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IACP PRESIDENT'S MESSAGE STEFAN G. HOFMANN, PHD

CBT FOR BRAIN DISORDERS?

In a recent *Science* editorial entitled, *"Brain Disorders? Precisely"*, the director of the National Institute of the NIMH, Thomas Insel made the case for precision medicine in psychiatry (Insel & Cuthbert, 2015). Precision medicine is "a more targeted approach to disease...where molecular diagnosis is leading to better defined, individualized treatments with improved outcomes" (p. 499). The editorial further states:

> As new diagnostics will likely be redefining "mental disorders" as "brain circuit disorders," new therapeutics will likely focus on tuning these circuits... Paradoxically, one of the most powerful and precise interventions to alter such activity may be targeted psychotherapy, such as cognitive behavioral therapy, which uses the brain's intrinsic plasticity to alter neural circuits and as a consequence, deleterious thoughts and behavior (p. 500).

I am sure you are as pleased as I was that the head of the largest funding agency for mental health in the US (and world) recognizes the central role of CBT for the future of psychiatry. At the same time, I felt very uncomfortable equating psychiatric problems to brain disorders. Certainly, without a brain, there is no mind and also no mental disorder; and certainly, the brain is the center of our mental processes. However, reducing psychiatric problems to mere disorders of brain circuitries all but ignores context and the very fabric of human existence, such as culture, social factors, and interpersonal processes.

What was also notable in this editorial was Dr. Insel's use of the word "paradoxically" when making the link between effective interventions tailored to specific individuals and CBT. I do not see a paradox. CBT is fully consistent with the general approach of precision medicine. In part because of its ability to tailor treatments to individual problems, CBT has become one of the greatest success stories in psychiatry. For example, a recent review of the CBT literature identified 269 meta-analytic studies examining CBT for nearly every psychological problem (Hofmann, Asnaani, Vonk, Sawyer, & Fang, 2012). The results clearly demonstrate that CBT is an efficacious treatment. Similar results were reported earlier by Dr. Beck and colleagues (Butler, Chapman, Forman, & Beck, 2006).

The success of CBT in psychiatry may be surprising to some because CBT targets DSM-defined disorders, which are based on arbitrary criteria rooted in a latent disease model (including a biological "brain disease model"). The latent disease model of the DSM assumes that psychological problems

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ACT PRESIDENT'S MESSAGE
JOHN WILLIAMS, MD

Dear Members of the Academy and the IACP:

In addition to serving as the President of ACT, I work full-time as a child, adolescent, and adult psychiatrist in Bryn Mawr, PA, offering cognitive behavioral therapy to my patients. To function optimally in that role, I read multiple journals each week. With a full-time clinical load and other responsibilities—as we all have—it can be difficult, but the rewards of the literature are immense.

Just this week, I came across a review by Almeida et al. (2013) entitled, "The impacts of cognitive-behavioral therapy on the treatment of phobic disorders measured by functional neuroimaging techniques: a systematic review." This is a remarkable review, and I suggest you take a look. The article has many findings, but it demonstrates the considerable evidence supporting the use of cognitive behavioral therapy in phobic disorders. Briefly, phobias are associated with over-activation of brain areas including the amygdala, anterior cingulate cortex, and the insular cortex in response to phobic stimuli. The authors demonstrate that following successful cognitive behavioral therapy, reduced amygdala and insula activation, and increased orbitofrontal cortex activation are observed.

Although not surprising, these results are profound, as they show the neuroanatomical correlates of successful cognitive behavioral therapy. Put simply, CBT changes the brain in a demonstrable way.

You may sense what I'm getting at....

Despite the passage of The Mental Health Parity and Addiction Equity Act of 2008, mental health remains at least partly ghettoized outside of mainstream health care in the United States. The reasons are complex, but I suspect that a main driver of this isolation was the relative lack of evidence demonstrating the physiological effects of our treatments. Such has not been the case with the rest of medicine. When Fleming isolated penicillin, for example, he knew he had done so because the bacteria on the petri dish where the penicillin-generating fungi had grown were dead. Dead bacteria equaled effective antibiotic.

For many reasons, we were unable before the 1990s to demonstrate similar physiological correlates of our treatments, but this is all changing, and cognitive behavioral therapy is at the forefront. As the neuroscience and molecular biology to prove CBT's efficacy become more developed, the value of CBT will continue to increase, as will certification in the therapy. It is an exciting time to be a cognitive behavioral therapist and a member of the Academy.

As always, 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 P. Williams MD

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STANDING ON THE SHOULDERS OF GIANTS: AN INTRODUCTION TO MARSHA M. LINEHAN, PHD, ABPP

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

As Editor of *Advances in Cognitive Therapy*, it's always an honor (and treat!) to reach out to a giant in the field and invite him or her to contribute to this column by writing about the people and/or events that have been influences in his or her training. Long-time readers of *Advances* will recall that 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, Edna Foa, and most recently David Barlow.

For this issue, I truly am honored to introduce you to the next featured giant: **Dr. Marsha Linehan**. I was first introduced to Dr. Linehan by Bill Sanderson at a workshop lunch break in NYC, sometime in the late 90s. I was a graduate student working with Bill, who had put together the day-long workshop on "*Advances in CBT*" and a few lucky students were invited join them for lunch. I remember feeling starstruck at the time. I've since often found myself feeling like a "colleague-in-law" to Dr. Linehan, as I've spent more than a decade at Montefiore Medical Center working alongside Dr. Alec Miller, one of the world's authorities on adolescent DBT. But my biggest thrill came back in November 2013, when Dr. Linehan agreed, along with Dr. Steve Hayes, and Dr. Jerry Davison to participate on a clinical roundtable I was chairing, entitled, "*What have you changed your mind about?*" Needless to say, it was a thrilling and enlightening conversation to a packed room. I still think we should write it up!

Before you hear from her, here's a brief biography: Marsha Linehan PhD, ABPP, is Professor of Psychology and of Psychiatry and Behavioral Sciences and is founder and director of the Behavioral Research and Therapy Clinics at the University of Washington where her primary research is in the development and evaluation of evidence-based treatments for high suicide risk, multi-diagnostic and difficult to treat populations with severe mental disorders. Together with her graduate training program in treating high suicide risk and difficult to treat adolescents and adults and in collaboration with the non-profit Linehan Institute and Behavioral Tech Research, Inc. both of which she founded, she is also highly involved in developing effective means of disseminating evidence based behavioral treatments for high risk and difficult to treat populations and for all others who need them.

MARSHA M. LINEHAN, PHD, ABPP
PROFESSOR, DEPARTMENT OF PSYCHOLOGY
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I have always been interested in understanding and treating suicidal behaviors, primarily because I always wanted to help the people I believed to be "the most miserable in the world" and I thought suicidal individuals were the best example of this group. (I now believe that one can be as miserable as a suicidal person and not want to commit suicide).

I went to Loyola University as an undergraduate planning to be a psychiatrist at a public mental hospital. While completing pre-medicine studies I took an undergraduate course taught by **Patrick Laughlin**, who assigned us to conduct a research project and present at a conference. Shocked that this was possible for an undergraduate I did just that and got turned on to research by being reinforced for it. By my senior year, I had discovered that no one really knew how to treat mental disorders. Disenchanted with the social value of being a therapist I decided on a research career. When I discovered psychiatrists aren't ordinarily trained in research, I withdrew my medical applications and applied to psychology programs. **Pat Laughlin** told me clinical psychologists weren't well trained as scientists so I applied to social psychology programs. I was turned down.

STOP **crying** said the Chair **Ron Walker** (**my angel**) we will take you and give you a three-year National Defense Education Act fellowship. Not a research assistant and not working for a professor I was largely given free rein to do whatever I wanted. I soon became captivated by **Mischel's** personality book and **Bandura's** behavior modification book. Social learning was my new mantra and I carried their books with me everywhere. The social program told me that social learning was not a social psychology topic to study. The **Chair** let me switch to experimental personality theory and when I took my general exams, he gave me a gift question "**what is Mischel's theory**." I couldn't answer it. I had thought that everything he said was a fact and hadn't thought of looking for a theory. (This was one of my most important leaning events).

To continue with becoming a clinical researcher I applied to every USA postdoctoral clinical training program. I was turned down by every one. By chance at a suicide conference, I met the director of the Buffalo Suicide Crisis Center who was looking for a secretary. He hired me instead (since every paper I had ever written was on suicide) All I needed was for him to agree to give me a clinical internship certificate. I carried **Bandura** into every session I had with a suicidal person and my only claim to fame is that no one died. I got the certificate.

I finally realized I could not learn behavior therapy on my own, even with **Mischel**, **Bandura** and now **Statts**. I applied to the Stony Brook Post Doc program (saying I wanted to use behavior therapy to treat suicide) and miraculously was accepted. There I started a relationship with, by far, my most influential mentors, **Jerry Davison** and **Marv Goldfried**. I had no assessment, psychotherapy or clinical research training. Just about everything I know now I learned from them. **Jerry** got me on the board of AABT. I tramped behind both to meet the stars and from there I was on my way. I learned from the best.

I got my first job at Catholic University in D.C. (although the director, on sabbatical, said hire anyone but a behaviorist) I immediately starting visiting nearby **NIMH** where I got extensive mentoring in writing fundable clinical research studies from the **NIMH STAFF**. They continued to mentor me after I got a job at University of Washington. Without their help I would never have succeeded. Once my first suicide study was published, I was on my way again and here I am today.

(Although not an academic mentor, it goes without saying that my work would never have had such an impact without the consistent teaching of my longtime Zen teacher, **Zen Master and Benedictine Monk Willigis Jæger**.)

COMMENTARY ON "THE EFFECTS OF COGNITIVE BEHAVIORAL THERAPY AS AN ANTI-DEPRESSIVE TREATMENT IS FALLING: A META-ANALYSIS"

AARON T. BECK, MD AND SCOTT WALTMAN, PSYD, ABPP, ACT
UNIVERSITY OF PENNSYLVANIA

Aaron T. Beck, MD, is University Professor Emeritus of Psychiatry, Perelman School of Medicine, University of Pennsylvania, and the founder of cognitive therapy. He has published over 24 books and over 600 articles in professional and scientific journals. He has been the principle investigator for more than 26 grants from NIMH, NIA, and CDC and has been the recipient of numerous awards and honorary degrees. He is a senior member of the Institute of Medicine and recipient of its 2003 Sarnat International Award in Mental Health and 2007 Lienhard Award for contributions to Mental Health Services. He has also received the 2007 Lasker Clinical Medical Science Award, often regarded as "America's Nobel Prize." He is Director of the Aaron T. Beck Psychopathology Research Center at the University of Pennsylvania and Honorary President of the Academy of Cognitive Therapy.

Scott Waltman, PsyD, ABPP, ACT, currently works as a CBT trainer for the University of Pennsylvania's Beck Initiative where he is involved in the training of frontline clinicians in high-caliber high-fidelity CBT. He is also an Academy certified trainer/consultant and provides ongoing consultation to Los Angeles County clinicians involved in the current implementation project. Clinically, Dr. Waltman works from a cognitive case conceptualization-driven approach and strives to flexibly and compassionately apply cognitive and behavioral interventions to help people overcome the barriers in their lives, in order to facilitate building meaningful lives that are guided by passion and values.

There has been considerable discussion about the article: *The Effects of Cognitive Behavioral Therapy as an Anti-Depressive Treatment is Falling: A Meta-Analysis* (Johnsen & Friborg, 2015). The authors conducted a meta-analysis of 70 studies from 1977 to 2014, and found that the effect sizes for Cognitive Behavioral Therapy (CBT) for Depression have steadily decreased since its inception (see Beck, Rush, Shaw, & Emery, 1979; Rush, Beck, Kovacs, & Hollon, 1977). We, of course, have found this news to be concerning and have been taking a second look at the paper.

After reviewing the 70 studies that they analyzed we have several concerns about the validity of their conclusions. Chiefly, we call their selection of studies to analyze into question, due to (1) the heterogeneity of the experimental sample and (2) the inappropriateness of the control groups. Of the 70 studies they analyzed, 28 involved CBT being compared to itself or therapies containing major component of CBT. For example, the studies included involved comparisons between: individual CBT and group CBT, CBT in a randomized control trial and CBT in an outpatient clinic, traditional CBT and religiously modified CBT, individual CBT and behavioral marital therapy, etc. Additionally, five of the studies were of a modified CBT compared to something else (e.g., CBT with psychodynamic components versus something else), which may speak to a loose methodology. Further, we have concerns about their ability to infer the potency of CBT in studies where it is being compared to itself. Finally, it's bizarre to us that contrary to best practice procedures they included in their analyses no unpublished manuscripts, given how successfully CBT for depression has been disseminated.

Another possible confound that they were unable to measure well was therapist competence. Out of 70 studies only 5 reported sufficient data from the cognitive therapy scale. Consequently, they found no relationship between competence and the reported time trend. Some of the research our lab published this past year (Creed, Wolk, Feinberg, Evans, & Beck, 2014) showed that a clinician's self-report of doing CBT may not be a good predictor of their being skilled in (or adherent to) CBT. We wonder about the caliber of the CBT in some of the reviewed studies. A number of them included atypical components such as meeting every other week or only meeting for 4-6 sessions. Many studies did not adequately describe their treatment procedures.

Consistent with our orientation as cognitive therapists is an empirical mindset. The recent findings are certainly interesting and we want to understand more about why these results were obtained. What makes this tricky is that the term "CBT" can refer to Beckian Cognitive Therapy or a whole range of therapies that may or may not align with the original model. We have seen many treatment manuals that fail to understand key CBT principles such as the importance of cognitive case-conceptualization, guided discovery, and the therapeutic relationship. It seems that the term "CBT" may be losing its specificity, which is why we encourage those who identify as CBT therapists to seek peer-review and certification through organizations such as the Academy of Cognitive Therapy.

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CBT IN ARGENTINA

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FAVALORO UNIVERSITY

Rafæl Kichic is the Director of the Anxiety and Trauma Clinic at the Institute of Cognitive Neurology (INECO) and Associate Professor at the School of Psychology, Favaloro University in Buenos Aires. In 1999, he graduated with honors at the University of Buenos Aires and received his PhD at Palermo University. He received extensive training at the Center for the Treatment and Study of Anxiety and visited the Center for Cognitive Therapy at the University of Pennsylvania. He works as a prolonged exposure supervisor in a randomized controlled trial for Hispanics with PTSD funded by the NIMH.

For many years, Argentina was famous for psychoanalysis. In fact, two decades ago it was difficult to find a graduate course in cognitive-behavioral therapy (CBT), let alone an undergraduate class. In 2000, fewer than 1 percent of the psychologists in the city of Buenos Aires adhered to a CBT framework (Muller & Palavezzatti, 2000). Since more than 46.9 percent of the psychologists in my country practice in Buenos Aires (Alonso & Klinar, 2013), adherence to CBT was likely negligible in the rest of the country as well (Muller & Palavezzatti, 2000).

When I was in college, the terms "cognitive behavior therapy" or "cognitive therapy" were hardly, if ever, mentioned by my professors at the University of Buenos Aires, the nation's largest school of psychology (Alonso & Klinar, 2013). We have witnessed a dramatic shift over recent years, however, and CBT is now a strong player in a field where psychoanalysis clearly once dominated. Many factors have converged to allow CBT to flourish in Argentina.

One reason CBT is more popular now is that it offers effective procedures for treating specific disorders, a feature difficult to resist for a novice clinician. As training resources from internationally renowned scholars such as Beck, Foa, Padesky, and Linehan have become available in Spanish, clinicians have begun to adopt these effective, empirically validated strategies. Availability of materials in Spanish has been extremely important for boosting dissemination, implementation, and research in CBT (Kichic, Vera, & Reyes-Rabanillo, 2011). As in the US and Canada (Cook, Schnurr, Biyanova, & Coyne, 2009), Argentine clinicians seem more likely to adopt a new approach if they have access to low-intensity and low-cost training materials that describe the intervention (McHugh & Barlow, 2012).

Another factor contributing to the increasing popularity of CBT is the fact that there are more and more workshops offered in Buenos Aires by international experts. Organized mainly by private institutions (e.g., Center for Cognitive Therapy, INECO Foundation, AIGLE Foundation, Foro Foundation) and associations (e.g., Argentinian Association of Anxiety Disorders), these workshops make it easier for clinicians to learn new approaches without leaving Argentina. One example is the upcoming conference featuring CBT for Social Anxiety by Dr. Stefan G. Hofmann, organized by the AIGLE Foundation this month. Finally, the internet has made training in cognitive behavioral therapy more accessible, with webinars and easy email access to colleagues across the world.

The Argentinian Association of Cognitive Therapy (AATC) has taken the lead in disseminating CBT as an alternative to the prevailing psychodynamic model. Founded in 1991 by a group of therapists working in private institutions who were interested in providing and teaching CBT (Korman, 2011), the AATC unites an increasing number of therapists interested in CBT, contributing to the development of CBT in Argentina through workshops and certification for cognitive behavioral therapists.

Because of the increasing public demand for CBT interventions, a major shift has occurred in the academic community as well. Most universities, including the University of Buenos Aires (Alonso & Klinar, 2013), now offer graduate programs in CBT as well as undergraduate classes. Although the majority of undergraduate courses are still psychodynamically oriented, some schools are increasingly adopting a scientist-practitioner model, which inevitably favors the dissemination of evidence-based treatments. In addition, private institutions offer training programs that reflect the array of models included under the umbrella of CBT. For example, the Foro Foundation currently offers graduate programs and clinical trainings in dialectical behavior therapy, in conjunction with the Linehan Institute's group, Behavioral Tech.

Needless to say, it's an exciting time for the dissemination of CBT in Argentina. Given that most of our psychologists adhere to a psychoanalytic theory or integrate a psychoanalytic theory with other theoretical approaches (Muller, 2008), a major challenge is to teach CBT with a special emphasis on its theoretical underpinnings and in a context that stimulates research consumption and production. One such attempt is the recently established undergraduate psychology program at Favaloro University. This program focuses largely on the scientist-practitioner model, drawing heavily on a multidisciplinary view. The program provides a strong foundation of neuroscience, research methodology, CBT and other evidence-based interventions.

Obstacles remain. For example, many clinicians lack access to training and supervision opportunities, due to issues of language, geographical distance, and financial cost. One way to improve the

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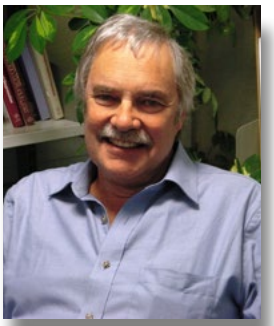

INTRODUCING COMPASSION FOCUSED THERAPY

PROFESSOR PAUL GILBERT, PHD, FBPSS, OBE

DERBY UNIVERSITY

Paul Gilbert is Prof of clinical psychology at Derby University. He was president of BABCP in 2002-3. His research interests have been in shame and self-criticism that underpin many chronic mental health problems. He has published over 200 papers and books chapters and 20 books. It was in trying to develop improved interventions for high shame and self-criticism that he developed compassion focused therapy. He received an OBE in March to 11 for his contributions to mental health.

Compassion focused therapy was born out of clinical observations and scientific findings. The clinical observation was that many complex and chronically depressed people had difficult backgrounds and often lacked much in the way of affection or a secure base. Some depressed people could become very good at generating cognitive alternatives to depressing thoughts but didn't actually feel better as a result. Back in the 80s I started to explore with people "how they experienced and heard" those alternative thoughts in their minds. It turned out that while they could generate realistic alternative thoughts they often heard them with a very hostile tone. In fact, it was extremely difficult for these individuals to generate validating, friendly and helpful internal tones to their 'helpful' thoughts. This was sometimes linked to their backgrounds of lacking much in the way of internalised caring others.

So for example, imagine generating an encouraging set of thoughts such as: "if I get out of bed, do some yoga movements perhaps, then go and make myself a cup of tea. this will help me – rather than lying in bed and ruminating." Now read this through in a hostile, contemptuous tone. Really note what that feels like. Then slow the breath, speak slowly, trying connecting to your motivation to be helpful, and try and generate as much kindness and understanding as you can in the tone of your thoughts. You will have a very different experience of exactly the same alternative thoughts. So working on creating an inner experience of friendliness and kindness, right at the emotional level, and welding that into the cognitive behavioural interventions was the beginning of CFT.

The last 20 years has generated extensive evidence that prosocial emotion and motivation have very major impacts on how our brains work. We know, for example, that there are different types of positive emotion. One form is activating and stimulating and works with the sympathetic nervous system. The other is very different , is associated with calmness, soothing, contentment peacefulness and feeling safe operates through the myelinated parasympathetic. Of special interest is that this calming and soothing is also linked to affiliative signals. So, for example, if a child is distressed, the care and kindness of the parent soothes them by the activation of the parasympathetic system and also hormones like oxytocin. These are crucial for helping to regulate threat. They can operate through non-cognitive pathways, via direct stimulus response contingencies.

Until recently psychotherapies did not try to understand the very different roles that the different positive emotions play in affect regulation, and in particular the role of affiliation and the parasympathetic system. CFT, however, has always been very rooted in evolutionary neuroscience approaches to motivation and affect regulation. So CFT focuses on various trainings that can be used for stimulating prosocial and parasympathetic/oxytocin activation.

CFT utilises an evolutionary model for formulation and also offers a series of exercises for stimulating different motivational and neurophysiological systems. For example, there is good evidence now that helping people cultivate a compassionate self-identity, in how they relate to self and others, has major impacts on emotional and social well-being. CFT focuses on creating the compassionate identity which has wisdom (that comes from understanding the model and the evolution of mind itself) strength (that is rooted in body grounding) and commitment (that is rooted in motivation development). With the orientation and cultivation of compassionate self-identity, individuals are encouraged to create that sense of self when dealing with difficulties or engaging in cognitive behavioural interventions.

CFT is an integrative therapy that utilises many evidence-based interventions. These include: building a collaborative therapeutic relationship, utilising Socratic dialogues, guided discovery, identifying and providing a functional analysis of safety behaviours, focusing on avoidance, agreeing and developing appropriate exposure programs. In addition CFT teaches inference chains, re-appraisal, behavioural experiments, attention training and mindfulness, empathy/metallization, distress tolerance, social skills/ effectiveness training, body/emotion awareness, breath training, imagery practices, supporting maturation, developing homework for out of session practices -- These are just examples. CFT also draws on contemplative traditions from the different 'schools' and in particular some of the core exercises developed for compassion cultivation (Gilbert & Choden, 2013).

The unique characteristics of CFT are:

- Psycho-education on evolved 'tricky' brain
- Model of affect regulation with special focus on affiliation and the parasympathetic system
- Specific focus on self-criticism and self-conscious emotions

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CBT FOR BIPOLAR DISORDER: WHAT DOES THE LITERATURE TELL US?

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Cory F. Newman, Ph.D., ABPP is Director of the Center for Cognitive Therapy, Professor of Psychology, in Psychiatry at the University of Pennsylvania Perelman School of Medicine, and Adjunct Faculty at the Beck Institute for Cognitive Behavior Therapy. Dr. Newman is a Diplomate of the American Board of Professional Psychology, and a Founding Fellow of the Academy of Cognitive Therapy. Dr. Newman is the lead author on the text, Bipolar Disorder: A Cognitive Therapy Approach.

Bipolar disorder, a serious, chronic mood disorder which often is described and classified across a "spectrum," has traditionally been treated somatically, most often pharmacologically. Indeed, this approach has been part of the standard of care in all but the most atypical cases. That said, there is an extensive literature on psychosocial factors pertinent to bipolar illness, as well as psychosocial treatments that augment pharmacotherapy and increase overall treatment efficacy. The following is a non-exhaustive summary of some of the most important and robust findings to date on cognitive-behavioral factors and therapy for this area of clinical concern.

- A thorough, structured assessment is indicated in order to confidently diagnosis a bipolar spectrum disorder. This is especially relevant for children and adolescents, where both false positives and false negatives in diagnosis readily occur in routine practice.

- Risk of suicide is a major concern with this population. Regular suicide assessment is highly recommended, and when patients are absent from treatment it is good practice to be proactive in reaching out to them in order to help them receive the care they need.

- Regardless of the bipolar patients' mood phase, an extreme attributional style confers a heightened degree of difficulty in treatment, and warrants special attention in CBT.

- Bipolar patients who demonstrate a marked increase in goal-directed behaviors are at increased risk for a hypomanic or manic episode, especially if their activities significantly interfere with getting adequate sleep. The CBT technique of activity scheduling and monitoring can be used to do behavioral experiments in *reducing* activities, such as by converting "low-priority" activities into times for rest.

- In general, it is very useful to teach bipolar patients to engage in regular self-monitoring as an ongoing homework assignment. For example, they can monitor their moods, sleep-wake cycle, and activities. This not only improves clinical data collection, but also gives patients a sense of empowerment in their treatment.

- A number of randomized controlled trials have shown that rates of symptomatic relapse can be significantly reduced even with short-term CBT, especially if bipolar patients learn to recognize prodromal signs of symptom episodes and to implement a coping plan (e.g., increasing the frequency of CBT sessions, soliciting social support, engaging in planned activities, and actively using cognitive skills that had previously been rehearsed).

- Nevertheless, as bipolar disorder is a longitudinal illness, booster sessions should be utilized whenever feasible, and repeated periods of re-entry into regular CBT should be considered in light of the recurring nature of symptom episodes.

- CBT can be used efficaciously in both a standard "relapse prevention" model, as well as in a "recovery focused" model that utilizes individualized case conceptualization and addresses comorbidity issues. Focusing on patients' personal goals, improving their quality of life (i.e., not just reducing symptoms), and working against self-stigmatizing beliefs are important parts of treatment.

- There is evidence that CBT has its best therapeutic impact if used earlier in the course of the illness. There is less evidence for the efficacy of CBT in patients who are late in the course of the illness. Nonetheless, CBT has been applied to older patients with bipolar illness in order to reduce suffering and disability, and to offer constructive support.

- Even when patients are officially assessed to be in an inter-episode period of wellness, their residual sub-syndromal symptoms can reduce their quality of life and cause much consternation. CBT practitioners must be sensitive to this phenomenon, and be empathic about the patients' struggles with remaining hopeful and maintaining the motivation to participate in treatment fully. Few things are as demoralizing as collaborating optimally with the treatment plan and yet still experiencing breakthrough symptoms.

- On a more hopeful note, CBT not only improves patients' coping and problem-solving skills (thus lowering stress levels that otherwise would be a risk factor for the activation of symptom episodes), it also helps address the patients'

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ONE LAST TIME! IS LEADERSHIP BORN OR MADE?

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Dr. Barling is the Borden Chair of Leadership at Queen's School of Business (Kingston, Ontario). He is the author of The Science of Leadership: Lessons from Research for Organizational Leaders (Oxford University Press, New York, 2014). Dr. Barling's research interests focus on the development of leadership, and how leaders' mental health affects the quality of their leadership

A question as old as the ages: Is leadership born or made? And a response that could only come from an academic: that depends on what leadership is. Why? Three very different aspects of leadership have been studied for close to a century: (1) who becomes a leader, (2) the behaviors and styles that existing leaders manifest and (3) leader effectiveness (i.e., the outcomes of leadership behaviors). Research on whether leadership is born or made have almost exclusively addressed the question of who holds a leadership position in the first instance. Research on this question started well before the end of World War 2, a time when identifying the right leader was often an issue of life or death, and Stogdill (1948) identified two broad findings (which have been remarkably robust across time) from more than 100 quantitative articles published by the end of World War 2.

First, research findings had already isolated the role of individual difference variables, or traits (e.g., extraversion, originality, self-confidence) and affect (e.g., self-control, emotional and mood control) before World War 2. The role of individual differences in leader emergence remains a popular topic for research (e.g., Bono & Judge, 2004), and three broad conclusions can be drawn. Individual differences such as extraversion (1) consistently predict leader emergence, (2) but the variance explained is typically weak at best. (3) Gender remains the most significant individual difference predictor of holding a leadership position, a phenomenon which becomes more pronounced higher in organizations (Barling, 2014).

Second, ascribed (rather than earned) status is a robust indirect predictor of later leader emergence. Socio-economic status either provides (or limits) critical developmental opportunities, for example the quality of schooling and roles models to whom children are exposed, which themselves directly predict whether who will assume a leadership position. Findings such as these, which reinforce within-status leader emergence and the appearance of an intergenerational transmission of leadership phenomenon, tend to leave many observers believing that leadership must be something people are "born with".

Perhaps not surprisingly, most research now focuses on genetic or neuroscientific explanations of leadership emergence. Twin studies over the past decade certainly point to the role of genetic factors in leader emergence. After appropriate statistical controls, genetic factors account for approximately 20-30% of the variance in leader emergence—substantially more than any individual difference variable studied, including personality or gender. At least two studies have now isolated specific genes, with Li et al. (in press) showing in separate samples that the DAT1 10-repeat allele indirectly affects leader emergence through its positive effects on moderate rule breaking, and its negative effects on proactive personality.

Complicating the issue for anyone ready to conclude that leadership is something you are born with, meta-analyses of well over 100 studies conducted over at least six decades across different countries show that leadership can indeed be taught (Avolio et al., 2009). Importantly from a practical perspective, this study shows that not only are leadership interventions effective, they are usually cost-effective too.

To conclude, is leadership is born or made? Both! And we should not be surprised. As with any complex social behavior, searching for simple answers to complex questions might satisfy the need for cognitive simplicity, but will always limit our understanding, and this is true for leadership emergence. Who becomes a leader is the result of multiple different determinants, and our understanding of leader emergence will be now expanded by crossing disciplinary boundaries and investigating the effects of gene-environment interactions.

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IACP'S PRESIDENT'S MESSAGE

CONTINUED FROM PG. 1

are expressions of specific latent disease entities. For example, feelings of low mood and fatigue are assumed to be expressions of one or more latent diseases (e.g., depression and anxiety). Because many of these diagnostic categories of the DSM are defined based on similar and sometimes identical symptoms, patients often show comorbid disorders. The latent disease model evolved from the hope that specific medications would eventually be discovered to treat these medically-defined and biologically-based disorders.

CBT does not rule out the possibility that biological factors contribute to the problem. However, we do not assume that psychological problems can be reduced to biological dysfunctions and that such dysfunctions fully account for these problems. Moreover CBT makes the critical distinction between ***initiating*** factors (i.e., factors that contribute to the development of a problem) and ***maintaining*** factors (factors that are responsible for the maintenance of a problem). These two factors are typically not the same. Unlike other models of mental disorders (including psychoanalysis), CBT is much more concerned about the maintaining factors of problems and much less concerned about the possible initiating factors. This is because understanding the maintaining factors is of far greater clinical importance than knowing the initiating factors. For this reason, CBT is focused on the functional relationship between factors in the here and now rather than the past.

In conclusion, I am thrilled that CBT finally receives the recognition it deserves from psychiatry, neuroscience, and major funding agencies. However, we need to be mindful of any misconceptions some of our friends from neighboring disciplines might hold. The solution is to educate – no matter whom that might be.

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COMMENTARY ON THE EFFECTS OF COGNITIVE BEHAVIORAL THERAPY

CONTINUED FROM PG. 4

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COMPASSION FOCISED THERAPY

CONTINUED FROM PG. 6

- Build compassion-focused motives, competencies and identities as inner organising systems
- Work with fears, blocks and resistances to compassion and positive emotion.

Further Reading

Germer, C. K., & Siegel, R. D. (2012). Wisdom and compassion in psychotherapy. New York, NY: Guilford

Gilbert, P. (2009). *The Compassionate Mind: A New Approach to the Challenge of Life.* London: Constable & Robinson.

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Hoffmann S. G., Grossman, P., & Hinton D. E. (2011). Loving-kindness and compassion meditation: Potential for psychological intervention. *Clinical Psychology Review,* 13, 1126–1132.

Keltner, D., Kogan, A., Piff, P. K., & Saturn, S. R. (2014). The sociocultural appraisals, values, and emotions (SAVE) framework of prosociality: Core processes from gene to meme. *The Annual Review of Psychology,* 65, 425–460.

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problematic beliefs about medication, leading to greater adherence to pharmacotherapy. Rather than being two parallel tracks of treatment, CBT and pharmacotherapy can be synergistic.

- The therapeutic relationship in CBT for bipolar disorder is enhanced when the therapist demonstrates the ability to empathically acknowledge the patient's real losses in life, and yet successfully promotes and maintains hopefulness and a sense of positive direction.

- Three major psychosocial treatment models for bipolar disorder – cognitive-behavioral therapy (CBT), family-focused treatment (FFT), and interpersonal social rhythm therapy (IPSRT) have been shown in a major, multisite effectiveness study (the Systematic Treatment Enhancement Program for Bipolar Disorder; STEP-BD) to be equivalent in outcome, and all superior to treatment-as-usual when used with pharmacotherapy for bipolar disorder. There is a great deal of compatibility and complementarity in these three empirically-supported psychosocial treatments, and it has been suggested that a "hybrid" treatment combining the best of these respective methods may be developed in the future.

There is much more to be said about CBT for bipolar illness. There are a number of widely used clinical texts on this subject, as well as extremely useful CBT "take-home guides" for bipolar disorder sufferers and their families. There is ever-increasing hope of achieving favorable results in treating bipolar illness via our diligent use of CBT methods, combined with ongoing collaborative consultations with the prescribing psychiatrist (or other pharmacologist on the case), along with the use of top-notch CBT self-help literature for the patients themselves.

Key Studies

Jones, S. H., Smith, G., Mulligan, L., Lobban, F., Law, H., Dunn, G...& Morrison, A. P. (2014). Recovery-focused cognitive-behavioural therapy for recent-onset bipolar disorder: Randomised controlled pilot trial. *British Journal of Psychiatry*, DOI: 10.1192/bjp.bjp.113.141259

Lam, D.H., Hayward, P., Watkins, E., Wright, K., & Sham, P. (2005). Relapse prevention in patients with bipolar disorder: Cognitive therapy outcome after two years. *American Journal of Psychiatry, 162*, 324-329.

Miklowitz, D.J., Otto, M.W., Frank, E., Reilly-Harrington, N.A., Wisniewski, S.R., Kogan, J.N., et al. (2007). Psychosocial treatments for bipolar depression: A 1-year randomized trial from the Systematic Treatment Enhancement Program. *Archives of General Psychiatry, 64*, 419-427.

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Scott, J., & Colom, F. (2005). Psychosocial treatments for bipolar disorders. *Psychiatric Clinics of North America, 28*, 371-384.

Key Texts

Frank, E. (2005). *Treating bipolar disorder: A clinician's guide to interpersonal socialrhythm therapy.* New York: Guilford Press.

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Key Self-Help Books

Basco, M. R. (2006). *The bipolar workbook: Tools for controlling your mood swings.*New York: Guilford Press.

Bauer, M. S., Kilbourne, A., Greenwald, D., & Ludman, E. (2009). *Overcoming bipolar disorder: A comprehensive workbook for managing your symptoms and achieving yourlife goals.* Oakland, CA: New Harbinger Publications.

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CBT IN ARGENTINA
CONTINUED FROM PG. 5

availability of top-notch training would be to develop internet-based training programs in Spanish, as well long-distance supervision. Argentina's fledgling CBT community will continue to expand as these resources become more available. As the next generation of therapists – the first exposed to these techniques -- reaches maturity, it is likely that the popularity of CBT in Argentina will continue to grow.

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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 September 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.