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**EDITOR**
Simon A. Rego, PsyD, ABPP, ACT




## ACT PRESIDENT'S MESSAGE

**JOHN WILLIAMS , MD**

Dear Members of the Academy:

Recently, on a welcome day off from my clinical and administrative responsibilities, I came across a story about a correctional facility in San Diego that, in an attempt to provide rehabilitation to offenders who are also veterans, is using a course known as Thinking for a Change. Created and revised since 1998 by the National Institute of Corrections, this program uses the precepts of cognitive behavioral therapy to reduce the risk of recidivism.[1]

I find this to be quite interesting. In addition to being the President of the Academy, I also sit on the Pennsylvania Board of Pardons, an organization mandated by my state's Constitution to evaluate applicants for clemency and commutation, and to recommend the same to the Governor. In evaluating these cases, I see countless stories of perpetrators with behaviors driven by automatic thoughts that lead to arrest, conviction, and incarceration.

This has often made me wonder how much less need States for a massive correctional system we would have in the United if the concepts behind cognitive behavioral therapy were taught in elementary, middle, and high school, along with math and social studies. Alternately, if cognitive behavioral therapy were regularly used in our prisons, we would likely have many fewer repeat offenses after release.

For example, if we assume that abuse offenders have themselves been traumatized, it would make sense that treating the underlying trauma using cognitive behavioral therapy would reduce symptomology. A 2012 study suggests exactly that.[2]

In another study use of CBT alcohol treatment programs for inmates in the United Kingdom resulted in a significant reduction in recidivism.[3] In New York City, the CBT-based Beyond the Bridge program has been shown to reduce both suicidality and recidivism.[4]

These results make sense. It has been shown that CBT, when provided to those with generalized anxiety disorder, is associated "with attenuated amygdalar and subgenual anterior cingulate activation to fear/angry faces and heightened insular responses to the happy face comparison condition." [5] Put another away, CBT is likely to lead to much less emotional reactivity in the face of perceived threats, and less emotional reactivity is likely to lead to less violence from the subject to himself or others.

In short, we should remember that CBT

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## IACP PRESIDENT'S MESSAGE
## STEFAN G. HOFMANN, PHD

As you know, Mehmet Sungur was recently elected as our next president. In addition, David Clark, Nikolaos Kazantzis, and Henrik Tingleff recently joined the board. Julie Snyder took over as our new coordinator. I thought this would be a good opportunity to introduce each board member to our membership. So I asked all of our members to send me a half-page biosketch, and here they are (in alphabetical order):

David A. Clark received his Ph.D. from the Institute of Psychiatry, Maudsley Hospital, University of London in 1984 and is currently Professor Emeritus, Department of Psychology, University of New Brunswick, Canada. In 1987-88 he completed postdoctoral training in cognitive therapy at Aaron T. Beck's Mood Clinic in Philadelphia. He has published over 150 scientific articles and papers on cognitive theory and therapy of depression and anxiety disorders with funding obtained from the Social Sciences and Humanities Research Council of Canada, Canadian Institutes of Health Research, and the Foundation for Cognitive Therapy. He has coauthored several peer-reviewed papers and books with Dr. Beck including "Scientific Foundations of Cognitive Theory and Therapy of Depression" (Wiley, 1999), Cognitive Therapy for Anxiety Disorders (Guilford, 2010), and The Anxiety and Worry Workbook (Guilford, 2012), as well as single authored works such as Cognitive Behavioral Therapy for OCD (Guilford, 2004) and The Mood Repair Toolkit (Guilford, 2014). David continues to offer training workshops worldwide on cognitive behavior therapy for depression, OCD and other anxiety disorders, and maintains a part-time private practice. He is a Founding Fellow of the Academy of Cognitive Therapy, and recipient of the Aaron T. Beck Award for Significant and Enduring Contributions to Cognitive Therapy in 2008. For further information visit: www.davidclarkpsychology.ca.

Stefan G. Hofmann is Professor of Psychology at Boston University, where he is the Director of the Psychotherapy and Emotion Research Laboratory. Stefan was born and raised in Germany. He came to the US in 1991 and has been calling Boston his home since 1996. He is currently IACP president and was ABCT president between 2012 and 2013 and Representative-at-Large for academic and professional affairs between 2008-2010. He was the recipient of ABCT's 2010 Outstanding Service Award, the 2012 Aaron T. Beck Award for Excellence in Contributions to CBT by Assumption College, and the 2015 Aaron T Beck Award by the Academy of Cognitive Therapy. He is also a Founding Fellow of the Academy of Cognitive Therapy (ACT) and is an ACT supervisor and trainer. He is presently editor-in-chief of *Cognitive Therapy and Research* and associate editor of the *Journal of Consulting and Clinical Psychology*. Stefan has published widely as an author of more than 250 peer-reviewed journal articles and 15 books, including *An Introduction of Modern CBT* (Wiley-Blackwell) and *Emotion in Therapy: From Science to Practice* (Guilford Press). He has been identified as a Highly Cited Researcher by Thomson-Reuters' Institute for Scientific Information. His research focuses on the mechanism of psychological treatment change, emotion research, translating discoveries from neuroscience into clinical applications, and cultural expressions of psychopathology. Stefan has been awarded generous research grants from the NIMH and NARSAD. He lectures internationally, is a licensed psychologist, and is married with two children. For further information visit: http://www.bostonanxiety.org/

Nikolaos Kazantzis is Director of the Cognitive Behavior Therapy Research Unit and Associate Professor in Clinical Psychology at the Monash Institute for Cognitive and Clinical Neurosciences in Australia (http://www.med.monash.edu.au/psych/cbtru/). He is also a practicing clinical psychologist and provides individual and group therapy and specialist supervision. Dr. Kazantzis received post-doctoral training in cognitive behavior therapy in the early 2000s at the Beck Institute under the direct teaching of Aaron T. Beck, M.D., and Judith S. Beck, Ph.D. He returned to Philadelphia in 2012 to receive the Beck Scholar Award for "*significant contributions to the field of cognitive therapy*", when he again received direct teaching from Aaron T. Beck, M.D., and Judith S. Beck, Ph.D. at the Beck Institute, and direct supervision under Cory Newman, Ph.D. at the University of Pennsylvania. Dr. Kazantzis has over 100 scholarly publications, including three books on the theory, research, and practice of cognitive behavior therapy, which have been translated into several languages. Dr. Kazantzis' fourth book "*The Therapeutic Relationship in Cognitive Behavior Therapy*" is currently in press with Guilford publishers of New York. He has developed training programs for over 6,000 professionals, and has presented workshops on the practice of cognitive behavior therapy in 20 countries. Dr. Kazantzis serves as Editor-in-Chief for the Australian Psychological Society's flagship professional practice journal "*Australian Psychologist*", and serves as Associate Editor for "*British Journal of Clinical Psychology*", "*Cognitive Therapy and Research*" and "*International Journal of Cognitive Therapy.*" Dr. Kazantzis is Deputy Chair of the scientific committee for the upcoming World Congress of Behavior and Cognitive Therapies (WCBCT 2016 http://www.wcbct2016.com.au/committee/), Australian delegate and board member for the International Association for Cognitive Psychotherapy.

Lynn McFarr is the Director of the Cognitive Behavioral/Dialectical Behavior Therapy Clinic, and Past Chief Psychologist/Director of Clinical Training at Harbor-UCLA Medical Center. She is also a Professor of Health Sciences in the Department of Psychiatry for the David Geffen School of Medicine and the

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## STANDING ON THE SHOULDERS OF GIANTS: AN INTRODUCTION TO ISAAC MARKS M.D., FRCPSYCH

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

Since taking over as Editor of *Advances in Cognitive Therapy*, my goal has been to have each issue feature a giant in the field writing about the people and/or events that have been influences in his or her training. Thus far, we've been lucky enough to have 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, David Barlow, and most recently, Marsha Linehan.

For this issue, I present to you *Dr. Isaac Marks*. In the event any of you are not familiar with the work of this world-renowned psychiatrist, I think it's fair to say that if you have any interest and/or experience in CBT for anxiety disorders, then it's likely you've been influenced by his research. In addition to this, he has been a leader in developing and studying various forms of computer-guided CBT (CCBT) for a variety of anxiety disorders, was influential in the creation of Triumph Over Phobia ("TOP UK") - a UK-registered charity which aims to help sufferers of phobias, obsessive compulsive disorder and other related anxiety to overcome their fears and become ex-sufferers, and was a founding member of the British Association for Behavioural and Cognitive Psychotherapies (BABCP).

Before you hear from him, here's a brief biography: Isaac Marks grew up in Cape Town and qualified with MB, ChB degrees at the University of Cape Town. He went to London in 1960 to qualify in psychiatry at the Institute of Psychiatry and the Bethlem-Maudsley Joint Hospital, and obtained the Academic DPM at the Institute in 1964. He became MRCPsych in 1971 and FRCPsych in 1976. The research for his MD dissertation was done at the Institute of Psychiatry in London and was published as a Maudsley Monograph (Patterns of Meaning in Psychiatric Patients, OUP, 1965). He has published 17 books and over 450 scientific articles.

## STANDING ON SHOULDERS OF GIANTS ISAAC MARKS

In 1962, during a 4-year psychiatry internship at the Bethlem-Maudsley Hospital and the Institute of Psychiatry (which became part of the University of London in 2000) Michael Gelder, Jack Rachman and Monty Shapiro introduced me to behaviour therapy for phobic and obsessive-compulsive disorders. Initially this involved Joe Wolpe's method of desensitisation in fantasy, in which patients were taught to relax while imagining anxiety-evoking scenes gradually up a fear hierarchy. This yielded improvement, but slowly.

When visiting North American psychotherapy units in 1967 I also saw Morrie Baum's research in Montreal. He conditioned rats to escape shocks delivered on the floor of a cage by jumping onto a ledge at the side as soon as they were placed in the cage. If the ledge was removed and the shocks ceased the rats still jumped about but soon learned that they got no more shocks even when they remained on the floor of the cage, and then stayed there calmly. An analogous procedure in phobic patients was to persuade them to confront (expose themselves to) their phobic situation and remain there until their fear began to subside, which might take half an hour or longer. In Stanford University in Palo Alto, Albert Bandura showed me his work on modelling which could be added to exposure therapy. Later, on Bandura's recommendation I was invited to spend a year at the Center for Advanced Study in the Behavioral Sciences at Stanford in 1981-2. At this think tank I met many fascinating researchers from diverse disciplines including biologists, linguists and psychologists, and had time to start writing my book Fears, Phobias and Rituals.

In 1969-71 John Boulougouris, Pedro Marset and I asked phobic patients to confront their feared situations in real life without relaxing, and to progress up their exposure hierarchy more rapidly than in fantasy desensitisation. This led patients to improve more quickly; and they maintained their gains over 1-2 years follow-up. In research with Richard Stern we found that relaxation was redundant and that longer was better than shorter exposure. In later research it turned out that cognitive therapy alone could be effective even without exposure. Other work showed the value of exercise to reduce some anxiety, and that blood-injury phobia responded to muscle-tension practice.

A problem which became apparent was that various therapists might use the same term to describe different procedures, and to use different terms for a similar procedure. This lack of a widely-agreed empirical classification of psychotherapy procedures has impeded therapists' attainment of a consensus about what is an essential core body of knowledge. The problem might be partly eased by classifying all psychotherapy procedures empirically by their domain profile, i.e. by those classes of action which feature in a practical description of a procedure. Such a classification could advance psychotherapy's scientific method by giving therapists from diverse backgrounds a quick way of summarizing for one another in a similar template what they actually do, and helping process-outcome researchers choose which facets to dismantle out of the many things done in any treatment.

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## WHEN A PERSONALITY DISORDER MAKES TREATMENT CHALLENGING

**JUDITH S. BECK, PH.D.**
**PRESIDENT, BECK INSTITUTE FOR COGNITIVE BEHAVIOR THERAPY;**
**CLINICAL ASSOCIATE PROFESSOR OF PSYCHOLOGY IN PSYCHIATRY, UNIVERSITY OF PENNSYLVANIA**

*Judith S. Beck, Ph.D., is President of Beck Institute for Cognitive Behavior Therapy in Philadelphia, a non-profit organization that provides a variety of training programs to health and mental health professionals worldwide, and a Clinical Associate Professor at the University of Pennsylvania. She has authored over 100 chapters and articles and several books, including Cognitive Behavior Therapy: Basics and Beyond, which has been translated into over 20 languages, Cognitive Therapy for Challenging Problems,and books for consumers on a CBT approach to weight loss and maintenance. She divides her time among teaching, clinical work, supervision, administration, program development and consultation, and writing.*

At least 5 studies (mostly post-hoc) show that clients who are co-morbid with a personality disorder and an acute disorder, such as depression or anxiety, do about as well in treatment as those who have an acute disorder alone. But, a greater number of studies show that while clients with this kind of comorbidity generally do well in CBT, they don't do quite as well.*

And no wonder; clients with personality disorders tend to hold fixed, overgeneralized, highly dysfunctional beliefs about themselves and other people (J. Beck, 2005; Beck et al., 2014), ideas they developed in childhood or adolescence. These clients tend to process information in a way that reinforces these ideas day after day after day after day, interpreting even neutral situations as confirming their core beliefs, and discounting or not recognizing positive data contrary to their core beliefs.

Mr. J, for example, believed that he was highly vulnerable and defective; that people would find out about his defects and reject him; and that he would not be able to tolerate the pain of rejection. His childhood history made it clear how and why he had developed those beliefs. At the age of 76, he still believed these cognitions strongly. He had never married, though he had been in two relatively long-term relationships and had a small circle of friends. But he still feared that one day these friends would reject him and he continued to engage in the same kinds of maladaptive coping strategies he had developed in childhood. For example, he was vigilant for signs that people were judging him negatively, and he proactively rejected others when he perceived that they were critical of him. Although he wanted to be in an intimate relationship, he was anxious about taking the necessary steps to meet a woman, predicting that they would find fault with him and, sooner or later, stop seeing him (as had been his experience many times).

Conceptualizing Mr. J according to the cognitive model allowed me to predict and avoid potential problems and to quickly and successfully repair ruptures in our relationship. At the beginning of treatment, Mr. J. assumed that I, too, would see him as defective and would wound him in some way. As he had terminated early with at least three therapists over the years, I assumed he would be at risk for doing the same with me. I recognized that I needed to help Mr. J feel safe.

In our first few sessions, Mr. J tested me. For example, he wanted to talk about meeting a new woman, but he was mired in hopeless cognitions ("I don't know if it's even worth it. It probably won't work out anyway.") In collecting evidence for his automatic thoughts, I asked him about his most long-standing relationship. He spoke about difficulties in vague generalities, stating a lack of common interests and alluding to their not seeing things eye to eye. When I asked him for a specific example of each, he looked angry, stopped making eye contact, and muttered, "I can't think of anything," then continued in an aggressive tone, "You know, this is *really* not helping." I conceptualized that his core beliefs had been activated and he was feeling unsafe.

My first response was, "Oh, it's good you told me that, then. Do you think it would help more if we talked about the beginning of the relationship when things were going better—or do you have another idea of what would help more?" Giving him control in the session decreased his sense of vulnerability and we successfully changed the subject. Reacting calmly to his aggressive tone, positively reinforcing him for expressing negative feedback, and collaboratively deciding what to talk about next in these beginning sessions increased his sense that he could trust me not to hurt him. We were then able to make fairly steady progress.

Clients with personality disorders often have a highly negative, default view of other people. The therapist can capitalize on clients' negative beliefs about them, demonstrating through action, problem-solving, and/or Socratic questioning of clients' thoughts that these beliefs don't apply in the therapeutic relationship. They can then help clients generalize what they have learned to specific relationships outside of therapy.

*For research citations, please email info@beckinstitute.org.

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## CBT AND SPORT/PERFORMANCE PSYCHOLOGY: WHAT IS THE OVERLAP?

### JONATHAN FADER, PHD

*Dr. Jonathan Fader, is a licensed clinical psychologist and the team sport psychologist of the New York Mets. He is the co-founder and Director of Psychology at Union Square Practice, a mental health practice based in New York City. He is currently a faculty member who teaches at the Beth Israel Residency Program in Family Medicine in New York City.*

*"Performance psychology is the study and application of psychological principles of human performance to help people consistently perform in the upper range of their capabilities and more thoroughly enjoy the performance process. "* (Portenga et al., 2010).

As a sport and performance psychologist, I have learned that is helpful to bring concepts and techniques from my work with athletes into my work with depression, anxiety, and other more mainline psychological problems. I frequently discuss how a feared presentation or plane trip is like an at-bat in baseball or a high-pressure foul shot in basketball. Sport enthusiasts and people who never watch sports seem to relate to the analogies and welcome those in our work to help them change the behaviors and thoughts that negatively contribute to their mental health.

In my view, sport psychology can be viewed as a kind of a specialization of CBT – it draws on the same tenets and skills, but has evolved to cater to a specific population. For example, Visualization (practicing vivid imagery of a performance activity) can be thought of as an evolution of imaginal exposure and, in the same way, Self-Talk (Mantras, Cue-Words and short messaging statements for high level performers) can be thought of as a specialized form of cognitive restructuring.

In my approach, I like to think that everything in life can be thought of as a performance. Individuals of all backgrounds; Physicians, Parents, Teachers and Therapists can improve their performance and their ability to enjoy their experience by practicing sport/performance psychology skills. This could mean that you are working to teach yourself to look at difficult moments as challenges instead of threats therefore improving your quality of life. The challenge-versus-threat mentality is a parallel of as the basic concept in CBT where you're changing your patterns of thinking to be more helpful and adaptive to a situation. You're learning to shift your perspective in order to get a clearer picture of the problem you're addressing.

In sport psychology, you're working with people who are usually functioning quite well and you're utilizing techniques to help them get to the next level. With direct use of CBT, you're often interacting with clients who might be doing less well, and are helping them get to a normal level of functioning. In sport psychology, I work to help people create a process-focused approach versus an outcome-focused one. This mentality can be applied to ourselves as therapists when doing CBT, because as therapists we are often focused on the outcome (whether a client can reduce anxiety or depression) and may forget that we can only control our contribution to the process of achieving any goal. In this way, taking a more performance-psychology spin on CBT can help expand on the concepts of cognitive and behavioral change by reframing objectives in therapy and making them more performance based.

References

Portenga, S. T. et al. (2010). Defining the Practice of Sport and Performance Psychology Division 47 (Exercise and Sport Psychology) of the American Psychological Association. Retrieved from: http://www.apadivisions.org/division-47/about/resources/defining.pdf.

## CBT IN LEBANON

### AIMEE KARAM, PHD

*Dr. Aimee Karam received her PhD in Clinical Psychology in 2001 from St. Joseph University Beirut - Lebanon. She is currently undertaking postgraduate Diploma (MSc in Advanced Cognitive Therapy Studies) - a two year part time course for advanced cognitive therapists leading to an award of the University of Oxford, UK. She is also a member of the Academy of Cognitive Therapy. Dr. Aimee Karam works as a Clinical Psychologist at the Medical Institute for Neuropsychological Disorders (MIND) in the Department of Psychiatry and Clinical Psychology at St George Hospital University Medical Center, Beirut, Lebanon. Dr. Aimee Karam is also a researcher and a member of IDRAAC (Institute for Development Research, Advocacy and Applied Care) an NGO specialized in Mental Health. For more information please visit: www.idraac.org .*

Reflecting on the status of Cognitive Behavioral Therapy (CBT) in Lebanon is quite a challenging task. The challenge resides in giving an accurate and realistic view to answer the question: where are we now?

In this part of the world, where we are still struggling to protect the unity of our community and where we are more than often preoccupied by defining and asserting our identity, uniformity and

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equal standards are difficult to reach in any end product.

On a national level, CBT figures in official recommendations as being a valid and recognized psychological treatment, along with pharmacotherapy.

In the area of college education, CBT is being taught in Psychology and medical schools. However, there are still no formal programs and training in CBT filling the criteria of the EABCT regulations available. Few years ago, after the completion of a two-year program for advanced studies in CBT at the OCTC (Oxford Cognitive Therapy Center) by a CBT pioneer who had been the first to implement CBT treatment in Lebanon, a proposal for instituting a two-year part-time course, offering training and supervision in cognitive therapy theory and practice and leading to a Professional Master Degree in Cognitive Behavioral Therapy was submitted and accredited by the Ministry of Education of Lebanon. Unfortunately, this program failed to gather a sufficient number of candidates to be able to survive. It is now waiting possible financial and format modification before being launched again. In the meantime, training and supervision are available by personal arrangement, within Departments of Psychiatry and Clinical Psychology embedded in Private General and Psychiatric Hospitals.

Because of significant gaps in formal programs and local education in CBT aimed at preparing students to become effective, knowledgeable and skilled CBT therapists, the practice of CBT varies from excellent to less than good. Some among us have been fortunate in being closely associated with CBT pioneers, through their numerous and continuous educational trips to the Beck's institute in Philadelphia, USA, the OCTC in Oxford, UK, Palm Spring workshops and camps directed by Christine Padesky, etc. Others claim to be CBT therapists with a less than acceptable level of knowledge, skills and attitudes. That is why clients in Lebanon should be well informed and directed in order to receive the right and effective treatment.

Efforts to address this issue are being made by Lebanese Mental Health NGO's who actively work to spread awareness and diffuse information among people, in the realm of mental health, through community services, research, publications, television programs and social media.

In parallel, The Lebanese Society for Cognitive and Behavioral Therapy was founded in 2002 and was accepted as the first non-European association by the EABCT under the section: affiliate member.

In addition to the clinical application of CBT, an innovative action was initiated in 2005 by CBT European colleagues to implement cognitive therapy principles and concepts in national and international negotiations and conflict resolution. Upon invitation, the Lebanese experience was presented at the EABCT conferences in Thessaloniki (2005), Barcelona (2007), Geneva (2012) and Marrakesh (2013), as well as at the WCCT (2010) in Boston. CBT has also served in the Civil Society actions through a think-tank, "The Third Voice for Lebanon " where concepts and actions promoting citizenship, peace building and the culture of dialogue are promoted and lead by CBT dynamic and processes.

It is our aim to meet the best internationally recognized practices in the field of psychological treatments and research, improve access to CBT and secure small islands of excellence in delivering CBT, hoping to spread the same motivation and vision on a National level.

## HOW NEW INTEGRATED TREATMENTS BASED ON CBT AND REHABILITATION CAN CHANGE THE PROGNOSIS OF SCHIZOPHRENIA

**TULLIO SCRIMALI**
**PROFESSOR OF CLINICAL PSYCHOLOGY, MEDICAL SCHOOL, UNIVERSITY OF CATANIA**

*Psychiatrist, Psychotherapist and Neuroscientist, Tullio Scrimali (www.tullioscrimali.it) teaches both at the Medical School at the University of Catania (Italy) and at ALETEIA International, a European School of Cognitive Therapy (www.aleteiainternational.it) of which he is founder and Director. Dr. Scrimali has given lectures in many countries on four continents and is the author of 170 scientific articles and several monographs, written in seven different languages. A seminal book, he wrote in the field of Cognitive Therapy for schizophrenia is: Entropy of Mind and Negative Entropy. A Complex and Cognitive Approach to Schizophrenia and its Therapy. London: Karnac Books, 2008.*

Schizophrenia is the central problem in the sciences of the mind and for public health, not only for its etiological and clinical aspects, but also because of its implications for therapy and rehabilitation. However, new integrated treatments based on cognitive and behavioral therapy and rehabilitation, could change the prognosis of schizophrenia today (Perris, 1989; Kingdon et al. 2008, Beck et al., 2011). For this reason, *recovery* and not progressive deterioration should be the expectation for schizophrenia.

To reach this goal, I recently started to carry out a research program to demonstrate an *inexpensive protocol* that is aimed to cure schizophrenic patients and carried out in specifically designed units, known as *Outpatient Intensive Treatment Centers.*

My research has already demonstrated that, according to a preliminary program, the new evidence-based and neuroscience-

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## COMPLICATED GRIEF TREATMENT

**NATALIA SKRITSKAYA PH.D.**
**COLEEN GRIBBIN M.A.**
**M. KATHERINE SHEAR M.D.**

*Dr. Natalia Skritskaya is a licensed clinical psychologist, Associate Research Scientist at Columbia School of Social Work and a CBT therapist. She received her PhD from Hofstra University and has been working in clinical research and has focused on complicated grief for more than five years. She is a CGT-trained therapist and supervisor and is Clinical Training Director at the Center for Complicated Grief. Dr. Skritskaya is interested in psychotherapy research, evidenced-based mental health treatments and treatment dissemination.*

*Colleen Gribbin is a graduate of Brown University with a B.S. and Teachers College, Columbia University, with an M.A. in Clinical Psychology. Colleen is the Program Manager, Center for Complicated Grief, Columbia School of Social Work and is involved in program development, planning and execution, fundraising, promotion, and outreach. Colleen is also a trained evaluator and member of the Center's assessment team which provides guidance to professionals in evaluating people with CG.*

*Dr. Shear is the Marion E. Kenworthy Professor of Psychiatry and Director of the Center for Complicated Grief at Columbia School of Social Work. Dr. Shear has spent decades conducting clinical research in anxiety, depression and related disorders. She developed complicated grief treatment and confirmed its efficacy in three large NIMH-funded studies. She is widely recognized for her work in bereavement, including both research and clinical awards from the Association for Death Education and Counseling and invited authorship of articles for Uptodate and the New England Journal of Medicine.*

Death of a loved one is one of the most painful experiences in life and yet it is universal and unavoidable. As difficult as loss is, we all have a natural capacity to adapt. However, for an estimated 7% of bereaved people the process of adaptation is stalled or halted by psychological problems that complicate the grief. For those who lost a child or a spouse the risk of such persistent grief is even higher. When acute grief persists indefinitely it can be associated with intense suffering. For many, physical health is also negatively impacted. This condition has been recently recognized and is currently designated as complicated grief, prolonged grief disorder, or persistent complex bereavement disorder.

We use the term "complicated" because it reflects our understanding that counterproductive thinking, excessive avoidance behaviors, ineffective emotion regulation or severe social or environmental problems can impede the process of adaptation. We developed and tested Complicated Grief Treatment (CGT) to help people suffering in this way. CGT is designed to resolve complicating problems and to facilitate the natural adaptive process. The latter entails accepting the reality (i.e., the finality and consequences) of the loss, redefining their relationship with the person they lost and re-envisioning their lives with a sense of meaning and purpose and possibilities for joy and satisfaction. The treatment is fundamentally a cognitive-behavioral approach that is informed by attachment theory, self-determination theory and premises of self-compassion and psychological immunity.

Consistent with the CBT spirit, one of the core components of CGT is psychoeducation - providing information about grief and about the nuts and bolts of the love relationships that spawn it. We also help clients understand the natural adaptive process and to see how symptoms of complicated grief can emerge when this process is stalled. We describe CGT as a treatment that encompasses processes needed to adapt to a loss and to restore a meaningful sense of the future. Treatment rationale and procedures are explained to gain clients' collaboration and commitment to treatment. Clients are also introduced to emotion regulation strategies that are used throughout the treatment. One of these is a daily grief monitoring diary. Exploring aspirational goals and helping clients to experience more positive emotions is another core component that is included in all sessions. CGT is provided using a scaffold of structure and support and a Sherpa-guide type of treatment alliance. As in all treatments, the therapist creates a safe and supportive environment for sharing the pain. This is a part of the component that focuses on building support. In addition, the therapist gently but persistently encourages the client to reconnect with other people in her or his life.

Revisiting the time when the client first learned about the death is the core loss-focused procedure in CGT and is possibly the most powerful of the core components. Informed by prolonged exposure for PTSD, it was modified to work with grief. In addition clients are encouraged to revisit the world, focusing on situations avoided because they are reminders of the loss. Studies by several research groups support the importance of these exposure-like components in treating complicated grief. During the closing phase of the treatment the therapist invites the client to have an imaginal conversation with the person who died and this serves to greatly

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strengthen the sense of connection to the loved one.

CGT has now been extensively tested. We have compared CGT to Interpersonal Psychotherapy (IPT) in two large clinical trials and most recently to antidepressant medication and pill placebo. Overall, more than 70% of participants treated with CGT in our studies have been much improved after 4-5 months of treatment. CGT was almost twice as effective for complicated grief as IPT. Now that we have confirmed its efficacy, we have launched a major training initiative. Information about our workshops and other training opportunities as well as training materials are available on our website www.complicatedgrief.org. Our goal is to train clinicians world-wide to recognize and treat people suffering with complicated grief.

## ACT'S PRESIDENT'S MESSAGE

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has the potential not just to treat individual patients but to have large public health benefits throughout our society, which may include the need for fewer jail cells. I suspect that this is an outcome which all of us, regardless of political stripe, could support.

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

Endnotes


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## IACP'S PRESIDENT'S MESSAGE

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Director of CBT California (CBTC). Dr. McFarr received her Ph.D. from New York University (NYU) in clinical psychology and trained as a cognitive behavioral therapist under Dr. Robert Leahy at the American Institute for Cognitive Therapy in New York City. She completed her internship at the Sepulveda VA and her postdoctoral fellowship at Harbor-UCLA Medical Center. Dr. McFarr is an award winning trainer of psychologists, psychiatrists, social workers and psychiatric nurses in Cognitive Behavioral Therapies including DBT, CBASP, and ACT. She has twice been acknowledged as Teacher of the Year for the Department of Psychiatry at Harbor-UCLA and has also received Psychologist of the Year from the LA County Department of Mental Health. She lectures for major universities, regularly presents at national and international conferences and publishes on CBT and DBT. Dr. McFarr is a Beck Scholar and is on the executive board for both the Academy of Cognitive Therapy (President Elect) and The International Association for Cognitive Therapy (IACP). She founded the Cognitive Behavioral Therapy Society of Southern California as well as the listserves for the Association for Behavioral and Cognitive Therapies (ABCT) and CBASP. Dr. McFarr was the senior editor of "*Cognitive Therapy*" for eight years. Dr. McFarr conducts research on supervision, training and adherence in CBT, DBT, CBASP and ACT as well as studies on Therapy Interfering Behaviors and Secondary Targets in DBT. She is a member of the Dialectical Behavior Therapy Strategic Planning Meeting, a consortium of international DBT researchers, and was the Program Chair of the annual meeting of the International Society for the Improvement and Teaching of Dialectical Behavior Therapy (ISITDBT) for 2014-2015.

Lata K. McGinn is Associate Professor of Psychology, Director of the Doctoral Clinical Program, and Director of the University-based Cognitive Behavior Therapy Training Program for Anxiety and Depressive Disorders at the Ferkauf Graduate School of Psychology, Yeshiva University/Albert Einstein College of Medicine and is Co-founder of Cognitive Behavioral Consultants. Dr. McGinn specializes in the cognitive behavioral treatment of anxiety and mood disorders, and has been treating and conducting research on these problems since she received her PhD in 1993 from Fordham University. She has authored numerous publications, including co-authoring two books, titled "*Treatment of Obsessive-Compulsive Disorder*" published in 1999 by Jason Aronson, Inc. and "*Treatment Plans and Interventions for Anxiety and Depression*," published by Guilford in 2011. Dr. McGinn presents her research worldwide and is regularly invited to conduct keynotes, lectures, seminars and workshops throughout the world to professionals, consumers, schools, agencies, and companies. Her research focuses on vulnerability and prevention of anxiety and depressive disorders. She has recently developed an intervention to prevent the development of depression and has tested the efficacy of this intervention in a NIH funded research study. Dr. McGinn is the immediate Past-President of the International Association for Cognitive Psychotherapy and is also on the board of the Academy of Cognitive Therapy. She has also previously served on the Board of Directors of the Association for Behavioral and Cognitive Therapies. She is a Founding Fellow and a Diplomate of the Academy of Cognitive Therapy and is a certified ACT Trainer. Dr. McGinn has earned the title of Beck Scholar by the Beck Institute for Cognitive Therapy and Research in recognition of her contributions to the field of cognitive therapy. The Association of Behavior and Cognitive Therapies awarded her a certificate of appreciation in recognition of her professional contributions made on a Trauma Taskforce following September 11, 2001. She is also a founding fellow of the New York CBT (NYC-CBT) association. Dr. McGinn is associate editor of the journal *Cognitive Therapy*

*and Research*, is on the editorial board of the *International Journal of Cognitive Therapy* and on the advisory board of the *Journal of Cognitive Behavior Psychotherapy*. She has also served on Division 12, APA's taskforce on Evidence-Based Doctoral Training.

John H. Riskind received his Ph.D. from Yale University and is currently a Professor of Psychology at George Mason University. Prior to that, he had faculty appointments with the University of Pennsylvania Medical School, where he was Research Director at the Center for Cognitive Therapy from 1983 to 1985, and with Texas A & M University. He is the current Editor of the International Journal of Cognitive Therapy. He was also the Editor of the *Journal of Cognitive Psychotherapy: An International Quarterly*, the previous official journal of the International Association of Cognitive Psychotherapy (IACP), and also formerly an Associate Editor of *Cognitive Therapy and Research*. He has authored more than 140 articles on various topics, many on cognitive styles in anxiety, and particularly his model of looming vulnerability and looming cognitive style, but also done work on cognitive models of depression and suicidality, as well as basic emotions theory and embodied cognition. He is the co-author of two books with Lauren Alloy, including the recently published edited book, *Cognitive Vulnerability to Emotional Disorders* (2006). He is currently completing a book with Neil Rector on the looming vulnerability model of anxiety and fear. Dr. Riskind is a Founding Fellow of the Academy of Cognitive Therapy and a former member of its executive board and is a licensed clinical psychologist.

Julie Snyder is the Clinical Director of CBT California, where she provides Cognitive Behavioral Therapy and Dialectical Behavior Therapy. Dr. Snyder also serves as volunteer faculty at UCLA David Geffen School of Medicine, supervising residents in CBT. She is also the volunteer coordinator for the International Association of Cognitive Psychotherapy. Dr. Snyder completed her Psy.D. in Clinical Psychology at Pepperdine University and an APA-accredited postdoctoral fellowship at Harbor-UCLA Medical Center. Dr. Snyder has been providing treatment under supervision for individuals in various settings for the last 10 years, working as an anger management consultant, as a program therapist at a licensed group home for adolescents, educational coordinator, and as a clinician at an outpatient methadone maintenance clinic.

Henrik Tingleff is a clinical psychologist from University of Copenhagen, Denmark with an intensive interest in CBT since his first clinical training at The Beck Institute in 2005 and certification by The Academy of Cognitive Therapy in 2006. Currently he divides his time equally between therapy, supervision and dissemination of cognitive methods and principles to professionals, companies and client groups. As Professional Director of Mindwork Psychological Center he heads the centers continued education program under the Danish Psychological Association, the anxiety and depression treatment programs and a CBT based personal-skills training program for unemployed under The Danish Agency for Labour, Market and Recruitment Related to Mindworks industrial psychology services Henrik Tingleff runs the work-life-balance projects as well as the CSR related activities. As Program Director and head of treatment at Danish Problem Gambling Treatment Center he heads the only evidence based problem gambling treatment program in Denmark and is the liaison to the programs research unit at Aarhus University. Henrik Tingleff is the author of three books on CBT for professionals in Danish and a self-help book on problem gambling, which has been published in both Danish and English. He has served as Chair of the IACP Training Committee since 2010 and is now Board Representative at Large.

Mehmet Z. Sungur is professor of psychiatry at the Medical Faculty of Marmara University, Istanbul, Turkey. He had his training on CBT and sexual and marital therapies at the Institute of Psychiatry, London. He was accredited as a cognitive behaviour therapist by the British Association of Behavioural and Cognitive Psychotherapy (BABCP). He is also certified as a cognitive therapist and supervisor by the Academy of Cognitive Therapy (ACT). He is appointed as the president elect of the International Association for Cognitive Psychotherapy (IACP) and he is one of the past presidents of the European Association for Behavioural and Cognitive Therapy (EABCT). He is also serving as an executive board member of the European Federation of Sexology (EFS). Mehmet Z. Sungur's clinical practice covers a wide range of clinical syndromes with a special emphasis on cognitive behavioural treatment of anxiety disorders, depression, schizophrenia and sexual and marital problems. He has published more than 100 articles in national and international scientific journals and has written books and book chapters. He has presented workshops and keynotes in national and international congresses. He played a leading role in the dissemination of the practice of CBT and sex therapy in Turkey. He established the Turkish Association of Cognitive and Behaviour Therapy (TACBT) in 1995 and is the chairman of this Association since its establishment. He has chaired numerous national and international meetings on sexual health and sexual problems in Turkey and elsewhere. He has received some national and international awards, the first one being "Schizophrenia Reintegration Award" and the recent one being "Gold Medal from European Federation of Sexology" in 2014. He also received "Julia Heiman Honorary Award" and recently "Lo Piccolo Award" for his contributions in the area of sex and couple therapy. He is a Diplomate, and Founding Fellow and supervisor of ACT, a certified supervisor from ACT. He has served as the past coordinator of the CBT Task Force of Turkish Psychiatry Association and he is currently the coordinator of the Couple and Family Therapy Task Force of the same association. He is on the advisory and/or editorial board of many national and international journals. He was a member of the task force on certification and accreditation committee of EABCT He is also a member of the task force on 'Common Language in Psychotherapy.' Mehmet Z. Sungur

has currently committed himself to the training of mental health professionals in clinical applications of CBT and sex therapy both in Turkey and abroad. He has been the president of 7 international and many national congresses about CBT and sex therapy. He is running training courses and certified CBT training programmes for a large number of mental health professionals in Turkey and abroad.

## INTEGRATED TREATMENTS BASED ON CBT AND REHABILITATION

CONTINUED FROM PG. 6

based treatments and the new setting proposed are efficacious, efficient, and lower costs when in comparison with hospitals, asylum, and traditional inpatient therapeutic communities (Scrimali, 2008).

The protocol I have developed, is named *Negative Entropy* and applied at the ALETEIA Clinical Center (Scrimali, 2008). This protocol is an integrated therapeutic program that should be articulated in a succession of strategically interrelated stages. New scientific and evidence-based methods that come from Neuroscience and have been integrated into psychotherapy and rehabilitation are used. Among them: computer-based electroencephalography (QEEG), computer-based monitoring of Electrodermal Activity (QEDA), biofeedback, neurofeedback, and neurotherapy (Scrimali, 2012).

The various phases of the *Negative Entropy* intervention, even though developed in specific terms for schizophrenia, constitute obligatory steps (in my opinion) for *any* therapeutic and rehabilitative project. These steps can be identified as follows:

- Development of the therapeutic relationship
- Progressive activation in the patient and the therapist of the motivational system of attachment between adults
- Construction of the *secure base* relationship
- Therapeutic and rehabilitative work with the patient on the behavioral, emotional, cognitive, and relational levels
- Biofeedback, neurofeedback, and neurotherapy
- Suicide prevention
- Strengthening of meta-cognitive functions
- Improving neuropsychological performance
- Development of social and relational competences
- Construction and development of a new structure of the self
- Promotion of a positive personal identity with effective self-esteem
- Activation and implementation of the narrative function
- Institution of the therapeutic relationship with the family
- Activation also with the family of a *secure base* relationship
- Therapeutic and rehabilitative work with the family
- Finding employment
- Conclusion of the systematic phase of the psychotherapeutic and rehabilitative treatment
- Activation and maintenance of the counseling phase as well as the monitoring of warning signs and the prevention of relapse

When describing this protocol, we are also talking about a new setting where multi-contextual and multimodal interventions can take place. This is the *Intensive Outpatient Treatment Center*, which I have founded and setup in Enna and Catania (Sicily). They are a new kind of outpatient unit, known as in Italian as *Centro Clinico ALETEIA* or in English as *ALETEIA Clinical Center.*

The outpatient program carried out at the ALETEIA Clinical Centers is designed to facilitate patient return to their maximum level of independence using *individual* and *group* therapy focused on coping skills, cognitive behavioral skills, life skills, medication education, stress management, and interpersonal relationship skills.

At moment, we are carrying out a further controlled study with this new protocol and in these settings.

References

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## STANDING ON SHOULDERS OF GIANTS ISAAC MARKS

CONTINUED FROM PG. 3

Psychotherapy has some ingredients which are consistently trainable and replicable across therapists. These can concisely capture many therapy actions in clinical practice. A pilot analysis by students of inter-rater reliability for the presence or absence of ingredients in 10 therapy procedures yielded encouraging results and was a teaching aid for the students. Therapists in general might find the use of such brief descriptions a convenient shorthand to convey what they do. Much more work is needed to refine the definitions of short empirical descriptions of more procedures, and to do further reliability analyses and process and outcome research.

The importance of common factors like therapist empathy and contingency management is widely emphasized in the

literature. Carers who understand and feel with their clients, praise them for desirable behaviour, and ignore undesirable behaviour, tend to improve their clients more, provided the therapists also use procedures which are effective for the clients' particular problems. This phenomenon is not unique to psychotherapy. Empathy and contingency management probably also improve the outcomes of consultations with accountants, architects, lawyers and priests, provided those professionals apply appropriate expertise to the matters in hand. However, there are limits to such enhancement. In most procedures for an anxiety disorder, no matter how much empathy and contingency management are present, their effect is generally small unless the procedure includes exposure or reframing. A classification of what therapists actually do has proved feasible across orientations. As brief portrayals appear of more procedures, further such work could speed the evolution of psychotherapy into a science whose empirical domains are generally applicable. The present preliminary framework can pave the way for further testing.

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

**The next deadline for submission is January 15th, 2016. 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.**