ADVANCES IN Cognitive Therapy newsletter

February, 2016

IACP Vol 16, Issue 1 / ACT Vol 17, Issue 1

Publication of the Academy of Cognitive Therapy (ACT) and the International Association of Cognitive Psychotherapy (IACP)

EDITOR
Simon A. Rego, PsyD, ABPP, ACT

IACP PRESIDENT-ELECT'S MESSAGE

MEHMET Z. SUNGUR, MD

It is a great honor, pleasure and responsibility to be the president elect of the IACP. First of all I would like to express my gratitude and thanks to the board members of IACP and to all of the members of the IACP community for nominating and electing me as the next president. No doubt, this will sometimes be an exhausting but mostly a very rewarding task. I will do the best I can to deserve such a unique and significant post. I would also like to express my sincere thanks to Simon Rego, who does a great job in continuing to offer this excellent newsletter for the members of ACT and IACP. When he asked me to write a column as the incoming president, I realized the beauty and difficulty of expressing myself to the members of two distinguished communities that I have always found to be supportive, educative, encouraging and compassionate. There is still more than a year to take over the position of the incoming president. Knowing that our present president, my dear friend and colleague Stefan Hofmann is irreplaceable (in many different ways) I do not see him as an outgoing president but as a reliable partner to collaborate with in order to achieve IACP's ultimate goals. Being a member of the IACP board for long enough, I had the unique privilege to work with giant role models such as Robert Leahy, Keith Dobson, Lata McGinn and Stefan Hoffman who have all been presidents of the IACP and contributed highly to the field of cognitive psychotherapy. I have no doubt that they will all collaborate and help guiding me through the right path to materialize our future mutual goals. One of my targets for the future will no doubt be improving communication and liaison with other CBT societies around the globe that share similar interests and goals to promote and disseminate CBT. These collaboration efforts will hopefully conclude by establishing a truly inclusive and integrative world federation of CBT. This can only be done through cooperation, communication, respecting different needs and via elegant care to preserve the uniqueness of each association while integrating mutual and multidimensional efforts.

I believe the time has come to talk not only about disseminating CBT but emphasizing the significance of disseminating good practice in CBT. Although CBT has long been recognized for its efficacy confirmed by the hundreds of meta-analytic studies conducted, some media reports emerge from time to time that challenge its effectiveness and claim its clinical significance is exaggerated. Most of these reports appear as "expert" opinions and are either not based on scientific data or stated without careful analysis of the conclusions drawn. Although experienced

(CONTINUED PG. 8)

CONTENTS

ACT PRESIDENT'S MESSAGE

JOHN WILLIAMS , MD

Dear Members of the Academy:

I have been thinking a lot about epigenetics recently. Epi- what? You might ask. Although some of you may be familiar with the concept, many of you likely are not, and you shouldn't feel bad about that. A Pubmed.gov search of "epigenetics" and "psychology" suggests that the first paper addressing both topics was only published in 2002. But what is epigenetics?

Wikipedia provides as good a definition as any: "Epigenetics is the study, in the field of genetics, of cellular and physiological phenotypic trait variations that are caused by external or environmental factors that switch genes on and off and affect how cells read genes instead of being caused by changes in the DNA sequence. Hence, epigenetic research seeks to describe dynamic alterations in the transcriptional potential of a cell."[1]

When I was a kid in the 70s and 80s, my father used to talk about nature vs. nurture. We knew about how nature was transmitted—through DNA—but the biological means of nurture was less clear. Specifically, how did life experiences lead to biological change and symptoms? One of the answers appears to be epigenetics. For example, we know that the concept plays a significant role in the evolution of post-traumatic stress disorder and may explain why some people develop the condition and others don't following traumatic exposures.[2] Similarly, epigenetics may plan an important role in the presence or lack of resilience, a concept of extreme importance not just in positive psychology but in any understanding of psychological pathophysiology. [3]

At the last Association for Behavioral and Cognitive Therapies Convention in Chicago in November, I had the opportunity to speak with Steven Hayes when he received the Aaron T. Beck Award. We discussed the sizable effects of mindful meditation on epigenetics. Mindfulness is a big component of Steven's work, and I feel an important component of cognitive behavioral therapy in 2016. This discussion got me thinking: What evidence do we have to show that CBT has positive epigenetic effects?

I looked at the literature, and there hasn't been a lot of work considering the epigenetics of CBT. This concerns me. Thanks to the evidence-driven focus of Dr. Beck in the past half-century, cognitive behavioral therapy achieved an enviable position as the most evidence-based based psychotherapy. To maintain that same position in the next half-century, we will need to continue with Dr. Beck's experimental approach.

I believe that the future will be about epigenetics, and so I encourage each of you to consider this in your academic work, your grant applications, and your clinical practices. We know that CBT works, and we have to be ever vigilant to use the latest biological concepts and techniques to illustrate the mechanisms of this efficacy. In this way we can best help our patients, our clients, and their families.

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

1. https://en.wikipedia.org/wiki/Epigenetics
2. Rampp, C., Binder, E. B., & Provençal, N. (2014). Epigenetics in posttraumatic stress disorder. *Prog Mol Biol Transl Sci, 128*, 29-50.
3. Zannas, A. S., & West, A. E. (2014). Epigenetics and the regulation of stress vulnerability and resilience. *Neuroscience, 264*, 157-170.

CBT HAS NOT LOST ITS MOJO

SCOTT WALTMAN, PSYD AND THE ACT BOARD OF DIRECTORS

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 provide ongoing consultation to Los Angeles County clinicians involved in the current implementation project. Clinically, he 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.

Since the inception of Cognitive Behavior Therapy (CBT) several decades ago, much has been said about the utility, effectiveness, and acceptability of the treatment. The questions often on the mind of clinicians involved in the provision of direct-care are, "*Dœs CBT work as well as they say it dœs?*" and "*Is it better than what I'm already doing?*" According to a recent clinician's digest article in *Psychotherapy Networker* by Chris Lyford (https://www.psychotherapynetworker.org/magazine/article/962/clinicians-digest), CBT may have lost its mojo [sic]. There are a number of reasons to question Lyford's conclusions including misrepresentations of the studies he cited and an unbalanced review of the literature.

(CONTINUED ON NEXT PAGE)

The *Psychotherapy Networker* is not designed to provide comprehensive literature reviews; however, the skewed presentation found in the article is irresponsible. For example, as evidence of CBT losing its mojo, he cited a study conducted by Sweden's Lund University where it was found that CBT was no more effective than the experimental treatment of mindfulness-based therapy in treating depression and anxiety. However, even the quickest of reads through that article would demonstrate that the mindfulness-based therapy being studied was based on Mindfulness-Based Cognitive Therapy—so CBT was no more effective than an enhanced version of CBT. This finding actually supports the effectiveness of CBT.

Lyford also cited a 2013 meta-analysis published in *Clinical Psychology Review*; however yet again, this was only one piece of the story. In 2010, David Tolin published a meta-analysis in *Clinical Psychology Review* that compared CBT to other *bona fide* treatments and concluded that CBT was superior to psychodynamic therapy (although not Interpersonal Therapy) for treating anxiety and depression. The 2013 meta-analysis that Lyford cited was conducted by Timothy Baardseth and a number of colleagues including Bruce Wampold (the famous proponent of Common Factors Theory) and was a re-analysis of the 2010 Tolin study. As Lyford points out, Baardseth and colleagues failed to replicate Tolin's findings. Thereafter, Tolin published another paper in *Clinical Psychology: Science and Practice* in 2014 that commented on the Baardseth meta-analysis and highlighted a problem with the analysis— excessive error variance. Tolin detailed how the excessive error variance in the Baardseth analysis created excessive "noise" in the data which buried the "signal" regarding CBT superiority. To better understand what this means, consider the following hypothetical situation. Imagine you are having a conversation with a colleague on your cell phone. Under optimal conditions, including have adequate signal strength and being in a quiet environment, it will be plausible that you'll be able to hear what your friend has to say. Now consider the same task under different circumstances, such as having the same cell phone conversation while walking down a busy street; even with reliable signal strength, the excessive noise will make it difficult to hear what your colleague is saying. Tolin highlighted this in his 2014 paper where he demonstrated that the superiority of CBT could be observed or not observed depending on what one chose to analyze. It is important for the non-statistician to understand that mathematically any set of numbers can be analyzed. However, the conclusions of a meta-analysis can only be held as valid if a number of conditions are met, and the conclusions of Baardseth and colleagues have been called into question.

The Johnsen and Friborg meta-analysis that Lyford focused on suffered from similar problems as the Baardseth article. Namely, excessive heterogeneity estimates, which calls into question the suitability of the comparisons being made. These heterogeneity estimates serve as an indicator of how appropriate it is to analyze the effect sizes from the included studies. High heterogeneity estimates cause concern about the analysis. A common criticism of a meta-analysis is that if misapplied it can be similar to comparing apples and oranges, in cases like these that metaphor is appropriate. As stated above, any set of numbers can be analyzed, but the confidence we can have in the corresponding conclusions is dependent upon a host of factors. A number of other problems have been identified regarding the Johnsen and Friborg study and a more comprehensive critique ("Are the Effects of Cognitive Behavior Therapy for Depression Falling? Review and Critique of the Evidence") was recently accepted for publication in *Clinical Psychology: Science and Practice*. Suffice it to say, it's premature to be overly confident in the conclusions of the Johnsen and Friborg article.

With this new information in mind the answer to the previous questions, "*Dæs CBT work as well as they say it dæs?*" and "*Is it better than what I'm already doing?* depends on who you ask. Notwithstanding, either answer supports the use of CBT. CBT is either superior to other bona fide treatments or it is on par with the best psychotherapies out there. As the state of the science advances, other effective treatments such as Interpersonal Therapy for depression have been developed. This is a good thing. The goal is to have good treatments and to refine our craft to help as many people as possible. Recent advances and current research on topics such as the inhibitory learning model, memory enhancement, personalized treatment for depression with brain scans, treatment failures, transdiagnostic approaches, and the use of medications like D-cycloserine to enhance exposure may revolutionize the field.

The cognitive and behavioral therapies are the most studied family of psychotherapies, and as Lyford points out there is an abundance of evidence supporting the efficacy and effectiveness of CBT and a clear majority of the approaches deemed empirically supported by the APA Division 12 task force as being empirically-supported treatments are cognitive and behavioral therapies. We would encourage any clinician, client, family member, or policy maker to check the Division 12 website (https://www.div12.org/psychological-treatments/disorders/) for assistance in determining what treatments have been found to be effective for a host of psychological disorders. While CBT is certainly not a panacea or silver bullet, sufficient evidence exists such that it should be considered a frontline treatment—the first thing you try. A clear benefit of CBT over other approaches such a medication are the lasting treatment effects.

Lyford was correct to include the commentary of Scott Miller on the importance of the therapeutic relationship. All bona fide therapies emphasize the therapeutic relationship. An often cited statistic on the topic are the findings of Michael Lambert and colleagues that common factors such as the therapeutic relationship account for 30% of the variance in treatment outcomes, and therapeutic technique account for only 15% of the variance in

(CONTINUED PG. 9)

THREE KEYS TO MORE EFFECTIVE CBT EDUCATION

R. TRENT CODD, III, EDS & DONNA M. SUDAK, MD

R. Trent Codd, III, Ed.S., is the Founder and President of Cognitive-Behavioral Therapy Center of Western North Carolina. He is a Fellow and Certified Trainer/Consultant of the Academy of Cognitive Therapy, and is actively involved in the training and supervision of professionals in CBT. More information about his training efforts can be found at www.BehaviorTherapist.org

Donna Sudak is Professor, Senior Associate Training Director and Director of Psychotherapy Training in the Department of Psychiatry at the Drexel University College of Medicine. She is a clinician-educator with a wealth of experience and multiple awards for her teaching. She is the Past President of The Academy of Cognitive Therapy, the former Editor of the PIPE examination, and serves on multiple national committees in Association of Behavioral and Cognitive Therapies and American Association of Directors of Psychiatric Residency Training. She is the incoming Program Chair of AADPRT, and will become president of that organization in 2018.

Despite decades of emphasis on obtaining data to guide the therapeutic process, there has been a relative lack of research regarding best practices in training and supervision of CBT. Evidence does support several "best practices" in training that are underused by most educators.

The following examples exemplify such practices.

1) *Training must be linked to objectives that fully reflect the future desired performance* –

Instructional design must begin with the specification of two types of objectives: Outcome and Performance. Outcome objectives specify the desired products of performance; performance objectives specify trainee behavior necessary to produce those products. For example, an outcome objective might be "Reduce patient depression to non-clinical range"; performance objectives would specify each of the behavioral skills required to do so. Training should be tailored to those performance objectives with precision.

Often performance objectives are written without fully considering outcome objectives, or objectives are written in accordance with "rules" rather than for their utility in designing and evaluating instruction (e.g., using language that is of no use to the instructional designer), or instruction fails to consistently maintain a tight association with the specified performance objectives. This reduces the efficiency of educational efforts.

Consider this learning objective provided by the American Psychological Association (http://www.apa.org/ed/sponsor/resources/learning-objectives.aspx): "At the conclusion of this program, participants will be able to: negotiate the regulatory and ethical information regarding publication and grant writing with colleagues or students." This objective contains multiple problems. First, why is it useful to "negotiate" regulatory and ethical information? Will it produce an important outcome like ethical behavior? Second, this objective blocks effective measurement. What behavior(s) would one measure to evaluate "negotiating?" The key principle is that performance objectives should facilitate design and evaluation of training programs.

Finally, instruction must not stray from performance objectives. If the objectives concern the development of specific clinical procedures then trainers should not dedicate time to reviewing historical information or research literature. There is a parallel principle in conducting therapy – CBT works best with specific and measurable goals that are adhered to by the therapist.

2) *Training activities must incorporate frequent, sensitive and accurate measures* –

Most trainers do not measure training effectiveness. When employed, measures often evaluate the learner (and only at the end of training) rather than the instructional intervention (i.e., exams), and rely solely on an accuracy dimension (usually percent correct). These mistakes are significant. Effective training should involve frequent, sensitive and accurate measures that allow the trainer to make real time changes in instruction. Thus, when learners are not progressing satisfactorily the trainer may modify the instructional intervention. Evaluating the learner at the end of training provides no opportunity to change course and correct deficiencies. Finally, using a percent correct measure creates a ceiling past which learners cannot progress and is incredibly insensitive as a measure. For example, if a measure required a trainee to reach an 80% benchmark, a trainee who emits eight correct and two incorrect facts in a minute about CBT and a trainee who emits 16 correct and four incorrect facts will score similarly on a percent correct measure (i.e., 80% correct) despite not being equally competent. Also training for learner one and two would end because they had reached the 80% benchmark, despite learner two's data indicating that performance could still be increased substantially. Frequency dimensions should always be combined with measures of accuracy. Measures should measure skill as well as knowledge if that is the objective of training.

(CONTINUED ON PG. 10)

CBT IN THE PHILIPPINES

JOSE ALBERTO S. REYES, PHD

Dr. Jose Alberto S. Reyes is currently a Full Professor at the Counseling and Educational Psychology Department of De La Salle University. He received his M.A. and B.A. degrees in Psychology from the University of the Philippines. He completed his Ph.D. in Counseling Psychology at the Washington State University where he merited the Leroy Olsen Memorial Award for excellence in Counseling Psychology. He completed his Pre-doctoral internship at the University of Florida. He is part of the first batch of Registered Psychologists in the Philippines. Dr. Reyes is the current Chairperson of the Philippine Association for Counselor Education, Research, and Supervision. He obtained most of his advanced training in CBT at the Beck Institute in Philadelphia, Pennsylvania.

In 2014, I co-authored an article on the perceptions of beginning Filipino mental health trainees on Cognitive Behavior Therapy (CBT) (Reyes & Garcia, 2014). This research was spurred by my curiosity on the current perceptions of Filipino mental health professionals on CBT after having been personally involved in disseminating CBT in the Philippines for the past 15 years. I started becoming involved in introducing CBT to graduate students of counseling and counseling psychology in 1998 in my capacity as a full time graduate faculty member of the Counseling and Educational Psychology Department of De La Salle University in Malate, Manila, Philippines. Around this period I was also active in providing CBT training workshops during annual conventions of the various professional organizations in the area of counseling and counseling psychology.

The 100 respondents who participated in this research were counselors, counseling psychologists and clinical psychologists who are still in the early stages in the training. The data was gathered through a semi-structured survey instrument.

Gleaning from the major findings of the study we conducted, I could say that CBT is still in its germinal stage in the Philippines. Filipino mental health professionals have started getting themselves acquainted with some very basic understanding of the theoretical propositions of the CBT approach and some of the more common CBT interventions but still lack the level of competence required for them to feel confident to employ the CBT approach in their practice.

The results revealed that there seems to be higher recall of the work of Albert Ellis and the importance of looking at "irrational beliefs" when they are asked about the major proponents of CBT, although there were also a good number who claimed to be familiar with the work of Aaron Beck and his propositions about the importance of "core beliefs". However, there is a seeming lack of familiarity with the more recent developments and current proponents of CBT. As mentioned above, there was also clear evidence that the participants have a basic understanding of the basic processes involved when using CBT as an approach but it does not appear to be at a level where they feel efficacious enough to apply these techniques in their actual practice. Most of the respondents reported that they acquired knowledge of CBT from their graduate training. Students report that more attention is now given to CBT in their introductory psychotherapy classes but only a few reported having taken advanced or specialized seminar training in CBT in their graduate programs. Other participants noted that they gained exposure to CBT by attending workshops sponsored by the major professional organizations. Those who attended these workshops also reported that although they may have achieved basic knowledge to conceptualize and develop treatments plans, they still feel hesitant to apply what they learned in their practice.

In conclusion, it was rather apparent based on the results of our study that there is still a lot of work that needs to be done to get Filipino mental health professionals to confidently employ CBT in their practices. One very frequently suggested need forwarded by the participants is the need for further training. Indeed, there are very limited opportunities for Filipino mental health professionals to receive intensive and supervised training in CBT. I for one had to fly to Pennsylvania to attend the Beck Institute workshops. However, I am optimistic that as the mental health profession in the Philippines heads towards pushing for more evidence-based mental health interventions, it will be inevitable that there will be more mental health professionals who will see the need to get further knowledge and training in CBT. It is my belief that 5 years from now, the impact of CBT on mental health practice in the Philippines will be more widespread and will have a more prominent presence in the delivery of mental health services.

Reference

Reyes, J. A. S. & Garcia, J. A. S. (2014) Perceptions of Filipino mental health trainees on Cognitive Behavioral Therapy. *Philippine Journal of Counseling Psychology, 16*, 94-103.

USING COGNITIVE THERAPY TO HELP STUDENTS MANAGE THE STRESS OF THE COLLEGE ADMISSIONS PROCESS

DEBORAH ROTH LEDLEY, PHD
PRIVATE PRACTICE
SUBURBAN PHILADELPHIA, PA

Dr. Ledley received her Ph.D. in psychology from the University of Toronto in 1999 and completed a post-doctoral fellowship at the Adult Anxiety Clinic of Temple University. She then spent several years on faculty at the University of Pennsylvania at the Center for the Treatment and Study of Anxiety. Since 2006, Dr. Ledley has been in private practice in the suburbs of Philadelphia where she primarily works with children, adolescents, and adults with anxiety disorders. Dr. Ledley's research has focused on the nature and treatment of anxiety. She has published almost 50 scientific papers and book chapters, as well as four academic books. Her book "Making Cognitive-Behavioral Therapy Work," soon to be published in its Third Edition, is a best-seller in the field of clinical psychology. It has been translated into several languages and is used as a textbook in many clinical psychology training programs in the United States and Canada. Dr. Ledley enjoys teaching other clinicians about the treatment of anxiety and regularly lectures both locally and nationally.

Over the past several years, I have noticed that teenagers who initially presented for treatment of an anxiety or mood disorder remain in treatment once these disorders have remitted in order to have support during the lengthy college admissions process. With hard-core homework and pressure to join elite travel sports teams beginning in first grade, it is no surprise that college stress gears up when the Preliminary SAT (PSAT) is administered (as early as sophomore year), right up until Spring of Senior Year when students are making their final college choices.

Fortunately, cognitive-behavioral therapy (CBT) has much to offer to students during this stressful time. CBT techniques can help our young patients approach this life stage differently than their peers and perhaps even influence their peer group in a positive way.

It is important to first ask why this stage of life is so stressful for young people, particularly in affluent areas of the country. For the vast majority of students in our country, the prime concern is how to pay for *any* college education. In affluent areas where paying for college is less of a concern, stress seems to be caused by the following beliefs:

1. Every choice I make will affect where I go to college.
2. I must go to a "top" college.
3. There is one "perfect" college for me.

Let's examine these thoughts.

From a very young age, students (and sometimes their parents) believe every choice they make must be calculated according to whether it will help with the college admissions process. One student who I worked with had stopped playing soccer, her most loved sport, and had started running track (which she excelled at, but hated) because her parents believed track was more likely to garner her an Ivy League scholarship. This is just one example, but repeatedly I see young people who have lost sight of what they truly love *right now* and instead are living for some future promise that may or may not come to pass.

In these cases, examining pros and cons can be helpful. While the pro of such choices *might* be admission to a great college, often the cons list is quite a bit longer – and is happening in the "here and now". CBT can help clients recognize that they are making undue sacrifices for outcomes that may or may not happen, and that may or may not even make them happy. I remind clients "we do not have a crystal ball." What we do have is the ability *right now* to make choices that make us happy and healthy. I spend time with my clients re-discovering what they love and helping them to find time to do those things – even if it means they decide to play the common violin instead of the rare English horn.

It is also helpful to have clients do surveys with adults who they admire. One client I worked with dreamed of being a neurosurgeon. She believed that to accomplish this goal, she needed to get an A+ grade in every course, through every year of school. This meant focusing on school to the exclusion of friends and activities. We did a survey of successful physicians, asking them about their grades throughout high school, college, and medical school. My client was amazed to learn that many of these "top docs" had been average high school students, and one had even failed her first year of medical school! This gave my client the confidence to dial back a bit on her schoolwork. Through these exposures, she actually saw that her grades stayed the same, but that she now also had time for activities and friends.

Many clients who I work with believe that they *must* go to a "top" university and that there is one "perfect school" for them. I take a stance of wonderment when clients share these beliefs! I point out to my clients that there are over 3000 colleges in the United States, not eight, as many people think! I ask my clients, "Why do you believe you *must* go to *that* school?" or "What do you think makes that school perfect for you?" So often, clients cannot provide one answer to these "why" questions and this allows the therapist to begin a very fruitful discussion of social pressure, stepping outside the "cookie cutter" and taking a unique path, and being okay with something that is less than the best (but still very good).

I encourage my clients to take a few nights off their SAT and ACT prep and instead read Frank Bruni's excellent book, "*Where You Go*

(CONTINUED PG. 10)

SUICIDE: THE URGENT NEED FOR MORE TRAINING AND BETTER TREATMENT

SHANE G. OWENS, PHD, ABPP

Shane G. Owens, Ph.D., ABPP is in private practice in Commack, NY and is the Assistant Director of Campus Mental Health Services at Farmingdale State College. He is board certified in behavioral and Cognitive Psychology. In addition to providing training on evidence-based suicide assessment and treatment, he specializes in the treatment of anxiety and mood disorders in college students and emerging adults. Follow him on Twitter @drshaneowens.

Suicide is an anxiety-provoking topic, even for those who deal with it frequently in their research or in their practice. For this reason, we tend to avoid talking about it with our patients, with each other, and with our trainees.

If you are like most psychologists trained in the United States, you have very little (if any) formal training in suicide assessment and intervention. You likely were taught to ask a couple of questions related to suicide and self-harm as part of a complete clinical interview. You dutifully ask those questions and document the responses in your records with something like, "denies suicidal ideation and intent." Unfortunately, this is insufficient in terms of appropriate treatment planning and woefully insufficient in terms of professional liability.

Even if you have formal training in suicide assessment, it is unlikely that you have updated it recently. Unless you have, your training is likely out of date. For instance, you were probably taught that active suicidal ideation should concern you more than passive suicidal ideation. As it turns out, there is no difference in predictive value for active versus passive suicidal ideation (Silverman & Berman, 2014). Very recent evidence—not yet published—suggests that many people attempt suicide without ever thinking about it prior to the act. You might also have been taught that hopelessness is closely tied to suicide risk. As it turns out, hopelessness might not be a good predictor of suicide attempts or death. Each time we look at what we think we know about suicide, we come closer to the conclusion that we cannot reliably determine who presents an imminent threat.

The same is true for treatment of suicidal thoughts and behaviors. Despite diligent work in this area, treatments do not appear to be very effective. It is worth noting that there are promising new treatments are currently in development.

The US suicide rate is higher now that it has been in more than 25 years. According to the Centers for Disease Control and Prevention, 42.773 people Americans killed themselves in 2014. It was the 10th leading cause of death overall and the 2nd leading cause of death for people between 15 and 24.

Suicide is not the only treatable behavioral problem that kills people, but it is the most immediately dangerous.

A sizable minority of people who die by suicide do so within a month of seeing a mental health professional. Most psychology trainees see a person in suicidal crisis. About 1 in 9 will have a patient die by suicide during his or her training (Kleespies, Penk, & Forsyth, 1993).

Even the smallest, most specialized practice sees at least one patient with suicidal ideation. In the case that your practice refers people who are at-risk for suicide to other practitioners, you and your staff still must be able to assess for suicide risk and make appropriate treatment decisions.

Suicide has historically been treated as a symptom of a larger syndrome, most often depression. While it is closely related to many diagnoses—anxiety, obsessive-compulsive disorder, post-traumatic stress disorder, eating disorders, schizophrenia—suicide is a distinct set of emotions, thoughts, and behaviors that must be dealt with directly. In cases where the threat is imminent or persistent, it must be treated and well-managed before any other treatment is provided.

We must rethink the way that most clinicians deal with suicide. Once even a mild threat appears, that must become the focus of treatment. Suicide must stay the focus of treatment until the threat is managed.

We must ensure that we and those we train receive adequate exposure to suicide assessment and treatment planning. This should be a requirement of curricula in the same way some states mandate child abuse reporting and bullying prevention courses.

Finally, we must devote more resources to the study of suicidality. We require better tools for the assessment of imminent threat. In addition, we must improve the effectiveness of our current treatments.

References

Kleespies, P. M., Penk, W. E., & Forsyth, J. P. (1993). The stress of patient suicidal behavior during clinical training: Incidence, impact, and recovery. *Professional Psychology: Research and Practice, 24(3)*, 293-303. doi:10.1037/0735-7028.24.3.293

Silverman, M. M. & Berman, A. L. (2014). Suicide risk assessment and risk formulation part O: A focus on suicide ideation in assessing suicide risk. *Suicide and Life-Threatening Behavior, 44(4)*, 420-431. doi: 10.1111/sltb.12065

IACP'S PRESIDENT-ELECT'S MESSAGE
CONTINUED FROM PG. 1

CBT therapists and researchers can easily identify the defects and pitfalls of such published material, this may cause confusion in the minds of many young mental health professionals who are not familiar with psychotherapy literature. Scott Miller's post in his blog in November 2015 (www.scottdmiller.com) highlights the headline from one of Sweden's largest daily newspapers that states "The one sided focus on CBT is damaging Swedish mental health..." and continues by saying that Swedish National Audit Office concludes that "When all you have is CBT, mental health suffers." He posited that after spending 7 billion crowns, the National Audit Office concluded that CBT had no effect on the outcome of people disabled by depression and anxiety and nearly a quarter of people treated with CBT dropped out. He concluded that the treatment approach does not account for the variance in outcome and therefore supports the old "dodo bird" verdict. This contradicts with the good news that states "The extent of evidence for effectiveness of CBT have reached to such an extent that professional and governmental organizations recognize its value and thus CBT is strongly advocated for treatment of anxiety disorders, unipolar depression and eating disorders in some national guidelines." We, as CBT therapists, obviously find the former type of news to be concerning and have to further investigate these kinds of contradictory findings.

Many studies do not adequately describe their treatment procedures and therefore, cannot reliably be measured in terms of adherence and competence. It is our need and perhaps duty to define better the key principles that constitute good practice of CBT.

Clinicians' self-reports of doing CBT may not always be a reliable predictor of their adherence and competence in pursuing good practice of CBT. The appropriateness and quality of its implementation and delivery needs to be defined better. No doubt, it has been a major advancement to establish internet based treatments. Unfortunately some professionals are keen to distort the reality and persist in making the most unfortunate interpretation out of a brilliant advancement in the field. If we look at the Guardian Post written by Oliver Burkeman on January 7, 2016 (www.theguardian.com/science/2016/jan/07/therapy-wars-revenge-of-freud-cognitive-behavioural-therapy?CMP=fb_gu) titled as "Therapy wars: the revenge of Freud", we will hear about the story of a British woman called Rachel from Oxfordshire who sought therapy from the NHS for depression. According to the article, she was asked to sit through a group of PowerPoint presentations that promised "improving mood states" and received CBT from a computer in between sessions. She remarked "I don't think anything has ever made me feel as lonely and isolated as having a computer program ask me how I felt on a scale of one to five" and carried on stating "I may be mentally ill, but I do know that a computer does not feel bad for me." No doubt that as CBT experts we all know that computerized CBT is not there to replace therapists, but can we imagine how a young therapist candidate may be influenced by a media-coverage like these? The same article emphasizes the significance of client therapist relationship in treatment outcome and tries to imply that CBT is a treatment approach in which therapist-client relationship is totally ignored despite many books and articles written by CBT experts about the significance of this issue. Unfortunately it also refers to CBT as a discipline that views painful emotions as "something to be eliminated" (quoted from the Guardian).

Getting back to the point I started with, we need to define our discipline better by referring to key principles and guidelines that constitute a good practice of CBT. That takes us back to issues of adherence and competence. Adherence measures tell how much therapists do what they are supposed to do, while competence measures tell how well therapists do what they are expected to do. In their commentary to the article "The effects of CBT as an anti-depressive treatment is falling: a meta-analysis" that appeared in a prior (June 2015) issue of this newsletter, Aaron Beck and Scott Waltzman elegantly discussed their concerns about the validity of the conclusions drawn by the authors of this article. In their discussion, they also refer to issues of measuring therapist adherence and competence. There is increasing data that shows that improving competence improves treatment outcomes. I want to draw attention to that fact that the term "CBT" may be losing its specificity. Dissemination is a necessary but not sufficient construct. If we only rely on dissemination, this may result in discrediting of the approach due to lack of competent adherence. The time has come to emphasize the significance of "dissemination of good-practice." This requires clarification of treatment procedures, defining the optimum pre-requisites that constitute a reasonable CBT. An effort that we initiated many years ago as a task force of EABCT under the leadership of Isaac Marks (Common Language in Psychotherapy Procedures; www.commonlanguagepsychotherapy.org) aimed to serve this goal where therapists explain what they do in their daily practice (with a case illustration) in order to facilitate the use of the same procedures to describe a therapeutic intervention. The lack of a widely agreed empirical definition ends up with various therapists using the same term to describe different procedures, which slows down the evolution of psychotherapy into a science.

We need to define the role and limits of low therapist input treatments such as internet based ones and how they can be competently utilized within a health care system and which patients would benefit from lower intensity interventions and which requires more contact with the therapist.

To conclude, CBT is the treatment approach with the strongest current evidence base for many psychological problems. However,

(CONTINUED ON NEXT PAGE)

when problems are identified as suitable to be treated by cognitive behavioral approaches, CBT may not be readily available and when CBT is available, the question of whether it is always CBT remains to be better analyzed. When professionals refer to patients as "treatment refractory", we need to find out whether this labeling is appropriate. This can only be done if client perceptions of what was done in treatment match with well-defined procedures of what should have been done in sessions and in between sessions. We need to make sure that effective components of CBT, such as in session and in between session activities are competently designed, as good adherence does not necessarily imply competent delivery. One of my aims will be working on defining "optimum" standards of training instead of "minimum" standards by having close collaboration with societies such as Academy of Cognitive Therapy (ACT) and European Association of Behaviour and Cognitive Therapies (EABCT) that have different standards for certification and accreditation of cognitive behavior therapists. Setting up similar standards in certification and accreditation procedures of CBT trainings may be an important issue to consider during my presidency.

I am hoping that my background experiences both with EABCT and ACT will help facilitate this cooperation and collaboration between the two major CBT societies. Having served in different positions including the presidency and particularly having worked as a member of the first training and accreditation committee of EABCT gave me the chance to learn about different and common needs of various European associations serving under the same umbrella. Having had a longstanding bond with ACT as a founding fellow and certified supervisor and trainer, I am hoping that both communities will be willing to cooperate in order to find common ground to set joint guidelines in certification and accreditation procedures.

Bridging the perceived gaps within the CBT family is another issue to be taken seriously considering the increasing demand to learn more about the "third wave" therapies which are sometimes perceived to be totally distinct approaches. An important initial step was taken at the last ABCT convention in Chicago where Steven Hayes and Stefan Hoffman had a dual conversation regarding how to fill in the perceived gaps. The IACP board will be happy to facilitate bridging these gaps given the task to take part in doing this.

And last, but not least, I would like to mention two major CBT congresses that will be organized in Europe in the year 2017. One of these congresses will be the 9th International Congress of Cognitive Psychotherapy (ICCP) that will be held in Cluj-Napoca, Romania (www.iccp2017.org) and the other one will be the 47th Congress of the European Association for Behavioural and Cognitive Therapies (EABCT) organized by the Turkish Association of Cognitive and Behavioural Therapies (TACBT) that will be held in Istanbul, Turkey (www.eabct2017.org) That gives me two hats to wear as the president elect of IACP and the president of TACBT. I will give more details about both of the congresses in forthcoming newsletters.

I thank you all for giving me the opportunity to take a leading role in this distinguished and highly esteemed CBT community. I look forward to serving you in the best way I can over the next few years. Please do not hesitate to guide me to serve you better.

Mehmet Sungur, MD
President Elect, IACP

CBT HAS NOT LOST ITS MOJO

CONTINUED FROM PG. 3

outcome. However, as Robert DeRubeis and colleagues noted in a 2013 *Psychotherapy Research* article, these figures were not derived through meta-analysis or other statistical approaches common to empirical reviews of the literature, and therefore the ability to verify or replicate these findings is limited. Empirical studies of treatment outcomes have consistently found correlations between outcome and the therapeutic relationship ranging from .21 to .29. Therefore, the corresponding percent of variance in clinical outcomes accounted for by the therapeutic relationship (coefficient of determination) could actually be between 4% and 8%. So while Lambert and colleagues reported that therapeutic relationship accounts for 30% of the variance in treatment outcomes, there are good reasons to think that the actual number is much lower, perhaps in the single digits. Therefore, although the relation between the therapeutic relationship and treatment outcomes is consistently demonstrated in the empirical literature, the magnitude of that effect remains unclear. The CBT practitioner holds that the therapeutic relationship is necessary but insufficient to bring about optimal clinical outcomes. Therapists do not have to choose between a good therapy relationship and specific CBT interventions. The state of the science suggests that both are important for patients to get the quickest and most durable results.

In considering the effectiveness of CBT it is important to note that this approach is much more than thought logs or telling the client to think positively. CBT is a principle-based skills-training approach that is highly relational, flexible, and collaborative.

Note: A 750 word version of this response was accepted by Psychotherapy Networker's Letters to the Editor Department and will be published in their next issue.

THREE KEYS TO MORE EFFECTIVE CBT EDUCATION

CONTINUED FROM PG. 4

3) *Training must incorporate practice of future desired performance* –

Learners must actively respond to instruction in ways that resemble the performance objectives. If a recitation of facts about CBT is the objective then they must practice this. If implementation of clinical procedures is desired then they must practice these with the trainer. Lectures and readings will not produce trainees who can employ the tools of therapy; role-play with observation, confirmatory and corrective feedback and eventual supervised clinical practice exemplify training practices that produce skilled therapists.

Reference

Sudak, D., Codd, III, R.T., Sokol, L., Gittes-Fox, M., Reiser, R., Ludgate, J. & Milne, D. (2015). *Training and supervising Cognitive-Behavioral Therapy.* Wiley: Hoboken, NJ.

Editor's note: The authors are pleased to report that readers of *Advances* who are interested in purchasing this book can order direct from Wiley (www.wiley.com) and save 20% by using the promotion code SCBT2.

Endnotes

1. A more extensive discussion of these and other principles can be found in Sudak et al. (2015).

USING COGNITIVE THERAPY TO HELP STUDENTS MANAGE THE STRESS OF THE COLLEGE ADMISSIONS PROCESS

CONTINUED FROM PG. 6

is Not Who You'll Be." In this book, Bruni reports that many highly successful people went to inexpensive state schools. They didn't go to these schools because it was their dream – they went because it was what their parents could afford, or because their boyfriend was going there, or because it offered a program that matched their interests, or maybe it was the only school that person got into - and yet they succeeded anyway! Following discussion of this book, we again use surveys to ask respected adults where they went to college, how they chose that school, and what they feel contributed to their success in life. These real world conversations can very powerfully shift beliefs.

During this process, it is fruitful to also meet with the client's parents. Although many clients put pressure on themselves, or absorb the high standards of their peers and schools, some have pressure put on them by their parents – either overtly or subtly. What are parents' views of the importance of going to a top college? Did they go to a top college and if not, do they feel that they were held back in achieving their goals and dreams? Do they feel pressure in their own social group to report that their children are going to excellent schools? Parents can also be encouraged to take a step back and examine their beliefs, and explore how their beliefs are impacting the health and happiness of their children. Changing beliefs within the whole family can serve as a barrier against the powerful social pressures we experience in our peer groups, schools and in the world at large.

Suggested reading:

Bruni, F. (2015). *Where you go is not who you'll be: An antidote to the college admissions mania.* New York: Grand Central Publishing.

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

The next deadline for submission is May 15th, 2016. Submissions should be 350-900 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.