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ACT PRESIDENT'S MESSAGE JOHN WILLIAMS, MD, ACT

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Dear Members of the Academy:

My name is John Williams MD, and I am a child, adolescent, adult, and forensic psychiatrist practicing in Bryn Mawr, PA. As of January 1st, I became president of the Academy. This a heavy responsibility for many reasons but most importantly because of the transitional time in which our organization finds itself. Last year, we began our collaboration with Los Angeles County to train its many mental health clinicians in cognitive behavioral therapy. This is a rather large effort that will likely prove transformative for the Academy.

Although CBT has long been available in university settings and private practice, it has not been as thoroughly disseminated in community mental health settings. The Los Angeles County project represents an important example of how innovative partnerships can ensure that even the most underserved populations receive the benefit of state-of-the art psychotherapeutic treatment.

I believe that the project will do much to enhance the brand recognition of the Academy and will establish its certification as the gold standard in cognitive behavioral therapy. In addition, it will provide a model for other public health authorities that have a similar interest in providing their populations with the best available care.

As president, I look forward not only to ensuring the success of the Los Angeles project but also to replicating our work in California across the nation. We believe that this will benefit all of our members.

In addition, I am committed to using the Academy to raise the profile of cognitive behavioral therapy with managed care organizations. To that end Troy Thompson, our executive director, and I have held a series of meetings with managed care executives, proposing ways that ACT certification could allow for preferential admissions into closed networks and potentially increased reimbursement for clinicians. In these meetings Troy and I have discovered how much managed care executives value cognitive behavioral therapy and the idea of certification. We look forward to expanding these discussions with large employers as well, especially as such companies—many of whom exercise strong control over the kind of health care that their employees receive—would likely have even greater interest in CBT.

In the interim I invite you to contact me directly with any questions or concerns you have about the Academy at jpw@mainlinefamily.com. I am always ready to listen.

Sincerely yours,

John Williams MD

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IACP PRESIDENT'S MESSAGE
STEFAN G. HOFMANN, PHD
PRIMUM NON NECERA

One of the perks for being president of IACP is to share my opinion with you on contemporary issues. I would like to warn you – this column will be disturbing. However, it is an important issue. Some of you will disagree with me, and I invite you to express your concerns to initiate a debate by sending in a letter to be published in the next issue of this Newsletter.

As some of you know, the USA is currently engaged in a heated debate about the use of torture as an interrogation technique in the aftermath of the 9/11 terrorist attacks in the USA and the role of psychologists. Similar debates are occurring in Europe and other parts of the world. IACP does not have an official position on this issue. Therefore, the opinion expressed in this column is my personal view. If you disagree, I would like to know why.

I am strongly opposed to the use of torture under any circumstances, which is in line with the Geneva Convention. As former president of the *Association of Behavioral and Cognitive Therapies* (ABCT), the organization that is most closely associated with us, I encouraged the ABCT board to formulate and distribute an official statement. We decided on the following:

> "ABCT strongly and unambiguously condemns the use of torture of any kind, for any reason, under any circumstances. Research indicates that torture often leads to destructive psychological and physical consequences. We consider the actions of the two psychologists who designed and carried out the United States CIA detention and interrogation program as described in the recently released Senate Select Committee on Intelligence's report to be wholly unethical and morally reprehensible."

To give the reader a background on this issue, I would like to present a summary of what is known so far. Some of the facts might be clarified as the investigations continue.

The story begins with the publication of the *US Senate report on the CIA detention interrogation program*. One particular conclusion put the spotlight on two psychologists. Specifically, the report described the following finding:

> "Two contract psychologists devised the CIA's enhanced interrogation techniques and played a central role in the operation, assessments, and management of the CIA's Detention and Interrogation Program. By 2005, the CIA had overwhelmingly outsourced operations related to the program. The CIA contracted with two psychologists to develop, operate, and assess its interrogation operations. The psychologists' prior experience was at the U.S. Air Force Survival, Evasion, Resistance and Escape (SERE) school. Neither psychologist had any experience as an interrogator, nor did either have specialized knowledge of al-Qaida, a background in counterterrorism, or any relevant cultural or linguistic expertise.
>
> On the CIA's behalf, the contract psychologists developed theories of interrogation based on "learned helplessness," and developed the list of enhanced interrogation techniques that was approved for use against Abu Zubaydah and subsequent CIA detainees. The psychologists personally conducted interrogations of some of the CIA's most significant detainees using these techniques. They also evaluated whether detainees' psychological state allowed for the continued use of the CIA's enhanced interrogation techniques, including some detainees whom they were themselves interrogating or had interrogated. The psychologists carried out inherently governmental functions, such as acting as liaison between the CIA and foreign intelligence services, assessing the effectiveness of the interrogation program, and participating in the interrogation of detainees in held in foreign government custody.
>
> In 2005, the psychologists formed a company specifically for the purpose of conducting their work with the CIA. Shortly thereafter, the CIA outsourced virtually all aspects of the program.
>
> In 2006, the value of the CIA's base contract with the company formed by the psychologists with all options exercised was in excess of $180 million; the contractors received $81 million prior to the contract's termination in 2009.
>
> In 2007, the CIA provided a multi-year indemnification agreement to protect the company and its employees from legal liability arising out of the program. The CIA has since paid out more than $1 million pursuant to the agreement" (Senate Select Committee on Intelligence, December 9, 2014; p. 11).

Shortly after this report was released, the New York Times published an article entitled Tortured by Psychologists and Doctors (December 16, 2014). In this article, the two psychologists mentioned in the CIA report were identified as James Mitchell and Bruce Jessen.

These two individuals were primarily responsible for developing the list of coercive techniques to be used in questioning prisoners. These so-called enhanced interrogation techniques included administering electric shocks, exposure to freezing temperatures, forced nudity, sexual humiliation, object rape, rectal feeding,

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STANDING ON THE SHOULDERS OF GIANTS: AN INTRODUCTION TO DAVID H. BARLOW, PHD

SIMON A. REGO, PSYD, ABPP, ACT, MONTEFIORE MEDICAL CENTER, BRONX, NEW YORK

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

For this issue, I am thrilled to introduce you to the next featured giant: *Dr. David Barlow*. I sometimes refer to Dr. Barlow as "grandpa" (although this may be first time I do so publicly!), not in reference to his age, but rather as way of acknowledging a connection, as he served as mentor to one of my mentors (Dr. William Sanderson). Although I never had the privilege of being trained directly by Dr. Barlow, I have certainly benefitted greatly from being supervised and mentored by Dr. Sanderson, and I have also been honored to have Dr. Barlow participate on several rather unusual clinical roundtable presentations I've put together for ABCT over the years. I am always thrilled when he agrees to one of my requests, and his agreeing to do this column is no exception! Before you hear from him, here's a brief biography:

David H. Barlow is Professor of Psychology and Psychiatry and Founder and Director Emeritus of the Center for Anxiety and Related Disorders at Boston University. He received his Ph.D. from the University of Vermont in 1969 and has published over 600 articles and chapters and over 75 books and clinical manuals mostly in the area of the nature and treatment of emotional disorders. His books and manuals have been translated in over 20 languages, including Arabic, Chinese, Hindi, Japanese and Russian. He is the recipient of numerous awards, including the Distinguished Scientific Award for Applications of Psychology from the American Psychological Association and James McKeen Cattell Fellow Award from the Association for Psychological Science honoring individuals for their lifetime of significant intellectual achievements in applied psychological research. He was a member of the DSM-IV Task Force of the American Psychiatric Association, and a Co-Chair of the Work Group for revising the anxiety disorder categories, and his research has been continually funded from the NIH for over 40 years.

FORMATIVE EXPERIENCES DAVID H. BARLOW, PHD

PROFESSOR OF PSYCHOLOGY AND PSYCHIATRY AND FOUNDER AND DIRECTOR EMERITUS OF THE CENTER FOR ANXIETY AND RELATED DISORDERS AT BOSTON UNIVERSITY

I began graduate school in the M.A. program in clinical psychology at Boston College in 1964. So I am now 50 years into a stimulating and rewarding career and a set of three very strong mentors launched me on the path I have followed. Before describing their influence I should note that I arrived at graduate school after an idyllic undergraduate experience at the University of Notre Dame where I was deeply immersed in both academics and athletics. I had a strong interest in literature and to some extent biography, and became fascinated back in the early 1960's with a literary form that was then popular, the psychoanalytic study of fictional characters. Since I was always interested in why people thought and behaved the way they did proceeding from these literary analyses to graduate school might be seen as a natural progression. But the totally different epistemology or "way of knowing" inherent in this literary exercise made the transition to graduate school with the beginnings of some emphasis on science a large leap indeed.

Fortunately, my first mentor was Joseph R. Cautela, an experimental psychologist at Boston College with a strong interest in learning theory and how principals of learning could be applied to clinical situations. He had studied with Joseph Wolpe the previous summer and Cautela presented a very different picture to me of clinical psychology than the prevailing view. He persuaded me that only through a reliance on the slow but inexorable process of science could the applications of psychological principals to human problems truly advance. This was in contrast to the message delivered by the others on the faculty of the clinical program, many of whom believed that the scientific method was incapable of unraveling the complexities of the human spirit, an activity that required a different more introspective way of knowing. Cautela also introduced me to the fledgling field of behavior therapy.

After two years at Boston College I was convinced that I wanted to pursue a more scientific approach to clinical psychology, and that the nascent field of behavior therapy seemed to provide the clearest path. But there were very few doctoral programs with anything approaching a more scientific approach to the field in 1966. Fortunately, I came upon the University of Vermont where I encountered my second and third mentors. Harold Leitenberg was a young assistant professor of psychology who himself had

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CBT IN MEXICO
LAURA HERNÁNDEZ-GUZMÁN, PHD

UNIVERSIDAD NACIONAL AUTÓNOMA DE MÉXICO

Laura Hernández-Guzmán is currently a full time Professor at National University of Mexico in Mexico City, Mexico. She serves as editor in chief of the Mexican Journal of Psychology and International Editor in Spanish for the Americas of Behavioral and Cognitive Psychotherapy, serves on the editorial boards of 5 other international journals, was General Editor of the International Journal of Psychology and member of the Editorial Board of the World Social Science Report (WSSR) UNESCO. She is also past-president of the Mexican Psychological Society (2000-2004), the Mexican Society for Behavior Analysis (1998-2000) and the Mexican Guild of Professional Psychologists (2009-2012).

In 1998, the World Congress of Behavioral and Cognitive Therapies (WCBCT) convened in Acapulco, Mexico, under the auspices of both the Mexican Psychological Society and the Mexican Society of Behavior Analysis. A group of enthusiastic behavioral psychologists, who had received their PhDs during the 1970's from American universities (mainly the University of Kansas), were behind the organization of the WCBCT. As members of the Association for the Advancement of Behavior Therapy, currently known as Association of Behavioral and Cognitive Therapies, they also obtained the support from ALAMOC (Latin American Association of Behavior Modification). Keynote lectures and workshops were conducted by the most influential leaders in CBT from around the world - David Barlow, Phillip Kendall, Paul Salkovskis, José Antonio Carrobles, Arthur and Christine Nezu, Neil Jacobson, Mark Dadds, Susan Spence, to mention just a few. This magnificent event, along with the growing recognition of data pointing to the efficacy of CBT facilitated its acceptance among many Mexican psychologists and psychiatrists, traditionally inclined toward the psychoanalytic approach.

Sadly, sixteen years after the Acapulco congress, CBT in Mexico has experienced a rather chaotic growth. Due to the increasing demand of CBT among clients, many practitioners claim to apply its techniques, some after receiving training and others just using other interventions, but calling them "CBT". There is also still an important gap when it comes to professional associations helping to regulate the practice of CBT in Mexico. For example, accreditation of training programs and certification of individuals practicing CBT, using quality assurance criteria is still a pending task. With respect to training, approximately 6 associations and institutes offer courses and even Master's Degree programs in CBT, none of them include its behavioral component. In addition, unfortunately, just three of them actually teach cognitive techniques, with the others addressing psychotherapy training within the frame of different theoretical orientations. Fortunately, CBT has been the focus of some research efforts by consolidated research groups at public universities. Creation of professional associations oriented to the protection of clients by regulating the practice of CBT must be a priority for future directions.

ARE MEDICATIONS ALWAYS NECESSARY IN THE TREATMENT OF PSYCHOSIS?

BRANDON A. GAUDIANO, PH.D. ALPERT MEDICAL SCHOOL OF BROWN UNIVERSITY AND BUTLER HOSPITAL

Brandon A. Gaudiano, Ph.D. is a clinical psychologist in the Psychosocial Research Program at Butler Hospital and Associate Professor (Research) in the Department of Psychiatry & Human Behavior at the Warren Alpert Medical School of Brown University. Dr. Gaudiano has published over 100 articles, chapters, and commentaries on various topics, including psychotherapy development and testing, psychotic and mood disorders, and mindfulness/acceptance-based therapies. His research on novel psychosocial interventions for psychosis has been funded by the National Institute of Mental Health. Dr. Gaudiano's forthcoming book is entitled Incorporating Acceptance and Mindfulness into the Treatment of Psychosis: Current Trends and Future Directions (Oxford University Press).

There have been many exciting developments in cognitive behavior therapy for psychosis (CBTp) since Dr. Beck first described the early use of this type of therapy for patients with delusions in 1952. Since that time, numerous randomized controlled trials have confirmed the safety, acceptability, and effectiveness of CBTp across a wide range of clinical subgroups and settings (Wykes et al., 2008). The latest success is the application of CBTp in individuals refusing to take antipsychotic medications. Dr. Anthony Morrison and colleagues (2014) conducted a pilot randomized controlled trial that was recently published in the prestigious journal, *The Lancet*, comparing unmedicated patients (n = 74) with psychotic-spectrum disorders receiving CBTp vs treatment as usual. This was a controlled follow-up study of a previous open trial (Morrison et al., 2012) showing that CBTp was safe and potentially effective for a similar group of unmedicated patients. In their latest study, Morrison et al. (2014) provided patients with up to 26 individual CBTp sessions over 9 months followed by 9 months of follow-up, in which they also offered up to 4 booster sessions. CBTp was fairly standard for this population, and included a normalizing rationale, behavioral experiments, and assessment/modification of appraisals. Those in the treatment as usual condition were provided regular monitoring as well as comprehensive early intervention services, which could have

included case management and other psychosocial interventions.

Relative to the comparison group, those receiving CBTp achieved significantly greater improvement on a number of different measures, including those assessing positive psychotic symptoms and social functioning. A good clinical response (defined as an improvement of > 50% in Positive and Negative Syndrome Scale scores) was achieved by 41% in the CBTp condition vs 18% in the TAU condition by 18 months. Most importantly, adverse events were relatively infrequent in both groups and there was no evidence of overall clinical deterioration in the sample during the study. It should be noted that 27% of these initially unmedicated patients were started on antipsychotics at some point during the trial, but rates were the same in both groups, so this did not appear to account for the differences in outcomes found between conditions.

Of course, much more research will be needed before we can routinely recommend CBTp for unmedicated psychosis. The Morrison et al. (2014) trial requires replication and extension due to limitations related to the modest sample size and study criteria that could potentially affect generalizability (e.g., excluding patients needing inpatient admission and requiring acceptance of early intervention services). Also, as is typical of early clinical trials, the study failed to address whether CBT would have been more effective than a credible, alternative psychosocial intervention that controlled for contact time and psychological support. Furthermore, Morrison and colleagues stress that they do not recommend that patients with psychosis be discontinued from their antipsychotic medications to receive CBTp instead. Most of the evidence for CBTp to date has demonstrated its efficacy when used in combination with pharmacotherapy. However, given the high antipsychotic nonadherence rates in psychosis, the potential for severe rebound psychosis for those who start but then abruptly discontinue medications, and the host of adverse effects associated with the long-term use of these medications, it will be essential to continue to conduct research on potentially safe and effective treatment alternatives.

The Morrison et al. (2014) study comes on the heels of another equally provocative trial that provides an important source of complimentary evidence. Wunderink and colleagues (2013) randomly assigned 228 patients with first episode psychosis to either antipsychotic discontinuation/dose reduction vs maintenance medication for 18 months (after 6 months of initial remission on antipsychotics). Over 7 years of follow-up, patients randomized to medication discontinuation/reduction (40.4%) demonstrated *twice* the rate of recovery compared with those receiving maintenance medication (17.6%). This differential recovery rate was driven mainly by greater improvements in functioning in the discontinuation group, with no differences in symptom remission between conditions. The Wunderink et al. findings mirror those reported in a similar 20-year naturalistic (non-randomized) follow-up study of antipsychotic discontinuation in psychosis (Harrow et al., 2014).

Increasingly, CBTp is focusing on improved targeting of negative symptoms, functioning, and quality of life in psychosis versus symptom alleviation alone. For example, Grant et al.'s (2012) randomized controlled trial showed that a recovery-oriented form of CBTp produced significantly greater improvements in functioning and motivation (which are less responsive to antipsychotic medications) relative to treatment as usual. Other recent research in CBTp is exploring the potential benefits of incorporating strategies focusing on mindfulness, acceptance, and compassion with promising early results (for a meta-analysis, see Khoury et al., 2013). The Morrison et al. (2014) study and other newer forms of CBTp will likely increase the demand for this treatment in the upcoming years. Further research is needed to inform evidence-based treatment recommendations for patients with psychosis who may decide to pursue alternatives to medications alone. Kudos to Morrison and colleagues on their forward-thinking and innovative research program!

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AN INTEGRATIVE, CBT-BASED TREATMENT APPROACH FOR PSYCHOSIS

NICOLA P. WRIGHT, PHD, CPSYCH & OWEN P. KELLY, PHD, DOUGLAS TURKINGTON, MD

Nicola Wright, PhD, CPsych, is a clinical psychologist in the schizophrenia program of the Royal Ottawa Health Care Group (The Royal) and author of Treating Psychosis: A Clinician's Guide to Integrating Acceptance and Commitment Therapy, Compassion-Focused Therapy, and Mindfulness Approaches within the Cognitive Behavioral Therapy Tradition. Wright provides individual and group therapy, as well as professional training workshops, integrating acceptance and commitment; mindfulness; and compassion-focused approaches in cognitive behavioral therapy (CBT) for people who experience psychosis. Wright is an active researcher and clinical professor in the School of Psychology at the University of Ottawa and a lecturer with the department of psychiatry, University of Ottawa. In addition, she is a founding member of the Canadian Association of CBT and a staff supervisor with the Beck Institute of CBT. Wright lives in Ottawa, Canada.

Owen P. Kelly, PhD, CPsych, graduated from Carleton University with a specialization in behavioral neuroscience and completed a postdoctoral respecialization in clinical psychology at Fielding Graduate University. He is a clinical psychologist in private practice at the Ottawa Institute of Cognitive Behavioral Therapy. He is currently an adjunct research professor in the department of neuroscience, and lecturer in the department of psychology at Carleton University. Kelly resides in Ottawa, Canada.

Douglas Turkingon, MD is a major research figure within the history of the development of cognitive behavioral therapy (CBT) for schizophrenia. He is a fellow of the Royal College of Psychiatrists and founding fellow of the Faculty of Cognitive Therapy in Philadelphia. He has written more than one hundred articles and more than half a dozen books on the subject of CBT for psychosis. Turkington lives in Newcastle, England.

CBT for Psychosis (CBTP) has been evolving rapidly. Integration of acceptance, compassion, mindfulness and positive psychology oriented approaches within CBTP have expanded CBT treatment. CBTP typically emphasizes fostering a strong, supportive, collaborative therapeutic alliance; providing psycho-education and normalization; developing a cognitive behavioral conceptualization; developing skills or strategies to address stress, barriers, and distress related to experiences such as hallucinated voices or unusual beliefs; utilizing cognitive and behavioral techniques such as cognitive reappraisal and behavioral experiments to diminish the distress associated with positive symptoms; focusing on relapse prevention and recovery; and addressing secondary or comorbid problems such as substance use, anxiety, and depression (Kingdon & Turkington, 1994; Rector & Beck, 2002).

When it comes to treatment for psychosis, CBT and acceptance- and mindfulness-based approaches have, at times, been assumed to be incongruent with respect to the goals of "control" and "change." But in their integration these approaches can complement one another by emphasizing the understanding, exploration, observation, and acceptance of thoughts and feelings rather than the "stopping" and "controlling" of unwanted thoughts and feelings. In addition, although the ultimate goals of our integrative CBT intervention for psychosis are many (including recovery, a reduction in distress, value-consistent living, working toward personal goals, and creating a more meaningful life), the emphasis is on change occurring as a result of work toward these goals rather than as a goal in and of itself.

"Third-wave" therapies (or contextual approaches) may be particularly applicable to the treatment of psychosis. The "third wave" of behavioral and cognitive therapies, which include acceptance and commitment therapy (ACT), mindfulness-based approaches (i.e. MBCT), and compassion-focused therapy (CFT), are particularly sensitive to the context and functions of psychological phenomena, and thus tend to emphasize contextual and experiential change strategies.

Central among these third-wave therapies is ACT (Hayes, Strosahl, & Wilson, 1999). From the perspective of ACT, mental health problems are thought to arise when the process of thinking is viewed as seamless with the products of thinking. Through the process of cognitive fusion, thoughts become functionally equivalent with actual events (Ciarrochi, Robb, & Godsell, 2005). For example, in an individual experiencing psychosis, the thought "I am being watched by the police" is evaluated not as simply a thought but rather as functionally equal to actual experiences of being watched by law enforcement officials.

The support for ACT in the treatment of psychosis is favorable. There is growing evidence that, among individuals affected by psychosis, ACT is effective in reducing the believability of psychotic experiences, reducing depressive symptoms, enhancing mindfulness, and lowering rates of rehospitalization and utilization of health services (Bach & Hayes, 2002; Bach, Hayes, & Gallop,

2012; Gaudiano & Herbert, 2006; Gaudiano, Herbert, & Hayes, 2010; White et al., 2011)

The foundation, philosophy, and theory underlying the integrated treatment approach presented in our book, ***Treating Psychosis: A Clinician's Guide to Integrating Acceptance and Commitment Therapy, Compassion-Focused Therapy, and Mindfulness Approaches Within the Cognitive Behavioral Therapy Tradition***, coauthored with Douglas Turkington, MD, David Davies, PhD, CPsych, Andrew M. Jacobs, PsyD, CPsych, and Jennifer Hopton, MA, incorporates acceptance-, compassion-, and mindfulness-based approaches in CBT and is based on positive psychology and recovery principles—that is, it is "positive psychology–infused.

Positive therapy approaches are implicit in the recovery movement for those with lived experience of psychosis (Copeland, 2010). The approach is inherently empowering, destigmatizing, and affirming. Rather than focusing predominantly on symptoms, deficits, distressing emotions, and pathology, a positive psychology infused orientation incorporates strengths, qualities, resources, and an emphasis on the development of strengths, positive experiences, and pleasurable emotions to move in the direction of valued life goals and enhance meaning in life.

Another element of our protocol is the piece drawn from compassion-focused therapy (CFT), which directly addresses high levels of shame and self-criticism that are often present in clients suffering from psychosis. Those who struggle with elevated levels of shame and self-criticism often born from a history of abuse, neglect, or bullying frequently do poorly in therapy and have difficulty feeling safe and equal in their relationships with others (Gilbert, 1992; Gilbert, 2009). Importantly, shame and self-criticism can evoke maladaptive patterns of thought and behavior that serve to maintain and exacerbate negative internal states such as psychosis (Gilbert et al., 2001).

Compassion-focused therapy is based on the relationship among three types of emotion regulation systems, drive, safety, and threat. Using compassion-focused approaches enhances the safety or compassion-based soothing system while diminishing the threat-focused emotion regulation system, thereby enhancing the ability to activate (drive) and move in the direction of valued goals. Drawing upon approaches of many empirically supported psychotherapies, compassionate mind training is highly amenable to integration into CBT.

There is considerable prima facie evidence for the use of compassion-focused therapy in the treatment of psychosis. For example, it has been demonstrated that severity of illness in psychosis often correlates with the intensity of self-criticism and negative interpretations of the self, particularly in the context of complex presentations with comorbid mood and anxiety disorders (Tai & Turkington, 2009). Moreover, among individuals with psychotic disorders, self-criticism appears to herald a risk factor for relapse (Gumley, Birchwood, Fowler, & Gleeson, 2006). Finally, it has been suggested that the distressing hallucinated voices often experienced by individuals with psychosis tend to echo and perpetuate negative dynamics evident in the individual's everyday life with others (Tai & Turkington, 2009).

Research and support for the effectiveness of compassionate focused therapy in the treatment of psychosis is growing. Laithwaite and colleagues (2009) found that among a small sample of individuals with psychosis who received a year long intervention with integrated compassionate mind training, significant benefits were apparent with respect to measures of social comparison, mood, shame, self-esteem, and overall well-being. Braehler and colleagues (2013) found significant clinical improvements and significant increases in compassion. Notably, significant increases in compassion were associated with decreases in depression and social marginalization ratings. For a description of the application of group CFT for recovery after psychosis, see Braehler, Harper, and Gilbert (2013).

While traditional treatments for psychosis have emphasized medication-based strategies, research indicates that individuals affected by psychosis can greatly benefit from psychotherapy. Working from a traditional CBT framework and integrating ACT, CFT, positive psychology and mindfulness approaches provides a humanistic, empowering and strengths orienting approach to enhancing the ability of those with lived experience of psychosis to move toward recovery and creating more meaningful lives.

For more information on this groundbreaking approach, check out ***Treating Psychosis: A Clinician's Guide to Integrating Acceptance and Commitment Therapy, Compassion-Focused Therapy, and Mindfulness Approaches Within the Cognitive Behavioral Therapy Tradition*** by Wright, Turkington, Kelly, Davies, Jacobs & Hopton.

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QUIET NARCISSISM: GETTING BEYOND THE ALOOF AND GUARDED WALL

DENISE D. DAVIS , VANDERBILT UNIVERSITY, NASHVILLE, TN, WENDY T. BEHARYTHE COGNITIVE THERAPY CENTER OF NEW JERSEY SPRINGFIELD, NJ

Wendy Behary, LCSW: Wendy Behary is the founder and director of The Cognitive Therapy Center of New Jersey and The New Jersey Institute for Schema Therapy. She is a distinguished founding fellow (and supervisor) of The Academy of Cognitive Therapy. She was also the President of the International Society of Schema Therapy (ISST) from 2010-2014, has co-authored several chapters and articles on schema therapy and cognitive therapy and is the author of (New Harbinger Publications - 2008 & 2013): "Disarming the Narcissist...Surviving and Thriving with the Self-Absorbed."

Denise D. Davis, PhD, is the Assistant Director of Clinical Training in Psychology at Vanderbilt University. She is a Founding Fellow of the Academy of Cognitive Therapy, a Fellow of the American Psychological Association, and certified by the Academy of Cognitive Therapy as a trainer, speaker and consultant. Davis was the founding Associate Editor of Cognitive and Behavioral Practice, and the first full term Editor. Her research and clinical interests include ethics, psychotherapy termination, and treatment of personality disorders. Her publication credits include co-editor with Aaron Beck and Art Freeman of the second and third editions of Cognitive Therapy of Personality Disorders, chapter contributions to each edition, as well as author of Terminating Therapy: A Professional Guide for Ending on a Positive Note.

Although personality disorders are characterized by specific beliefs, strategies and modes, many patients present clinical variations within and across these prototype composites (Beck, 2015; Fournier, 2015). For example, boasting, bullying and demanding attention are hallmark strategies of narcissistic personality disorder, yet some people show a very different pattern of narcissism by quietly cultivating a superior cover for their fragile self-image. These individuals project an image of cool self-confidence by suppressing and avoiding emotions, and pride themselves on rising above such "weakness". They are often highly ambivalent about therapy, and the reasons for their consultation might seem puzzling, as they rarely endorse any personal problems or distress. It's usually "*someone else's fault.*" We call this variation "quiet" or covert (Behary, 2013) narcissism.

Quiet narcissism can easily slip under the radar, making it difficult to accurately pinpoint core beliefs, early maladaptive schemas, overdeveloped strategies and even the degree of functional impairment. Conceptually, a narcissistic patient's attitude of superiority functions as a protection against the possibility of the *intolerable* experiences of lost entitlements or being regarded as weak, awkward, or inferior (Beck, 2015; Behary, 2013; Behary & Davis, 2015). Persons with overt narcissism are usually quite open about their desire for status and validation. Those with quiet or covert narcissism are more avoidant of emotional display in general, and may spend more time imagining the admiration they are due, and ruminating about how they aren't getting it. Their sense of superiority and specialness come from keeping a strong grip on their emotions and maintaining that they are unbothered by the kind of feelings that "ordinary" people might have, likely the result of growing up in an emotionally deprived environment—one that emphasized emotional control. They tend to believe that seeking attention and expressing emotions will make them "look bad," "too needy", or may even make them appear "narcissistic" (funnily enough), and thus they resist direct discussion of their feelings.

The emotional schemas proposed by Leahy (2002), in particular a simplistic view of emotion, guilt over emotion, and numbness, may be helpful in conceptualizing the key beliefs that underlie this individual's stance toward emotion. In particular, people who show this pattern of narcissism may tend to have a paradoxical view of validation and consensus. The experience of having their uncomfortable feelings validated by others, and connected to a sense of common human experience is perceived as a threat to their self-image as "different and special." This patient is inclined to feel distressed rather than relieved by the idea of being emotionally similar to others as it signals a loss of exception or entitlement.

Although they are aloof, persons with quiet narcissism aren't necessarily anxious around others, provided their sense of superiority isn't challenged. They build self-esteem through perfectionism, extreme benevolence or self-sacrifice, and may even take pride in "not needing" attention. The rewards of these efforts are often insufficient—since they don't really meet the underlying frustrated emotional needs—and this individual may be prone to discretely act out in ways that allow him or her to feel powerful, uniquely special, and less emotionally vulnerable. The acting out might include behaviors such lying, infidelity, disparaging others with contempt, social manipulations, unprovoked outbursts, or cynicism.

One key target in the treatment of this more subtle form of narcissism is helping the patient to develop skills for emotional awareness and the ability to recognize and differentiate their

(CONTINUED PG. 11)

beatings with enough violence to break bones, prolonged sleep deprivation, mock executions, various forms of sensory deprivation to include confinement in coffin boxes, prolonged standing and suspension from ceilings and door frames, and repeated waterboarding (i.e., perhaps the most controversial interrogation technique in which a person is immobilized by tying up the hands and feet while pouring water over a cloth covering the person's face, causing the experience of drowning).

The two individuals also personally conducted some of the interrogations in which they tortured some C.I.A. detainees. Although the two psychologists had no specialized knowledge of Al Qaeda or background in counterterrorism they earned tens of millions of US dollars for these services. According to the senate report, the effectiveness of these techniques was questionable. Furthermore, some of the prisoners apparently died as a result of the procedures.

As mentioned in the report, Mitchell and Jessen designed the interrogation program based on learned helplessness studies and the learned helplessness model of depression. According to Mayer (2009), these techniques were designed by military psychologists who had been training elite U.S. soldiers to resist torture, an effort that has been in existence in the military for decades in what is called the Survival, Evasion, Resistance and Escape (SERE) program.

In late 2001, both the CIA and the Pentagon first requested interrogation assistance from various SERE psychologists. Mitchell and Jessen agreed to reverse-engineer their torture-resistance training tactics into the so-called enhanced interrogation techniques. Essentially, the idea was to create a state of learned helplessness in prisoners in order to obtain intelligence information. There is some indication to suggest that executive board members of the American Psychological Association (APA), and possibly also former APA presidents, were involved in providing assistance with developing the enhanced interrogation techniques. It should be noted that neither Mitchell nor Jessen are APA members or members of ABCT or IACP.

There is further evidence suggesting that the APA might have bent its ethical guidelines to give psychologists permission to conduct such interrogations (Risen, 2014). In response, the APA commissioned an independent review into whether it colluded with the government's use of torture (The New York Times, December 16, 2014). These accusations are based than 600 e-mails that chronicled an online discussion from 2003 to 2006 among officials at APA, the CIA, and the White House under President George W. Bush (Risen, 2014). The source of these e-mails came from Scott Gerwehr, a contract researcher for the CIA who died in a motorcycle accident in 2008. After Gerwehr's death, these 600 e-mails were retrieved from his computer and shared with the FBI, Risen – a Pulitzer Prize recipient and author of the recent book on this topic (Risen, 2014) - and others by an unknown person (Bohannon, 2014).

A complaint filed against Mitchell to revoke his license to practice psychology failed. APA denied the allegations that it worked with the U.S. intelligence and defense officials by supporting torture techniques and bending its ethical code. Nevertheless, the APA recently hired a lawyer to examine this issue. APA's justification for this hire was to address the confusion Risen's book has created. "This confusion, coupled with the seriousness of the allegation, requires a definitive, independent and objective review of the allegation and all relevant evidence" (APA, 2014).

Although IACP has no involvement in the enhanced interrogation issue to the best of my knowledge, the issue strikes close to home, given the nature of the techniques. The question about ethics surrounding torture crosses borders and continents. ***Primum non necera*** (first, do no harm) is the Hippocratic Oath of the medical profession; psychologists and psychotherapists should adhere to it as well.

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STANDING ON THE SHOULDERS OF GIANTS

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only begun he career several years earlier. He had trained at Indiana University with James Dinsmoor who focused on operant conditioning in the animal laboratories and therefore, had little or no clinical experience. But a young associate professor of psychiatry, Stewart Agras, with whom Harold had recently teamed up to initiate a clinical research program, not only was a clinician, but had access to patients in the psychiatry inpatient and outpatient settings. Stewart had gone to medical school in London and completed his residency in psychiatry at McGill University in Montreal, and he brought with him a British empirical approach with an emphasis on careful observation and measurement and diagnostic precision that was very unusual in its day in North America dominated as it was by psychoanalytic theory and practice.

Having had the good fortune to work with Cautela, and then to spend a summer of intensive clinical training with Joe Wolpe in 1966, I was able to bring to the table some rudimentary knowledge of behavioral therapy techniques such as they were. Our new team was deeply interested in the possibility of applying operant methodologies to the clinic by studying individual patients utilizing repeated measurements and functional analyses. Over the next three years we met for two hours each day reviewing data from individuals with severe psychopathology who were most often hospitalized. These experiences contributed to the origins of single case experimental designs utilized in clinical settings (e.g. Barlow & Hersen, 1973). Stewart very much took to a behavior analytic approach and went on to become the editor of the journal *Applied Behavior Analysis*, the only psychiatrist to hold that position, as well as the president of the Association for the Advancement of Behavior Therapy (AABT, now the Association for Behavioral and Cognitive Therapy). Joe Cautela was also an early president of the AABT.

I could continue the story and talk about major figures who influenced my career after finishing training, particularly Tim Beck, as well as other colleagues and students, but that's another story and suffice it to say I was very fortunate during my graduate school years to have had a diverse and rich set of mentors who influenced me deeply.

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AN INTEGRATIVE, CBT-BASED TREATMENT APPROACH FOR PSYCHOSIS

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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 May 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.

Gilbert, P. (2009). *The compassionate mind: A new approach to life's challenges.* Oakland, CA: New Harbinger Publications.

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QUIET NARCISSISM

CONTINUED FROM PG. 9

interpersonal style with others, including use of language, posture, gesture, and other behaviors like interrupting, or becoming distracted by self-righteous thoughts. They may frustrate others with their emotional distance and ignore feedback about the hurtful impact of their neglectful response patterns, all while believing themselves to be generous, loving and attentive. In part, this is a function of poor internal awareness of emotions, theirs and others. Small pieces of psycho-education on the universality of emotions can be a first step in motivating their attention to their own internal experiences, i.e., *"We all have emotions and feelings Jæ... Yes, even you."* This might be followed by the installation of a mindfulness awareness practice. Are they able to spend any time quietly with themselves? Promoting an appreciation of emotions and emotionally informed patterns and reactions, as *useful* information, asks the patient to participate in the treatment by noticing and reporting on collected observations about themselves and others.

It may be useful to help this patient to explicitly distinguish between the concepts of self-reflection and self-reference. Self-reflection could be defined as openly looking for information, non-judgmentally, to understand one's emotional state and emotional impact on others. Self-reference might be defined as appraising and judging one's standing or performance relative to others. Persons with quiet narcissism spend quite a bit of time doing the latter, and are relatively unskilled in the former, given their (typical) underlying schemas of shame, inadequacy, mistrust, and isolation. Framing the notion of self-reflection as a tool for supporting one's "best" and "healthy" self, might make this challenging effort more acceptable, especially when commenced early in therapy. It may also help to focus initially on awareness of positive emotions, to encourage the self-reflection practice in a less threatening way.

Another target can be identifying which emotions to express and which to contain, with attention to levels of intensity and social reciprocity. For example, the quiet narcissist may show low expression of positive regard or warmth toward others, even though they endorse liking or loving someone. At the same time, they may expect significant displays of adoration from others toward them, despite their distance or other-negating behaviors.

Behavioral interventions such as structuring the practice of expressive positive statements and body language (including facial expressions) in session, to convey those warm emotions in a more exaggerated way, can serve two purposes. First, it helps to build a relevant vocabulary and practical communication skills that are essential to the "art" of validating and connecting with others. Second, this practice can trigger discomfort and elicit key beliefs, feelings, and reactions that are obstacles to this type of interpersonal behavior, such as "I'll look weak... She will use this to get the upper hand", or simply, "This feels awkward". With therapist facilitation of deeper discussion about beliefs and self-schemas, the patient begins to identify, make sense out of, and reorganize distorted meaning that is rigidly attached to early experiences imbedded in the emotional belief system. The links between current struggles and early life experiences become clearer, and the associated impulses can be cognitively and emotionally mediated.

A deeper schema to examine in therapy includes the belief that superiority, extreme self-sacrifice or holding a revered position will provide supreme happiness or a satisfying sense of self-worth. And although they don't actively seek approval from others—as is more the case with overt types—and don't seem to be reliant on constant admiration, these individuals still internally monitor their status through day-to-day and situation-by-situation social comparisons. The tension of this constant monitoring is exacerbated by a tendency to perceive others as failing to adequately recognize, love, or serve them. Suppressed anger and periodic temper tantrums and/or lying, stonewalling or other acting out may be problems that the patient does not identify as linked with this *(wounded)* experience of distress.

Although they may present with the, *"I couldn't care less"* attitude, the well of resentment or distress may run very deep.

Loving-kindness practice and self-other compassion become more feasible when the patient is willing to work on fostering an accepting relationship with their own emotions. The narcissist, whether overt or quiet, must first make way through the heavily barricaded door to connect with his own emotions before he can connect with another's.

What stance can help a therapist to work effectively with this hard to reach patient? Here are some tips.

- Be *real.* Share your smile, your warm, relaxed, and accepting face. This patient is more sensitive to possible social threats than they might appear. Your nonverbal signals will help them to be calmer in your presence even though they may not easily convey their appreciation early on. Sometimes they may even become suspicious of your "acceptance" as motivated by the fee for service bottom line, or you being a "nice" person to everyone (making them average and not special), or perhaps using them for some other purpose, like a case study. These reactions are largely linked to life themes emerging from deeply encrusted and unexamined experiences.

- Be *real.* Practice your own calming and self-regulating strategies to rid yourself of unnecessary distractions in the treatment room that lead to maladaptive responses. Be aware that this patient may activate schemas and therefore uncomfortable feelings in you, in response to their social signals of distance and mild (or greater) condescension.

- Be *real.* Hold them accountable for lying, being dismissive, and other disrespectful behaviors, by using a schema therapy strategy, empathic confrontation (Young, Klosko & Weishaar, 2006). For example, a therapist might say, "*I understand this type of emotional language makes you feel awkward Jæ... this was not a familiar or learned way of relating to others in your family of origin, in fact it was looked upon as weak and useless, but the truth is that this is really important Jæ; in fact it is likely the key to having a warmer and more constant connection to your partner."* From there, a therapist might explore the function of both the maladaptive and the adaptive behavior for their short and long-term best interests.

- Be *real.* You are already the expert with nothing to prove. Remind yourself of your skills, and look beyond the face value of this patient's overdeveloped strategy of acting superior and self-confident. They may sit in your office and act like they don't need you. In reality, they need your encouragement and confidence in the value of their participation in therapy. The focus of your work is in the workings of their emotional life, and helping them to reduce defensive distance from themselves and others. The therapy relationship *is* a strategy unto itself. Capture the moment-to-moment experiences that occur with you, ones that may represent the very obstacles in their relationships with others.

- Be *real.* This patient masks distress. You need to predict the truth about what might happen if they don't work with you to dismantle the "wall". Therapeutic leverage – the ability to engage the person in a therapeutic process based on consequences they do not want to face – is also likely found in their desire to be closer to others, to change something about how their life is working, or to finally achieve their elusive happiness or a sense of contentment. Consider the use of the narcissist's childhood photos to assist you in maintaining a grounded view of the narcissist as vulnerable at the core, while holding them accountable.

- Be *real.* Working with narcissistic patients, whether overt or covert, may be one of the toughest challenges we face in the treatment room. Engage in self-therapy, in supervision, and in continuing education about narcissism and the fragile world that lies beneath their facades.

The *quiet* narcissist harbors many of the same unmet emotional needs as his/her "louder" kindred counterpart. The difference in the manifestation of these protective and compensatory modes may lie in temperaments of shyness, inhibition, sensitivity, or passivity, matched with caretaking environments that run rife with the absence of adequate emotional nurturing and empathically attuned models of social engagement, thus arousing the fantasies that take place behind the wall—a fortress of guarded insecurities where grandiose and self-righteous beliefs permit the aloof and martyr-like masks to be worn as the sole representatives of identity and personality.

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