 2001).

Some have pointed to IRT as a treatment for PTSD; whereas, we think of it as an adjunctive therapy. Nonetheless, in recent training programs conducted for mental health professionals at several U.S. army bases, I learned that some providers start PTSD treatment by focusing on nightmare therapy first and then progress to evidence-based prolonged exposure therapy or cognitive-processing therapy. The anecdotal reports on the integration of this therapeutic model indicate patients were not only increasingly receptive to IRT due to its simplicity, but also success with IRT appeared to enhance receptivity to move forward with more intensive PTSD treatment. The most frequently reported explanation by mental health providers for the utility of this approach was that patients who were sleeping better due to fewer nightmares were more ready, willing and able to enter into PTSD treatment.

Another development with potential implications for the aforementioned sequential pathway is the emergence of an exposure-oriented variant of IRT. The original IRT model we developed in 1988 involved no exposure therapy, and over the course of the 1990s it was clearly organized as a behavioral sleep medicine therapy without the adoption of exposure elements. This sleep model is the most widely researched among practitioners with a bent towards sleep medicine or other sleep focus; whereas, the IRT models with added exposure have arisen from researchers and clinicians with other backgrounds in psychology and in the specific use of exposure treatments for assorted mental health conditions. Of late, two meta-analyses were published demonstrating the two variants (sleep-oriented vs. exposure-oriented) appear roughly the same in efficacy (Casement & Swanson, 2012; Hansen, Hofling, Kroner-Borowik, Stangier, & Steil, 2013).

For those interested in learning the sleep-oriented version of IRT, we offer three main resources available at our website www.nightmaretreatment.com. Our two hour video presentation introduces IRT and earns 2 CEUs. Or, a more in depth program will be found in our *Turning Nightmares into Dreams* book and audio series, comprised of a 100 page workbook and 4 hours of audio instruction. Last, the book *Sound Sleep, Sound Mind* provides the framework for our Sleep Dynamic Therapy™ model for treating sleep disorders in mental health patients and within which one section covers imagery use and IRT for nightmares. For more information on exposure-oriented IRT, Dr. Joanne L. Davis has pioneered the variant known as Exposure, Relaxation, and Rescripting Therapy described in her book Treating Post Trauma Nightmares.

All these approaches remain under-utilized by mental health practitioners in that the most typical treatment a nightmare patient would receive is either psychotherapy or medication directed at the underlying mental health disorder. The lack of dissemination of newer, evidence-based, cognitive-imagery treatments into the mainstream is also a function of the relative paucity of patients who conceive that a nightmare treatment actually exists. In 2006, we looked at this topic at our own sleep center, Maimonides Sleep Arts & Sciences in Albuquerque, NM, where we specialize in the treatment of mental health patients with sleep disorders and where we have a reputation for the treatment of nightmare patients. Notwithstanding, the number of patients unequivocally seeking treatment for nightmare problems is quite low. Of 718 consecutive patients, 26% reported nightmare problems. Of these 186 patients, 117 linked their disturbing dreams to sleep disruption, thus qualifying for the diagnosis of a Nightmare Disorder. Yet, none of these patients had presented to the sleep center with an exclusive complaint of nightmares or for the purpose of seeking treatment for nightmares (Krakow, 2006).

Clinically, in working with nightmare patients for more than 25 years, we are now persuaded this disorder often presents to a sleep center as a Nightmare Triad Syndrome, in which co-occurring insomnia and sleep apnea manifest as well. What is so intriguing about the discovery of this triad is that some studies clearly suggest treatment of sleep apnea with positive airway pressure therapy (PAP) decreases nightmare frequency. In 2000, we published the first case series in a small sample of patients with nightmares and

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COGNITIVE THERAPY FOR INSOMNIA

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Allison Harvey is a Professor of Clinical Psychology at the University of California, Berkeley. Dr. Harvey's research is funded by NIMH, NIDA and NICHD. She has published over 160 research articles and book chapters and authored two books. Her research has been acknowledged with various awards including an Honorary Doctorate from the University of Orebro, Sweden. Dr. Harvey serves on numerous editorial boards and is an Associate Editor for SLEEP.

Insomnia, the most prevalent sleep disorder, is reported in around 10% of people. This rate markedly increases among individuals who have a psychiatric and/or medical disorder. Also, basic science shows that sleep is critical for almost every basic human activity—for health, emotion regulation, learning, memory and so much more. Hence, it is no surprise that, relative to good sleepers, individuals with insomnia report more psychological distress, more impairment in daytime functioning and they have more accidents, take more frequent sick leave and utilize more health care resources (Sivertsen, Øverland, Bjorvatn, Mæland, & Mykletunb, 2009). Moreover, insomnia heightens the risk of developing subsequent depression, anxiety, and substance-related problems (Baglioni et al., 2011; Breslau, Roth, Rosenthal, & Andreski, 1996).

Our program of research on chronic insomnia began more than a decade ago when we noticed that the cognitive level of explanation had been minimally studied. The small amount of work that had been published, along with the reports from our patients with insomnia, seemed to clearly indicate a need to better understand the role of cognitive processes such as worry, rumination, attentional bias and unhelpful beliefs about sleep. So we began by scouring the existing literature for science related to cognitive processes in insomnia, in sleep and, following the pioneering work of Dr. Aaron T. Beck, we also examined the substantial literature on cognitive processes and cognitive therapy for other mental disorders. We summarized all that we found in a theoretical framework of the maintenance of insomnia at the cognitive level of explanation (Harvey, 2002). Our goal was to use this framework as a map for guiding the next phase of our research.

The central idea in the framework is that, regardless of the original trigger, chronic insomnia is maintained by a cascade of cognitive processes operating during the night and the day. The cognitive processes included in the framework are: worry/rumination, attentional bias toward sleep-related threat, misperception of sleep and daytime functioning, unhelpful beliefs about sleep and the use of safety behaviors that prevent correction of unhelpful beliefs about sleep.

We then set about empirically evaluating the framework by: (1) conducting experiments that manipulate each cognitive process (see Kaplan, Talbot, & Harvey, 2009 for review) and (2) refining and testing a new cognitive treatment designed to reverse the cognitive processes specified in the framework.

The initial results from an initial open trial of this cognitive treatment suggested that reversing cognitive maintaining processes was indeed helpful for people with chronic insomnia. Insomnia severity reduced and the cognitive processes we sought to reverse did indeed reverse (Harvey, Sharpley, Ree, Stinson, & Clark, 2007). But the results of an open trial are limited because we cannot rule out the possibility that they are simply due to the passage of time or to the positive effects of seeing a therapist.

Hence, in a next step, we began a collaboration with Dr. Charles Morin's group at the Université Laval in Québec, Canada. We added the Laval cognitive approach targeting unhelpful beliefs about sleep to the cognitive treatment just described and then conducted a randomized controlled trial of 188 adult patients with chronic insomnia who were recruited and treated at UC Berkeley or at the Université Laval. Our main goal was to examine the unique contribution of behavior therapy (BT) and cognitive therapy (CT) relative to the full cognitive behavior therapy (full CBT). These treatments were individually delivered across 8 weekly sessions.

There were significant improvements across all three conditions on measures of insomnia symptom severity, nighttime sleep disturbances, and daytime functioning, and these improvements were generally sustained at 6-month follow-up. The full CBT was associated with greatest improvements, the improvements associated with BT were faster but not as sustained and the improvements associated with CT were slower and sustained (Harvey et al., 2014).

The latter result seems particularly interesting because the different trajectories of changes may well provide unique insights into the process of behavior change via behavioral versus cognitive routes and they point to a need for future research to identify why an intervention targeting behavioral change generates faster improvement but is not as well sustained, while an intervention targeting cognitive processes generates slower but more sustained change.

These findings raise many questions. Is this pattern of findings specific to insomnia or do these findings replicate in BT vs. CT for other conditions? Are the behavioral adjustments that are core to BT easier for a patient to implement when a therapist is available for 'coaching'? Do we need more emphasis on establishing the behavioral recommendations as habits that the patient automatically reinitiates if/when insomnia recurs? Are there features of the

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BUILDING COMMITMENT AT THE WORKPLACE

DANIEL J. MORAN, PH.D., BCBA-D

I'd prefer my biography to reflect the most vital and meaningful things in my life, so I should prioritize writing about my family, friends, and love for heavy metal. Alas, this is a professional biography, so it is more appropriate to focus on the fact that I am the founder of the MidAmerican Psychological Institute, a thriving behavior therapy clinic in Chicagoland. I am also the founder of Pickslyde Consulting, an organization aimed at using evidence-based applications to improve performance and wellness in the workplace. Because I have excellent colleagues helping me run these organizations, I was able to accept a position as Senior Vice-President for Quality Safety Edge, a pioneering organization aimed at implementing behavior-based safety processes worldwide.

I earned my Ph.D. from Hofstra in 1998, worked as a university professor for a decade, helped treat dozens of people with Discovery Studio's Hoarding: Buried Alive show, and currently serve the ACBS Board as secretary-treasurer. I co-authored ACT in Practice (New Harbinger) with my friend Patty Bach. Last year, I published the book Building Safety Commitment in an effort to help front-line workers and leaders improve their safety by learning about mindfulness and values-based motivation.

Several years ago, I made the commitment to reinterpret the evidence-based treatments I had been using in my clinic, and bring those applications to organizations aiming to become more psychologically healthy workplaces. My inspiration came from assisting a great non-profit organization, Trinity Services, in winning the American Psychological Association's Psychologically Healthy Workplace Award. During the award ceremony, I learned there was great opportunity for using the cognitive-behavioral approach to improve quality of living for employees in at the workplace, while also having a positive impact on the bottom-line for the organization.

When I founded Pickslyde Consulting, my aim was to assist organizations in improving safety behaviors, increasing productivity, and accelerating skills in leadership and innovation. I quickly learned that most organizations were already using established processes for these targets. For instance, Behavior-Based Safety was already implemented at a majority of industries, while Lean Manufacturing and Six Sigma were also in place at factories and production plants. Reinventing the wheel was not my aim, but I did discover a potential flaw in all these major consulting approaches. Oftentimes, employees and leaders were not *committed* to following through on these evidence-based approaches. That problem harkened back to what I had dealt with in the clinic: Clients would often lack commitment to following through on good behavioral health practices. The individuals who came to see me for weight-loss concerns demonstrated a lack of commitment to a healthier diet and exercise regimen.

When people with an OCD diagnosis were given exposure exercises as behavioral homework, they would often report not doing something that would help them. In the clinic, I always aimed to have the person learn the skills related to keeping a commitment. I thought that doing the same thing could help employees and leaders stick to executing the important tasks for safety, productivity, innovation, and management. In order to help organizations, I started offering Commitment-Based Leadership workshops, and wrote a book called Building Safety Commitment.

Committing means *acting in the direction of what is important to you even in the presence of obstacles.*

During a consultation, I discuss committing as a verb, and it requires action. A commitment is not just saying you are going to do something. A commitment requires actually doing it. If you just say you are going to do something, that is just a declaration, or at best, a promise. Committing involves measurable execution. When I am working with people in industry, we discuss very conventional CBT concepts, such as operational definitions of behavior and goal-setting, in order to get a commitment started.

And we also discuss why certain actions are important to the workers and leaders. It is very difficult to commit to an action that has no personal relevance or purpose. I like to bring CBT "values-clarification" exercises into the consulting room in order to make the operationally defined actions become meaningful to the person. There are many reasons I do this, but my biggest impetus is to change the corporate culture from one of compliance to one of commitment. Compliance is about doing a task because the boss says so, and to avoid potentially aversive contingencies. In the safety world, compliance is when a person wears a hard hat so she doesn't get fired if she is caught without it on. Commitment, especially when strengthened by a values clarification exercise, is when the person wears the hard hat because she links wearing the hat to going home to her children and keeping her cherished health. From a different perspective, a hospital vice-president might be told to execute a difficult Six Sigma spreadsheet project. When a person is just doing it to be compliant "because the boss said so," the vitality and motivation is probably less than if the vice-president can see the meaning and ultimate purpose of this task. If the vice-president clarifies that she does her job because she wants to help reduce suffering in her community, and she can link the fact that this spreadsheet project will be used for a hospital grant expanding services to more people in her county, perhaps that added values-based motivation will increase her commitment to the task.

At the workplace, there are often obstacles that impede progress. Good consulting processes aim to remove the external obstacles to productivity and solid leadership. But what about the *internal* obstacles to productivity and leadership? Many times, faulty thinking can get in the way of proper execution of work tasks. Emotional

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COMPASSION-FOCUSED THERAPY FOR PROBLEMATIC ANGER

LEAH PARKER, B.A., AND RUSSELL KOLTS, PH.D.

Leah Parker, BA is a graduate student in psychology at Eastern Washington University. She has worked with Russell Kolts, PhD conducting research on anger, shame, mathematics anxiety, and Compassion-Focused Therapy. Her research interests include shame and its influence on education, specifically in mathematics. She is currently utilizing a Compassion-Focused Therapy model to create a protocol for treating mathematics anxiety and mathematics shame. E-mail: leahmparker@eagles.ewu.edu.

Russell Kolts, PhD is a licensed clinical psychologist and a Professor of Psychology at Eastern Washington University, where he has been for the past 15 years. Dr. Kolts is the author of The Compassionate Mind Guide to Managing Your Anger, Living with an Open Heart: Cultivating Compassion in Everyday Life *(with Thubten Chodron), and the forthcoming books,* Buddhist Psychology and CBT: A Practitioner's Guide *(with Dennis Tirch and Laura Silberstein), and* CFT Made Simple: A Straightforward Guide to Compassion-Focused Therapy.Compassion-Focused Therapy for Problematic Anger

Anger, as an emotion that tends to evoke distance rather than empathy from others, provides a unique challenge both for individuals who struggle with problematic anger and for those seeking to help them. Individuals who express anger elicit more negative emotions from others than do those who display depressed reactions to distress (Karasawa, 2003). Rather than receiving support from those around them, individuals who express anger may often receive distance and rejection.

Compassion-Focused Therapy (CFT) is best considered a relatively recent form of Cognitive-Behavior Therapy that draws heavily from evolutionary psychology, attachment theory, and a model of emotions drawn from research on affective neuroscience - particularly the neuroscience of affiliation (Gilbert, 2010). CFT provides a model through which individuals struggling with problematic anger can begin to understand and explore the origins, dynamics, and current functions of their anger in non-shaming ways (Kolts, 2012). In brief, CFT conceptualizes anger as an evolved threat response that is designed to activate rapidly and powerfully in the face of perceived threats, but plays out in ways that are ill-suited to most contemporary environments. CFT facilitates an individual's awareness of the ways in which the mind is organized during anger, which involves a set of interacting processes that can serve to maintain the experience of anger once it is triggered. Clients explore how anger manifests in terms of felt emotional experience in the body, impacts on attention, reasoning, mental imagery, and motivations. It also assists clients in exploring the more tangible behavioral and interpersonal dynamics of how anger plays out. For example, when angry, our attention and thinking is narrowed and perseverative. We tend to experience a strong felt sense of certainty and urgency, both of which may exacerbate an emotional situation.

The awareness and understanding of anger is rooted in helping clients to contextualize anger within the CFT model of three evolved emotion-regulation systems - threat, drive, and safeness. Recognizing their anger as an evolved response that arises in reaction to perceived threats, individuals can begin to shift from a perspective of blaming and attacking others (or themselves), and move toward one that is focused on working with the experience of feeling threatened. Contextualizing anger within this model, it is possible to help them learn how to work with anger through understanding how to activate feelings of safeness, for example, by using imagery exercises. Operating through neurological systems involving neurochemicals like oxytocin and the endorphins, such work can help clients learn to balance out feelings of threat and shift from a perspective of acting out of anger to one of compassionately working with it.

As can be seen, CFT places a strong emphasis on de-pathologizing and de-shaming anger problems, working to undermine shaming and blaming cognitions that can potentially fuel ongoing anger and experiential avoidance that keep clients from acknowledging their anger problems and working with them.

Many clients who struggle with anger may identify with their angry experiences and habits. In addition to giving clients a repertoire of adaptive tools for working with anger that will be familiar to those who have used typical anger management programs, CFT seeks to help clients develop a compassionate self-identity, and involves assisting them in cultivating compassionate qualities such as distress tolerance, mindfulness, kind motivation towards self and others, assertiveness, confidence, empathy, and mentalization skills. The goal is to increase awareness and motivation around working with anger, develop adaptive skills for doing so, and facilitate the cultivation of an adaptive experience of the self. Some clients may be reluctant to give up anger-driven coping because it helps them feel powerful. CFT aims to give them a new way to be powerful - the cultivation of compassionate strengths that will help them work directly and effectively with the challenges in their lives.

(CONTINUED PG. 9)

COGNITIVE THERAPY FOR INSOMNIA

CONTINUED FROM PG. 6

procedures used in CT that are more conducive to habit formation? Does change to cognitive processes take longer but, once the skills *are learned, are they more easily sustained?*

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COMPASSION-FOCUSED THERAPY

CONTINUED FROM PG. 8

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IACP'S PRESIDENT'S MESSAGE

CONTINUED FROM PG. 1

to the success of our organization. At the risk of omitting some, I would like to mention a number of individuals whom I have been working most closely with (in alphabetical order); these include Frank Dattilio, Member-at-Large and chair of the International Delegate Program, Lynn McFarr, Member-at-Large and chair of our Public Domain Committee and interim secretary/treasurer, John Riskind, editor of our excellent *International Journal of Cognitive Therapy*, Simon Rego, Editor of this Newsletter, Henrik Tingleff, the chair of the IACP's International Training Committee, Julie Snyder, our new Coordinator and Membership Chair, and Mehmet Sungur, Member-at-Large. I want our members to know that your Board is a group of incredibly dedicated, caring, reliable, and hardworking people. I am looking forward to continuing working with this excellent group. If you have any comments or thoughts, please feel free to send me an email at shofmann@bu.edu. I am looking forward to serving our organization.

NIGHTMARE THERAPY UPDATE

CONTINUED FROM PG. 5

sleep apnea undergoing various forms of treatment, predominantly PAP, and observed a significant association between treatment and improvements in nightmare frequency, posttraumatic stress symptoms, and sleep quality (Krakow et al., 2000). Additional studies were recently published. In 2012, research on 99 nightmare patients demonstrated sizeable nightmare reductions in sleep apnea patients using their PAP devices compared to minimal changes in sleep apnea patients not undergoing treatment. Nightmares disappeared in 91% of the patients who used PAP (50 of 55 patients) compared with only 36% of patients (16 of 45) who refused PAP therapy ($p<0.001$) (BaHammam, Al-Shimemeri, Salama, & Sharif, 2013). Another study examined changes in nightmare frequency in PTSD patients with sleep apnea. Working with 69 patients, divided into two groups based on either REM-sleep predominant or NREM-sleep predominant sleep apnea, nightmare frequency dropped nearly 50% in both groups and was clearly associated with greater compliance with PAP devices. A 10% improvement in compliance was associated with a mean decrease of 1 nightmare per week (Tamanna, Parker, Lyons, & Ullah, 2014).

It cannot go without saying, however, that PAP therapy is viewed by many patients as a "nightmarish" treatment in and of itself. Thus, for our nightmare patients we have seen much more expedient results when they use advanced PAP therapy devices that deliver dual pressures for inhalation and exhalation and which auto-adjust the airflow settings to suit patient needs second by second. We have described the specific use of these devices in a case series of insomnia patients with sleep apnea (Krakow, Ulibarri, Romero, Thomas, & McIver, 2013).

In sum, many new therapeutic windows of opportunity are opening

up for nightmare patients (and the practitioners who treat them) in addition to the excellent results that may be obtained in treating specific nightmares with the older and established interventions of dream interpretation therapies or related psychotherapies. Still, it remains to be seen how much and how many nightmare patients (and therapists) will avail themselves of either newer or older therapies for this vexing condition once perceived as relatively uncontrollable and untreatable.

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BUILDING COMMITMENT

CONTINUED FROM PG. 7

turmoil can also be an obstacle. When teaching workers about commitment, we blend in CBT approaches to help people have a different relationship with their thoughts and emotions. This can take the form of teaching about how to deal with cognitive distortions, and by imparting the skills of mindfulness and acceptance.

Modern CBT approaches have been shown to have a significant effect on important work variables (Bond, Hayes, Barnes-Holmes, & Austin, 2007) and have been formulated for leadership training (Moran, 2010) and safety processes (Moran, 2013). Given the power of modern CBT approaches and the need for better commitment to effective process in the workplace, our community of behavioral health professionals can do a great deal of good in industry and organizations.

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Submissions to Advances in Cognitive Therapy are reviewed on an ongoing basis. Topic areas may include clinical issues, research updates, conference and training information, book reviews, and summaries of any CBT-related activities from around the world! Articles co-written by professors and students are particularly encouraged.

The next deadline for submission is January 15th, 2015. Submissions should be 350-700 words with no more than five references (using APA style and as an MS Word document). In addition, please include a brief (50-100 word) author bio and high quality photo/headshot with your submission.

Submissions and/or suggestions for how to improve the newsletter and/or topics that should be considered should be sent to: Simon A. Rego, PsyD, Editor: srego@montefiore.org.

STANDING ON THE SHOULDERS OF GIANTS

CONTINUED FROM PG. 3

wrote together.

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CBT IN KOREA

CONTINUED FROM PG. 4

and are being used. However, we still have some challenges, such as increasing the number of certified therapists.

Academy of Cognitive Therapy

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