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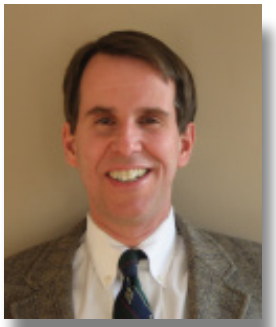

ACT PRESIDENT'S MESSAGE

JOHN WILLIAMS , MD

Dear Members of the Academy:

With a wistful sense of the passing of all things human, I begin my last column as president of the Academy of Cognitive Therapy. It has been a remarkable year of growth for the Academy. We have agreed to commence, are completing, or have finished cognitive therapy training projects in California, Texas, North Carolina, and most recently New York. Currently, we are also negotiating to provide training in a major country where the potential demand for cognitive behavioral therapy is essentially unlimited. Our certification numbers continue to show strong growth as well, but perhaps the most exciting news is that we have established an endowment for the Academy, ensuring its survival for many years to come.

With an unanimous Board vote, the Academy of Cognitive Therapy decided to set aside $300,000 to establish the endowment - the first in the organization's 16-year history. This effort began in earnest roughly a year ago. I would like to personally thank ACT's Executive Committee: Lynn McFarr, PhD, President Elect; Dennis Greenberger, PhD, Past President; and Leslie Sokol, PhD, Secretary. I also extend a very special thank you to ACT's Treasurer, Allen Miller, PhD, MBA. Allen took especial care in vetting investment firms and drafting an investment policy.

Based on Allen's recommendation, the Board of Directors chose the investment management company Pennsylvania Trust as the fiduciary responsible for managing ACT's endowment. Pennsylvania Trust is a prudent organization with over 30 years of experience as an investment manager. The firm is client-focused and is known throughout Greater Philadelphia for its integrity and production of superior investment results, as well as its modest fees. I could not be happier with the Board's decision and am confident in Pennsylvania Trust's ability to grow ACT's investment.

Now a brief word about the purpose of ACT's endowment. The assets of the Academy for Cognitive Therapy's investment portfolio are intended to last in perpetuity to support the ongoing operations and programs of the Academy. The primary objective for the investment portfolio is long-term capital appreciation, with income generation as a secondary consideration. The account will be invested so as to provide the greatest probability of achieving the return objective with the least amount of risk.

So, although all of us must pass, endowments live on, and with its new fund, ACT, already a strong organization, will

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STANDING ON THE SHOULDERS OF GIANTS: AN INTRODUCTION TO RICHARD G. HEIMBERG, PHD

SIMON A. REGO, PSYD, ABPP, ACT, MONTEFIORE MEDICAL CENTER/ ALBERT EINSTEIN COLLEGE OF MEDICINE, BRONX, NEW YORK

A major perk in being Editor of *Advances in Cognitive Therapy* is the opportunity that it provides to connect with colleagues around the world who share the same passion for CBT. And for a big fan of CBT like me, the ultimate thrill has been to be able to reach out to some of the luminaries in the field and invite them to write about the people and/or events that have been influences on their training. Thus far, *Advances* has featured contributions from giants in our field such as Art Nezu, David M. Clark, Christopher Fairburn, Philip Kendall, Jack Rachman, Aaron Beck, Anne Marie Albano, Edna Foa, David Barlow, Marsha Linehan, Isaac Marks, and most recently, Gerald Davison.

For this issue, I present to you Dr. Richard G. Heimberg. It's difficult to imagine where the treatment of Social Anxiety Disorder would be without Dr. Heimberg – and the many doctoral students and post-docs that have come out of his lab. As the Director of Psychology Training at Montefiore, I pressure Dr. Heimberg each year to tell me which of his students I should interview – and he always has the same response: all of them, because they are all excellent! So I typically do. And they typically are. All I can say is thank goodness for your mother's requirement (and Dr. Droppleman's course on abnormal behavior), Rick!

Before you hear from Dr. Heimberg, here's a brief biography:

Richard G. Heimberg received his PhD from Florida State University in 1977. He is the Thaddeus L. Bolton Professor of Psychology and the Director of the Adult Anxiety Clinic of Temple University. He is well known for his efforts to develop and evaluate cognitive-behavioral treatments for social anxiety disorder. Dr. Heimberg has published 11 books and more than 425 papers on social anxiety and related topics. He was recently listed among the top 1% of cited authors in his field according to Thomson Reuters' Essential Science Indicators.

Dr. Heimberg is Past President of the Association for Behavioral and Cognitive Therapies (ABCT) and the Society for a Science of Clinical Psychology (SSCP) and Past Editor of *Behavior Therapy*. Dr. Heimberg was the inaugural recipient of the Academy's A.T. Beck Award for Significant and Enduring Contribution to Cognitive Therapy (2001). He has mentored over 60 doctoral students in clinical psychology over his career and has received several awards for his mentoring work: from ABCT (Outstanding Mentor 2006), from the Society of Clinical Psychology (Toy Caldwell-Colbert Award for Distinguished Educator in Clinical Psychology, 2014), from the American Psychological Association of Graduate Students (Raymond D. Fowler Award for Outstanding Contributions to Students' Professional Development, 2015), and from SSCP (Lawrence H. Cohen Outstanding Mentor Award, 2016). This year, he received the Philadelphia Behavior Therapy Association's Lifetime Achievement Award.

STANDING ON THE SHOULDERS OF GIANTS

RICK HEIMBERG, PHD

I am deeply honored to contribute to this series and be included in the list of luminaries who have come before, several of whom have had a meaningful impact on my career. That said, my first influences were my parents. My father, a physician who studied lipid metabolism in a long and productive research career and who is still going strong at 91, taught me much about how to approach problems with the mindset of a scientist and how to approach other people with humility and kindness. He also set a very high standard for hard work and productivity, and I hope I have made him proud.

My mother, an educational psychologist, required that I take at least one psychology course as a condition for her support of my college tuition at the University of Tennessee at Knoxville. I took intro psych, and I hated it! However, I knew that there had to be more to it than the unappealing mass lecture course I took at UT, and I enrolled in a course on abnormal behavior. I was totally captured by the subject matter, and importantly, by the instructor, Dr. Leo Droppleman, a former Catholic priest who made the material come alive in a way that touched me. I knew then that I wanted to be a clinical psychologist. I was transformed from a middling student going nowhere to one with a goal, and I excelled in the remainder of my college studies.

I entered the doctoral program at Florida State University the fall of 1972. My original mentor left for private practice in my first year, and I searched for a new one. I found Charles Madsen, Jr., and he has probably been the single largest influence in my career. Charlie was a clinical and school psychologist who had devoted much of his professional life to contingency management in the classroom, but I wanted to study topics that today would fall under the rubric of social anxiety disorder. Charlie stepped outside himself and agreed to mentor me through most of my graduate career, allowing me the freedom to pursue my interests and doing everything he possibly could to facilitate my journey. Charlie, I do not know if you ever fully appreciated your impact on me. Because I was a shy young guy with a lot of knowledge about how to get things done, you focused your efforts on helping me build a basis in self-confidence that has given me the chance to have the career I have had so far. Also a part of my journey was Anne Marie Albano, my very good friend since

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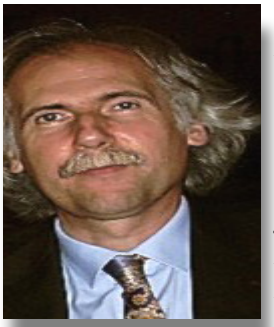
COGNITIVE BEHAVIOR THERAPY IN ITALY
GIOVANNI A. FAVA, MD AND RITA B. ARDITO, PHD



Giovanni A. Fava, M.D., is currently Professor of Clinical Psychology at the University of Bologna and Clinical Professor of Psychiatry at the State University of New York at Buffalo. He has authored more than 500 scientific papers and performed groundbreaking research in several fields. He is editor-in-chief of Psychotherapy and Psychosomatics, a journal published by Karger that, with its current impact factor of 7.63, ranks fourth among the Science Citation Index psychology journals (but it is the first of those publishing original research), and seventh in the psychiatry ranking.

Rita B. Ardito, Ph.D., is Associate Professor of Clinical Psychology at the University of Torino. She is currently the President of the Italian Society of Behavioral and Cognitive Therapy. She is an Adult Attachment Interview (AAI) reliable coder, has authored many papers in the domain of clinical psychology and psychotherapy, and is editorial board member of various peer-reviewed journals.

Cognitive behavior therapy is achieving increasing importance in Italy. Up until the 1970s the psychotherapy field was largely dominated by the psychodynamic orientation. In 1972, however, the Italian Society of Behavioral and Cognitive Therapy (Società Italiana di Terapia Comportamentale e Cognitiva, SITCC, www.sitcc.it) was founded. Then, in 1977, the Italian Association for Behavioral Analysis and Modification (Associazione Italiana di Analisi e Modificazione del Comportamento e Terapia Comportamentale e Cognitiva, AIAMC, www.aiamc.it) was established. Due to the efforts of early pioneers such as Vittorio Guidano, Giovanni Liotti, Bruno Bara, Mario Reda and Ezio Sanavio, both societies have shown considerable growth. SITCC has now 3800 members and holds a national meeting every other year. It also publishes the journal Quaderni di Psicoterapia Cognitiva. AIAMC has 2300 members and also has a national meeting every other year. It also publishes the journal Psicoterapia Cognitiva e Comportamentale. Both societies are accredited by the European Association of Behavior and Cognitive Therapy (EABCT) and are involved in a number of schools for professional training.

Several Italian authors have also contributed to new developments and conceptualizations of the CBT approach (Guidano and Liotti, 1983; Guidano, 1991; Bara, 2005), with the latest monograph being on Well-Being Therapy - a new technique that combines CBT techniques with monitoring of psychological well-being instead of distress (Fava, 2016).

Research has also played an important role in the growth of Italian CBT. For example, the first randomized controlled trial introducing the sequential combination of pharmacotherapy in the acute phase of depression, followed by CBT in its residual phase was performed in Italy (Fava et al., 1994). In light of current evidence, this appears to be the best strategy for preventing relapse in depression (Guidi et al., 2016). Other important research contributions regarding, for example, metacognitive functioning in psychotherapy (Semerari et al., 2003) and the role played by disorganized attachment in trauma-related disorders (Liotti, 2004) have appeared in international journals.

Finally, CBT is an increasingly important component of clinical practice in Italy, both in the public and private sectors. It is the favorite target of specialization by young graduates in clinical psychology, supplanting other approaches that were very popular two decades ago.

In summary, there has been an impressive progress growth of CBT in the past two decades in Italy, as well as a number of indications for positive future developments.

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ROADBLOCKS TO THE USE OF SOCRATIC QUESTIONING IN COGNITIVE BEHAVIORAL THERAPY SUPERVISION

LYNN MCFARR, PHD AND RACHEL HIGIER, PHD
HARBOR-UCLA MEDICAL CENTER AND CBT CALIFORNIA

Dr. Lynn McFarr is the Director of the Cognitive Behavioral/Dialectical Behavior Therapy Clinic, Interim Training Director, and Interim Chief of Psychology 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 Director of CBT California (CBTC). 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. Dr. McFarr is a Beck Scholar and is on the executive board for both the Academy of Cognitive Therapy, 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 is the Chair of the annual meeting of the International Society for the Improvement and Teaching of Dialectical Behavior Therapy (ISITDBT) for 2014-2015. She is published in the areas of CBT for schizophrenia, medication compliance and adult friendships issues as well as papers on DBT processes and the development of model curricula for training doctoral students in CBT.

Dr. Rachel Higier is a staff psychologist at Harbor-UCLA Medical Center and CBT California. Dr. Higier has completed several years of training in Dialectical Behavior Therapy (DBT) and Cognitive Behavioral Therapy (CBT) as well as Acceptance and Commitment Therapy (ACT) and Cognitive Behavioral Analysis System of Psychotherapy (CBASP). She also teaches and supervises graduate-level clinicians at Harbor-UCLA on the most current evidence-based therapies. Dr. Higier completed her Ph.D. in clinical psychology at University of California, Los Angeles where she studied the biological bases of severe mental illness with a focus on transdiagnostic research. She also completed an APA-accredited clinical internship at Weill Cornell Medical Center/NewYork-Presbyterian Hospital in New York City where she gained expertise in CBT for mood and anxiety disorders and personality disorders. Dr. Higier has presented her research at multiple international conferences and published several papers on the etiology of severe mental illness. Her current clinical and research interests include emotion dysregulation in borderline personality disorder.

It's 2pm on a Tuesday. Your student or staff member is coming to you with six cases they need to discuss in supervision. One case lost their housing, another had a wife leave them, still another is angry with the therapist and requested a new one. You have also listened to a tape of the supervisee's session with another patient and want to discuss the way they handled evaluating a core belief. The pull for many supervisors, especially busy supervisors with other responsibilities, is to go through each issue and tell the supervise what to do. This can work well for both supervisor and trainee. The supervisor possesses the knowledge that can be helpful to the student and can solve the student's problems in each of these arenas. But what is lost?

Cognitive behavioral therapy supervision is held in parallel to therapy, encompassing many of the same key principles (Newman, 1998). A key component of the cognitive supervision model is the use of Socratic questioning – a collaborative dialogue between the supervisor and supervisee that supports guided discovery and learning (Vyskocilová, & Praško, 2012). In an iterative conversation, the supervisor uses a Socratic style of questioning in order to help the supervisee deepen their understanding of individualized case conceptualization, technical skills and interventions, transference and countertransference phenomena as well as generalization of learning. In this way, Socratic questioning intends to help the supervisee explore the underlying meaning of client's thoughts and behaviors as well as his/her own thoughts, behaviors, and emotions as applied to their practice. The use of guided discovery in the context of supervision accomplishes two important tasks: (1) to model a key technique in cognitive behavioral therapy in order to enhance supervisee learning, and (2) to experientially deepen the supervisee's understanding of cognitive and emotional processes.

While we recommend the use of guided discovery in the practice of supervision, it is worth noting some individual factors that may impact its effectiveness. First, supervisors may want to consider developmental factors in training. Early supervisees beginning their training may require – or even desire – more didactics and explicit instruction in supervision, for example modeling how to elicit automatic thoughts, conduct cognitive restructuring, or engage in behavioral activation. Using Socratic questions to guide the discovery of the supervisee may exceed their developmental capabilities, and it is the role of the supervisor to assess and match the supervisee's level of training. However, it may still be worthwhile to utilize guided discovery as a means to teach reflexive and critical thinking from a cognitive model with the caveat that the technique is used to explore meaning and deepen understanding as opposed to guide the supervisee to a pre-determined destination (Padesky, 1993).

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NON-SUICIDAL SELF-INJURY IN YOUTH: CONSIDERATIONS FOR CLINICAL PSYCHOLOGY TRAINING

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Courtney Santucci is a 5th year clinical psychology doctoral candidate at Fairleigh Dickinson University in Teaneck, New Jersey. She is currently completing her psychology internship year at Montefiore Medical Center, where she is specializing in the treatment of children and adolescents. Her clinical experience focuses on the implementation of evidence-based treatments, including Dialectical Behavior Therapy (DBT), with depressed and suicidal adolescents and their families.

Sandra Pimentel, PhD is Chief of Child and Adolescent Psychology, Associate Director of Psychology Training, and Assistant Professor in Psychiatry and Behavioral Sciences at Montefiore Medical Center/Albert Einstein College of Medicine. She is also Director of the Anxiety and Mood Program in the Child Outpatient Psychiatry Department. Dr. Pimentel specializes in cognitive behavioral treatments for anxiety, mood, and behavioral difficulties in children, adolescents, and young adults. Advanced training and mentorship in clinical child and adolescent psychology are core professional interests.

Non-suicidal self-injury (NSSI) is a salient public health concern with potentially grave consequences. NSSI is observed in especially alarming rates in youth with studies suggesting that NSSI reaches rates as high as 17% of college students and 14% of high school students within community samples (Ross & Heath, 2002; Whitlock, Eckenrode, & Silverman, 2006).Yet, historically, evidence indicates that formal and comprehensive suicide-related training in graduate clinical psychology programs and internships is largely inadequate with some surveys revealing that as few as 40-50% of programs provide comprehensive suicide training to their trainees (Dexter-Mazza & Freeman, 2003; Ellis & Dickey, 1998; Bongar & Harmatz, 1991). Further, as an emerging clinical phenomenon, the assessment and treatment of NSSI may also be overlooked.

A significant majority of youth who engage in NSSI meet diagnostic criteria for internalizing, externalizing, and/or substance use disorders (Nock, Joiner, Gordon, Lloyd-Richardson, & Prinstein, 2006). Furthermore, despite the fact that suicide attempts are distinct from NSSI in regards to intent and function, there also exists a high rate of co-occurrence between these two behaviors, with up to 70% of adolescents who engage in NSSI reporting a history of suicide attempt (Nock et al., 2006). This finding that cannot be ignored. In Joiner's theory (2007), which explains why individuals engage in suicidal behaviors, he suggests that the elements of a thwarted sense of belongingness, a perceived burdensomeness, and an acquired capacity to enact lethal harm to oneself are critical factors leading to an increased risk of suicidal behavior. Based on this model, an acquired capacity for lethal self-harm is derived from ongoing NSSI, causing NSSI to be a potential significant risk factor for suicide. This important link highlights the need to ensure that NSSI is being appropriately assessed and targeted. Although NSSI was historically observed in patients diagnosed with Borderline Personality Disorder (BPD), its relevance as an issue of clinical importance extends far beyond this diagnostic category. Given the unique and significant levels of impairment in functioning observed among individuals engaging in ongoing NSSI, some researchers have argued that it even warrants consideration as a stand-alone diagnosis (Selby, Bender, Gordon, Nock, & Joiner, 2012).

Given that the majority of clinical psychology trainees are likely to encounter patients who are at-risk for suicide (Dexter-Mazza & Freeman, 2003; Kleespies, Penk, & Forsythe, 1993), and NSSI as an emerging potential risk factor for suicidal behavior, clinical psychology graduate and internship programs need to provide more formal and comprehensive suicide-related training that includes NSSI. More specifically, we suggest that the following recommendations be taken into consideration:

1) All programs can strive to develop and include systematic suicide- and NSSI-related curricula that includes didactics, supervision, case conferences, readings, and other traditional instructional methods.

2) Suicide- and NSSI-related assessment can be specifically identified as competence skills to be learned and therefore targeted via behavioral rehearsal with simulated patients as an instructional tool (Beidas, Cross, & Dorsey, 2014).

3) Recent advances in the field's understanding of NSSI include a more thorough examination of its link to difficulties in affect regulation and interpersonal communication, which help to highlight the interpersonal and intrapersonal functions the behaviors may serve (Nock, 2009). Thus, it is imperative that trainees are provided with not only the appropriate language to employ in thoroughly assessing the presence of NSSI, but also a comprehensive understanding of the function of the behavior in an effort to establish a targeted treatment plan. Therefore, providing direct training on functional behavior/chain analyses regarding suicidality and

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TRAINING PSYCHIATRY RESIDENTS IN CBT – WHAT'S NEW AND WHAT WORKS

DONNA M. SUDAK, MD
DEPARTMENT OF PSYCHIATRY, DREXEL UNIVERSITY COLLEGE OF MEDICINE

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 in teaching and patient care. She has made a number of significant contributions to the literature in CBT education and has played a major role in developing suggested curricula and guidelines for resident competency in Cognitive Behavior Therapy. She also has multiple publications regarding combining treatment with medication and CBT.

In addition to her teaching responsibilities at Drexel University College of Medicine, Dr. Sudak is an adjunct faculty member at the Beck Institute. 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 the Association of Behavioral and Cognitive Therapies and the American Association of Directors of Psychiatric Residency Training, including her current position as Secretary of AADPRT.

Dr. Sudak's latest book, Teaching and Supervising CBT , written with R. Trent Codd, John Ludgate, Leslie Sokol, Marci Fox, Robert Reiser, and Derek Milne, is a significant addition to the literature supporting CBT educators.

As most CBT educators in psychiatry training programs know, there has been a mandate to train psychiatry residents in cognitive behavioral therapy since 2001. The landscape in training in psychiatry residency has changed dramatically since that time - in 2001 at least 25% of programs in United States had no training required in CBT (Sudak, Beck & Gracely, 2002) and now 99% endorse having some training (Weissman et al, 2006). The number of patients seen and didactic hours available to psychiatrists in training, however, varies widely (Sudak & Goldberg, 2012). One frequently acknowledged obstacle to adequate training is a lack of faculty available, particularly for supervision.

Residency training programs are now required to specify educational attainment by residents to the ACGME (Accreditation Council for Graduate Medical Education). Such specification transpires in the form of "milestones", which are a series of ratings of measures of competency which are reported twice yearly on each resident. Milestones include a specific item regarding effective delivery of CBT with patients of increasing complexity. There is, however, no specified mandate regarding how such competency is determined. Residency programs report that they are currently far more likely to use tape review as a means of assessing residents, which is a significant shift in how evaluation occurs (Sudak & Goldberg, 2012). There is a psychotherapy committee within AADPRT (the Association of Program Directors in Psychiatry) which is developing instruments to measure milestones in basic and more advanced psychotherapy skills and disseminate these among members, so that there may be better standardization among resident evaluation in the future.

Challenges in CBT training in psychiatry residents remain considerable. First, there is significant time pressure - enormous numbers of diverse experiences are required in psychiatry residency training. Residents are required to have a six-month exposure to internal medicine and neurology, followed by eight months of inpatient psychiatry, in addition to consultation liaison psychiatry, child and adolescent psychiatry and emergency psychiatry. A one-year experience in outpatient psychiatry is mandated, but the clinical sites where this experience occurs and the types of patients available for residents to see are extremely variable among programs. Inpatient services available for training frequently have quite a short average length of stay and many have a lack of CBT programs for patients. Finally, there is an increased emphasis on learning neuroscience within psychiatry training, which is certainly important, but another consumer of educational resources. Most psychiatry departments, like many departments in academic medicine, are financially struggling, and must choose what to fund from among many competing priorities.

Another challenge in psychiatry residency training in CBT is that medical students frequently have very little in the way of behavioral science training. It is not uncommon to need to teach basic principles of behavioral and learning theory to residents (try asking a group about principles of reinforcement as an illustration). Residents come to training from a wide range of cultures, and often have beliefs about psychotherapy that need to be addressed for optimal participation in learning CBT. They also may need to assert themselves in their clinical setting to be assigned patients who are not chronically mentally ill and in need of medication management and, therefore, extremely challenging as an initial patient to treat with CBT.

The following are some tips for working with psychiatry residents.

- Know your learner. Conceptualize her training needs.
- Determine what didactic lectures are available to your learner, if you are not involved in providing these, and determine whether the didactic learning is at all experiential. Role-play will likely be a necessary part of supervision, as there is often little experiential practice in didactic training in CBT in residencies.
- Familiarize yourself with the clinical setting in which your learner is working in order to tailor your efforts to the types of patients available to the trainee.

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ADVANCES IN COGNITIVE THERAPY: CHANGE OF EDITOR

SIMON A. REGO, PSYD, ABPP, ACT

MONTEFIORE MEDICAL CENTER/ ALBERT EINSTEIN COLLEGE OF MEDICINE

It's hard to believe that three years have passed since I took over as Editor of *Advances* from Dr. David Dozois. In keeping with tradition, I think that the passing of three years marks a great time to now pass the torch on to someone else who will no doubt take the newsletter to new heights (more on that in a moment). Before doing so, I would like to send my sincere thanks and gratitude to Dr. Dozois for giving me this opportunity, to the Presidents of both ACT and IACP for their wonderful contributions to each issue over the years, and especially to Mr. Troy Thompson, Executive Director of The Academy of Cognitive Therapy, for his guidance, support and (unending!) patience in helping me to put together each issue. I literally could not have done this without you, Troy!

Along the way, I think we've had some really interesting newsletters that both continued some of the wonderful features that David had put into place (e.g., Standing on the Shoulders of Giants, CBT in different parts of the world), as well as stretched us readers in new directions (e.g., Trial-Based Cognitive Therapy, Integrating Spirituality Into CBT, CBT for the Unemployed, Using Technologies to Enhance CBT, CBT for Insomnia and CBT for Nightmares, etc.). So last but not least, I would like to send my sincere thanks to all of you who took the time to contribute to furthering our knowledge of CBT and its various applications and off-shoots.

As I hinted at above, however, as much as I've enjoyed serving as your Editor, it's now time to hand over the reins to someone new. And so it is with great pleasure that I introduce Dr. Jamie Schumpf as incoming Editor of the newsletter!

Dr. Schumpf is a licensed psychologist, specializing in Cognitive Behavior Therapy. She is a diplomate of the Academy of Cognitive Therapy, a member of the Association for Behavioral and Cognitive Therapies and has been elected for a second term as Treasurer on the board of New York City-Cognitive Behavior Therapy Association. She is also a program delegate for the National Council of Schools and Programs in Professional Psychology.

Dr. Schumpf is also the Assistant Director of Clinical Training in the Clinical PsyD Program at Yeshiva University, Ferkauf Graduate School of Psychology. At Yeshiva she is also a Clinical Associate Professor, and serves as Assistant Director of CBT Training and Director of Internship and Externship Training. In addition to all this, she is an adjunct Clinical Assistant Professor at Weill Cornell Medical College where she teaches and supervises psychology pre-doctoral interns and third year psychiatry residents.

Dr. Schumpf has been involved in various research projects, as a cognitive therapist on a multi-site randomized controlled trial for the treatment of panic disorder, as an investigator on a federally funded grant to provide training for graduate students in the treatment of severe and persistent mental illness and as a CBT competency rater on a federally funded study for depression. Dr. Schumpf has presented her work at national conferences and has given numerous seminars and workshops on CBT and sleep disorders.

On a personal note, I had the pleasure of working with Dr. Schumpf when she was an intern at Montefiore Medical Center back in 2007-2008. And since then, I have felt great pride in witnessing all of her post-internship accomplishments. In addition to being incredibly knowledgeable about our field, she is highly organized and efficient, as well as a true pleasure to work with. I am sure you'll agree with me when I say she has the right training, experience, and personality style to make an excellent new editor! But rather than end things here, why not finish with a few words from your incoming Editor, directly?

Congratulations Jamie, I can't wait to see where you take the newsletter!

ADVANCES IN COGNITIVE THERAPY: CHANGE OF EDITOR

JAMIE SCHUMPF, PSYD

FERKAUF GRADUATE SCHOOL OF PSYCHOLOGY, YESHIVA UNIVERSITY

Dear Colleagues: I am so excited to take over as Editor for the Advances in Cognitive Therapy Newsletter. I have some big shoes to fill following one of my mentors, Dr. Simon Rego. For me, being editor will be a nice way to

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

The next deadline for submission is January 15th, 2017. 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: Jamie Schumpf, PsyD, Editor: jamie.schumpf@einstein.yu.edu.

I look forward to hearing from you all!

be more involved with ACT and IACP and larger CBT community, and interesting for me to use a different skill set than my usual day to day (teaching, supervising, and clinical work). I am looking forward to continuing the legacy of some really fantastic columns set up by my predecessors—Standing on the Shoulders of Giants and the Application of CBT in different countries and regions. I would also like to have a more regular column reviewing new release books in our community. If anyone is interested in being a book reviewer, please contact me.

ACT'S PRESIDENT'S MESSAGE
CONTINUED FROM PG. 1

continue to ensure its growth - and by extension the value of your certification.

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

Academy of Cognitive Therapy

ACT Annual Meeting and Aaron T. Beck Award Ceremony

Philip C. Kendall, Ph.D., ABPP and Steven D. Hollon, Ph.D.

October 29th at 7:00 PM

New York City

Marriott Marquis New York, Times Square 7th Floor

STANDING ON THE SHOULDERS OF GIANTS
CONTINUED FROM PG. 2

1970-something, when she served as a research assistant on my dissertation.

Of also great importance at the time was the work of Isaac Marks, Michael Gelder, and others that made social phobia into "a thing," and in so doing, opened up many opportunities for me. Similarly important was the work of Dick McFall, Michel Hersen, and Alan Bellack on assertive behavior.

After internship at West Virginia Medical Center, supervised largely by Rick Seime, and a postdoctoral year back at FSU, I took a job at the State University of New York at Albany, where I had the pleasure of working with Ed Blanchard and Dave Barlow for many years. Ed was Director of Clinical Training for much of my time there, and he was an invaluable source of guidance and support. Dave, of course, was "the man" in the study of anxiety, and I learned so much from him I cannot put voice to it all. Anne Marie Albano was also back in my life as a post-doc for Dave. Another person of huge influence has been Ron Rapee, another former post-doc with Dave and now a Distinguished Professor at Macquarie University. When I was on sabbatical in Sydney in 1994, Ron and I crafted the first paper on our cognitive-behavioral model of social anxiety (Rapee & Heimberg, 1997), which has been so widely cited and well-received. That was a most exciting time.

In 1987, I met Michael Liebowitz, MD (then of Columbia University), who was the leading psychiatrist in the study of the pharmacological treatment of social phobia, and we began a collaboration that continues into the present day. Michael taught me much about teamwork and "reaching across the aisle" to work together in true multidisciplinary fashion. Frank Schneier and Carlos Blanco have been important influences in that way as well.

In 1996, I was recruited to Temple University, and there I remain. Working with Phil Kendall and Lauren Alloy (and my other wonderful colleagues) has reinforced everything I know about working hard, being appreciated, and appreciating the work of others.

The list goes on. Tim and Judy Beck, David Clark, Edna Foa, Jackie Persons, Gail Steketee, and Randy Frost have been influential in so many ways. James Gross has taught me much about emotion regulation. Deb Hope and Cindy Turk continue to shape my vision of social anxiety and how it should be treated. Meredith Coles, Doug Mennin, David Fresco, Deb Ledley, and Tom Rodebaugh challenge me in new ways on a regular basis, and Gayle Beck is always there when I need someone's advice, counsel, or support. Marisol Tellez, my collaborator in studies of dental anxiety, has taught me much. Finally, I thank my many current and former doctoral students and post-docs, named herein or not, for the privilege of mentoring you. I stand as much on your shoulders as you do on mine.

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ROAD BLOCKS

CONTINUED FROM PG. 4

Second, cultural considerations must be considered in using Socratic questioning in the context of supervision. Just as in therapy, cultural components enter into the supervisory relationship and impact the nature of the relationship and the supervisee's experience of techniques used in supervision. For example, some cultures prefer a directive model of learning whereby the supervisor would directly instruct the supervisee in a didactic or apprenticeship manner. In this situation, the use of guided discovery would not match the supervisee's expectations of supervision and may impede learning or frustrate the supervisee. Likewise, supervisees may be hesitant to engage in the Socratic process due to automatic thoughts such as, "I cannot look stupid in front of my supervisor," "I need to have them tell me," "I can't figure this out myself." Most of these are based in anxiety, although, as mentioned above, they may also be developmentally appropriate. It is also true that the Socratic process may elicit thoughts that are aligned with the supervisee's negative core beliefs. In some cases the supervisee may believe "I am paying a lot of money for this education, just tell me what I need to do." If the supervisor is already reinforced by being smart and correct in supervision, both the supervisor and supervisee can engage in a transaction that perpetuates this cycle and could hinder the supervisee's learning.

Strategies such as informed consent and careful assessment of expectations and cultural histories may be relevant – perhaps by using guided discovery to explore the supervisee's experience of supervision. Moreover, the nature of the supervisory relationship should be considered. Notably, individual factors, such as performance anxiety, personality correlates, learning histories concerning past supervision experiences, cultural considerations, and expectations of supervision, should be assessed throughout supervision in regards to guided discovery. However, it is crucial to point out the differences between supervision and therapy as outlined in Newman (1998) and assure the supervisee that although similar beliefs may present themselves in their work as the therapist, both the supervisor and supervisee must be vigilant to keep the discussion pertinent to the patient at hand.

Third, the context of the supervision may effect a supervisors' ability to effectively use Socratic questioning in supervision. For instance, while the Socratic method of teaching in groups has long been recommended, in group supervision, it common for other students to jump in to answer the question for the supervisee rather than giving them time to ponder the answer. The skilled supervisor must take this as an opportunity to model not only good Socratic questioning, but also good group therapy behavior by returning the focus to the supervisee with the original question.

Fourth, supervisor factors need to be considered when trying to implement Socratic questioning in supervision. Supervisors may have beliefs that interfere with taking the time to do Socratic questioning, particularly thoughts such as "There is no way he will figure this out, I just need to tell him," or, "I don't have time for this." "It's more efficient to just tell her what to do," or "I'm the only one who can really answer this question." The prior thoughts speak to beliefs about the perceived efficiency of Socratic questioning whereas the latter thoughts appeal to the supervisor's sense of specialness, as mentioned above. Of course it is generally true that the supervisor has more knowledge than the supervisee. At the same time, we generally have more knowledge than our patients as well. However, hopefully we understand that Socratic questioning is an integral, effective part of therapy that enhances the learning of the patient. Likewise, we argue that Socratic questioning is an integral, effective part of CBT supervision.

Finally, time is the enemy of Socratic questioning. In the example at the beginning of this paper, both the supervisor and supervisee can feel the pressure of time to tackle multiple pressing issues in the supervision hour. However, just like in cognitive therapy, too many agenda items reduces the therapist's ability to adequately address each one. Also, as in therapy, we recommend that supervisors collaboratively set the agenda and prioritize the items, with high risk items being at the top of the agenda. If the agenda is kept to 2-3 items, this will free up the time to focus on using guided discovery to help the supervisee develop their own clinical judgment and voice while simultaneously modeling a key cognitive therapy technique.

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NON-SUICIDAL SELF-INJURY IN YOUTH CONTINUED FROM PG. 5

NSSI may provide the necessary bridge between more preliminary risk assessment and possible intervention (Nock & Prinstein, 2004).

4) Relatedly, and more broadly, training in case formulation and conceptualization should be prioritized (Carmin & Albano, 1993; Friedberg, Gorman, & Beidel, 2008). Having foundational skills in cognitive behavioral case formulation will help to provide trainees with a theoretical framework for understanding suicide- and NSSI-related behaviors in the context of their particular patient (Andover, 2012). For youth patients, case formulations will also provide context for family and developmental considerations.

Considering its prevalence and its presence transdiagnostically, clinical psychology trainees will likely encounter a patients who are engaging in NSSI. Therefore, it is critical to provide formal, systematic, and comprehensive training that ensures clinician competence in evidence-based assessment and treatment of NSSI and its diagnostic correlates and, of course, optimal patient care.

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TRAINING PSYCHIATRY RESIDENTS IN CBT CONTINUED FROM PG. 6

- Recognize that training will take longer because residents are required to learn so many different types of therapy at a single time and that supervisors of different orientations maybe discussing the same patient with the trainee.

- Expect difficulty with specifying patient problems rather than making diagnoses.

There are several resources and references listed below that may assist you in working in this very important educational enterprise.

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Editor's note:

Interested readers can listen to a podcast by Donna Sudak on the topic of "Training and Supervising Psychiatry Residents in CBT" on "CBT Radio" here: http://cbtradio.libsyn.com/training-and-supervising-psychiatry-residents-in-cbt