

Publication of the Academy of Cognitive & Behavioral Therapies (ACBT) and the International Association of Cognitive Psychotherapy (IACP)

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ACBT PRESIDENT'S COLUMN LYNN MCFARR, PHD

The

Academy wraps
up the decade

with a year of growth. The 2010s have been very good to the Academy with the development of the largest implementation of CBT in community mental health in the country. With the new decade ahead, we have many new endeavors and changes to come. The Academy's research, training, conference presence and awards will all have a new inclusive focus.

Research

We wrapped up the first five years of our contract with Los Angeles County. The LA County Roll Out of CBT (LACROCBT), based on IAPT from the UK has trained over 1800 clinicians to basic competency. We are in the process of cleaning and entering the data and plan to evaluate and publish main outcomes in the New Year with our principal investigators Drs. Stefan Hofmann, Lata McGinn, and John Riskind. To that end, the Academy has approved of a new research committee, chaired by Scott Waltman, Psy.D., and includes Hollie Granato, Ph.D., and Lizbeth Gaona-Dill, Ph.D., who are not only excellent researchers but also know LACRO from the inside out, having served as trainers and consultants on the project. We have additionally created the Academy Research Scholarship which will fund one scholar dedicated to the Academy's research endeavors. Nicholas Davis is the first recipient and will focus on the LACROCBT data. LACROCBT has received international notice and has been cited in several invited talks and papers

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including a presentation on supervision data at the World Congress of Behavioral and Cognitive Therapy (WCBCT) in Berlin. The Academy presence in Berlin was strong with a wonderful social event attended by leaders in the field.

Conferences

Speaking of conferences, The Academy Event at ABCT was a true success. We honored Tom Ollendick for his lifetime of work on CBT with children. Dr. Lata McGinn led an engaging conversation highlighting Dr. Ollendick's myriad accomplishments.

The student award went to Dr. Catherine Nobile, a psychology post-doctoral fellow from Yeshiva University, currently at the Military Family Center at NYU Langone for her work on telemental health.

IACP

Speaking of conferences, our collaboration with IACP continues. We had our first joint board meeting and developed key initiatives particularly around the International Journal of Cognitive Psychotherapy edited by Dr. John Riskind and the IACP

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IACP PRESIDENT'S COLUMN
MEHMET SUNGUR, PH.D.



On behalf of IACP, I would like to thank the board members of both of the organizations for being so supportive and collaborative during the mutual meetings we had in the year 2019.

There is some good news to be shared. The first one is that IACP has been one of the associations represented at

the World Confederation of Cognitive and Behavioural Therapies (WCCBT). WCCBT is a new global organization with a mission that matches perfectly with that of IACP. That is to promote health and well-being all around the globe through implementation and dissemination of good practice of evidence based cognitive behavioural strategies. WCCBT hopes to set guidelines for hosting tri-annual World Congresses of CBT, develop a worldwide network to share recent news and info regarding CBT and develop and support effective implementation of CBT through training. Working together for similar goals will certainly lead to reduction of human suffering in the area of mental health by promoting and improving the quality of care given in clinical and non-clinical contexts.

Another piece of good news is the increase in the number of IACP members. Thanks to everyone who has joined us. We hope that this will bring you benefits in many different ways.

And finally, in other good news—we have the pleasure of announcing the approaching 10th International Congress of Cognitive Psychotherapy (ICCP) that will be held in Rome between 18th and 21st June, 2020.

I am very happy to inform you that the congress presidents Antonella Montano and Gabriele Melli supported by the IACP have concluded the major scientific events and the preliminary scientific programme. During the 10th ICCP, there will be more than 15 keynotes, 9 pregress workshops and many other scientific activities which can be found in details at <http://www.iccp2020.com> (facebook: ICCP2020). I have no doubt that the excellent scientific programme combined with the charm of Rome and hospitality of our Italian hosts (Antonella and Gabriela) will turn this traditional tri-annual congress into a memorable one.

We are looking forward to seeing the distinguished members of IACP and ACT in Rome to establish closer links between colleagues from all over the world.

Warm regards,
Mehmet Sungur, MD
President of IACP

**FOSTERING CBT IN IN-LAND CHINA WITH HARD WORK,
A GREAT TEAM, AND HELP FROM THE ACADEMY OF
COGNITIVE THERAPY**
YANG LIU PH.D



Yang Liu Ph.D is currently the head of CBT Department of Chengdu Doreen Psychological Consulting Co. Ltd. She received her Ph.D. degree in Academy of China in 2009, and certified as National Psychological Consultant (in China) in 2011. Her current works include the management of CBT training of Doreen Psychological Consulting Co.Ltd., the supervision for staff and the therapists for clients.

I'm excited for an opportunity to write something for our newsletter. I represent a team of clinicians in Chengdu, China. In our clinic, we have a great love for CBT. I was initially drawn to CBT by the promise of a short-term therapy that was clinically effective. I valued the efficiency of it.

My first encounter with the Academy of Cognitive Therapy (ACT), was with a workshop that I attended in 2016. This workshop proved to be a valuable experience, as I was so surprised to find that some difficulties in clinical work that had bothered me for a rather long time were solved immediately! AMAZING! So, I made a decision at that moment that I should share this excellent training with my Chinese colleagues and help more and more Chinese therapists and consultants have the opportunity to learn and practice CBT from the source.

In 2018, we were so glad to have a CBT workshop from ACT in Chengdu, China. While Chengdu is more than 4 times more populous than Los Angeles, it can be hard to get quality training this far from coastal cities like Beijing or Hong Kong. We were able to design an initial intensive workshop personalized to the local clinic. We also used the experience as an opportunity for our clinic to network with other local providers, helping to increase the prestige of our clinic. More than 100 Chinese therapists and consultants learned the principles of CBT and a treatment protocol for Depression. The attendees were able to discuss their confusions and typical stuck points in their clinical work with one of the Academy's certified trainers (Dr. Waltman) who offered case consultation for local cases. AMAZING AGAIN! Since the training, I've noticed a difference in the clinical practice of my staff and myself. I look forward to further training opportunities for myself, for my staff, and for the clients that we serve. With hard work, a great team, and help from the Academy, we are building a CBT stronghold here in Chengdu. We'll continue to use this effective and efficient therapy to change the lives of those we serve.

STANDING ON THE SHOULDERS OF GIANTS

ZINDEL V. SEGAL, PH.D.



Zindel Segal, PhD, is Distinguished Professor of Psychology in Mood Disorders at the University of Toronto – Scarborough and a Senior Scientist in the Campbell Family Mental Health Research Institute at the Centre for Addiction and Mental Health. Dr. Segal has pioneered the use of mindfulness meditation for promoting wellness in the area of mood disorders.

He is the recipient of several awards,

*including the Douglas Utting Research Prize and the Mood Disorder Association of Ontario's Hope Award and has been continuously funded by the National Institute of Mental Health and the Canadian Institutes of Health Research for the past 15 years. His over 130 scientific publications have helped to characterize psychological markers of relapse vulnerability in affective disorder, especially the link between affective and self-devaluation components of dysphoria. This work has, in turn, provided an empirical rationale for offering training in mindfulness meditation to recurrently depressed patients in recovery. His books include *Interpersonal Process in Cognitive Therapy* (1996, with Jeremy Safran), *Mindfulness Based Cognitive Therapy for Depression* (2013) and the *Mindful Way Workbook* (2014) with John Teasdale and Mark Williams, Guilford Press) and *The Mindful Way Through Depression* (2007, with Teasdale, Williams and Kabat-Zinn, Guilford Press). Dr. Segal continues to advocate for the relevance of mindfulness-based clinical care in psychiatry and mental health.*

It is a true privilege to be invited to reflect on my professional career and highlight the pivotal role played by certain colleagues in shaping its trajectory. My undergraduate studies in Psychology at McGill University left me with a profound appreciation for the complexity of psychopathology along with a hopeful attitude that, while people suffering from emotional disorders had been stigmatized and underserved, clinical research and evidence-based care were the tools required to reverse this trend. I started my graduate studies in clinical psychology in 1978, working with Bill Marshall at Queen's University. Bill was trained at the Maudsley Institute of Psychiatry in London and was an 'early adopter' of behavioral methods for the treatment of phobic and anxiety disorders, having studied with Jack Rachman and Isaac Marks. He introduced me to exposure therapies and the importance of between session therapy homework, two concepts that still feature in my clinical work, although in a somewhat different format.

In 1983 I started a postdoc at the Clarke Institute of Psychiatry in Toronto with Brian Shaw, a coauthor of *The Cognitive Therapy of Depression* (1979). Brian was funded by NIMH to provide supervision to CBT therapists in the large Treatment of Depression

Collaborative Research Program and, as a postdoc, I was fortunate to sit in when Tim Beck, John Rush and Marika Kovacs would visit the CBT Clinic for rater calibration meetings. Dr. Beck would usually ask us about a patient were having difficulty with and I was struck by his willingness to quickly jump into a role play and get 'experiential' in order to understand the context and provide informal CBT supervision. Looking back at it now, this is where my immersion and embrace of cognitive therapy really started.

Fortuitously, Jeremy Safran's office was a few doors down from mine on CBT Clinic and we became fast friends, often taking walks at lunch to Kensington Market where we would buy some bread and cheese so that we could keep talking, walking and eating (not exactly a moment of mindfulness). Most of these conversations had a dialectical bent. Jeremy would do his best to convince me about a number of quasi-psychodynamic/gestalt concepts and their relevance to therapy, e.g. attachment theory, embodied wisdom, Harry Stack Sullivan's view of interpersonal cycles and I would do my best to resist with the well worn phrase, "interesting yes, but where is the evidence?". We kept each other intellectually honest and found out that there were a number of concepts we agreed on, culminating in the book *Interpersonal Process in Cognitive Therapy*. Jeremy was an original and syncretic thinker who anticipated the increased emphasis on emotional processing and interpersonal factors in cognitive therapy. His recent passing was tragic and has deprived our field of a true innovator whose work has had a broad impact on how we understand psychotherapy.

At about the same time, I received a small grant from the McArthur Foundation to develop a 'maintenance' version of CBT, much like the once a month version of Interpersonal Therapy that Ellen Frank and David Kupfer had shown could prevent relapse over a three year period. I used these funds to arrange a series of meetings with two colleagues who I felt were doing cutting edge work in the area of cognitive vulnerability – John Teasdale and Mark Williams. John was a creative and thoughtful clinical scientist and I learned a tremendous amount from him about how to blend experimental methods with intervention strategies. John's particular insight was that cognitive therapy teaches people how to how to decenter or step back from their thoughts, especially when dysphoric moods re-trigger rumination. We decided that this is the very skill a maintenance version of CBT should teach patients and that is how Mindfulness Based Cognitive Therapy was born. As we saw it, training in mindfulness meditation was providing patients with direct training in decentering skills.

Of course, coming to understand that the practice of mindfulness could be relevant to the management of mood disorders was not entirely straightforward. Jon Kabat-Zinn was hugely influential in allowing me to approach this possibility from two worlds, data-based and personal experience. Jon's empirical work on mindfulness meditation and chronic pain allowed us to find

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CBT FOR PSYCHOSIS

SALLY RIGGS, DCLINPSY, SARAH KOPELOVICH, PHD & JENNIFER GOTTLIEB, PHD



Sally E. Riggs, DCLinPsy is a licensed psychologist specializing in Cognitive Behavioral Therapy for psychosis and Founder & Director of NYC CBTp, the first ever private practice group dedicated to providing evidence based cognitive behavioral therapy for people with psychosis, and at high risk for psychosis, as well as evidence-based training and case consultation in CBT for psychosis to

mental health professionals. She splits her time between New York City, where she sees clients, supervises other psychologists seeing clients in her practice, and provides case consultation, and traveling nationwide to provide on-site workshops for mental health agencies and hospitals. She is also a Founding Member and currently serves as President of the North American CBT for psychosis Network.



Sarah Kopelovich, PhD is a forensically-trained licensed clinical psychologist and Assistant Professor in the Department of Psychiatry and Behavioral Sciences at the University of Washington, where she also holds the first Professorship in Cognitive Behavioral Therapy for Psychosis. Dr. Kopelovich currently serves as the Director of Training for the SAMHSA-funded Northwest Mental Health Technology

Transfer Center and is the Clinical Director of the CBT for psychosis Extension for Community Healthcare Outcomes (ECHO) Provider Network in Washington State. Her work focuses on adopting, adapting, and innovating implementation and dissemination strategies for psychotherapeutic and psychosocial interventions for individuals with serious mental illness and their families.



Jennifer Gottlieb, PhD, is a licensed clinical psychologist, serves as Vice-President of the North America CBT for Psychosis Network and is a Diplomate in the Academy of Cognitive Therapy. Dr. Gottlieb's work is dedicated to the development, evaluation, implementation, and dissemination of effective psychotherapeutic interventions for psychosis, schizophrenia, and other severe psychiatric conditions. She has provided CBT clinical training, consultation, supervision, and treatment implementation guidance to therapists and administrators at numerous mental health agencies locally, nationally, and internationally. Dr. Gottlieb has been on the faculty at Massachusetts General Hospital/ Harvard Medical School Dept. of Psychiatry Schizophrenia Program,

Dartmouth Medical School, and currently Boston University. A fluent Spanish speaker, Dr. Gottlieb recently received a Fulbright Senior Researcher Award to Spain where she adapted and began implementation of the specialty CBT for PTSD intervention for persons with severe psychiatric conditions.

In North America, psychotherapeutic interventions have not been offered in the routine treatment of individuals with, or who are at risk for, psychosis. Cognitive Behavioral Therapy for psychosis (CBTp) is an evidence-based intervention recommended as an adjunct to medication management by national psychosis best-practice guidelines (e.g., Dixon et al., 2009; Pringsheim & Addington, 2017). The primary goals of CBTp are to reduce the distress associated with the symptoms of psychosis and to improve functioning and quality of life. Dr. Aaron Beck initially applied cognitive and behavioral change strategies to an individual with psychosis prior to fleshing out the cognitive model of depression and anxiety (Beck, 1952). Roughly 40 years later, CBT for psychosis interventions were developed by European researchers as both an individual and, later, as a group-based treatment. Since that time, roughly 50 randomized clinical trials have demonstrated that CBTp can result in decreased positive symptoms (i.e., delusional beliefs and auditory hallucinations), improvement in negative symptoms (i.e., avolition, anhedonia), and enhanced overall functioning (Wykes et al., 2008; Lutgens et al., 2017). In addition, there is evidence to suggest that CBTp can be effective in preventing or delaying the transition to a psychotic episode when used with individuals identified as being at risk of developing psychosis (van der Gaag et al., 2013).

Although training is available through a number of accredited internship placements for a small number of interested doctoral candidates, CBTp is seldom taught in graduate or post-graduate training programs in the U.S. (Kimhy, Tarrier, Essock, Malaspina, Cabannis, & Beck, 2013). As a result, only an estimated 0.1% of licensed clinicians in the U.S. are trained in this intervention (Mueser et al., 2015). From the consumer side, this means that only 0.3% of the 5 million Americans with psychosis are presumed to have access to CBTp today (Kopelovich, Strachan, Sivec, & Kreider, 2019). Consultation with CBTp experts in Canada suggests a similarly demoralizing picture. In contrast, recent estimates of CBTp availability in the United Kingdom—where psychosis treatment guidelines more stringently require that CBTp is offered to individuals with psychosis (NICE 2013, 2014)—suggest that as many as 20-35% of UK citizens receive at least one session of this intervention (Colling et al., 2017).

Preservice training and workforce development are critically important to begin to rectify the extreme shortage of CBTp-trained providers in the U.S. At the same time, it's important to maintain and assess the quality of care provided to ensure that CBTp in-

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practice is able to deliver the clinical and functional promises of the clinical trial research. One such organizational effort to address these goals—the North American CBT for Psychosis Network (CBTpNet)—brings together CBTp trainers, scholars, clinicians, and implementation specialists across the United States and Canada with the mission of advancing the implementation and dissemination of CBTp across North America.

The objectives of the North American CBT for Psychosis Network are:

- To further the availability of high-quality, effective, evidence-based training in CBTp throughout North America,
- To consider issues of competency in the delivery of CBTp, including the definition and measurement of competency,
- To discuss training and implementation of CBTp skills and/or CBTp-informed care along the lines of a ‘tiered approach’ to ensure that all practitioners, regardless of their level of training, receive recognition for these intervention components,
- To foster a community of CBTp practitioners by sharing training materials, relevant literature, and discuss challenging clinical cases within the network,
- To foster communication among its members related to CBTp practice, training, research, advocacy, resources & certification.

CBTpNet is now “open for business.” We offer general membership, available to any professional with a graduate license-eligible degree and an interest in CBTp. Current membership benefits include access to job listings, an index of nationwide CBTp workshops, a bi-annual newsletter, a members’ listserv, as well as an index of CBTp-based clinical resources. Coming soon is the opportunity for CBTp-accredited membership – for eligible clinicians meeting CBTp competence criteria.

CBTpNet looks forward to continuing to augment membership benefits as we grow as an organization. We are also looking forward to expanding our reach within North America, in order to foster a productive CBTp practitioner network and substantially increase consumer access to and awareness of this important and effective intervention. More information about the North American CBT for Psychosis Network can be found at www.nacbtp.org.

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MINDFUL ACCEPTANCE VS. COGNITIVE CHANGE

RANDYE J. SEMPLE, PH.D.



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Mindfulness-based therapies have grown quickly in popularity and acceptance over the past two decades. Although there are other models of mindfulness-based therapies, I will speak only about the one that I know best—*Mindfulness-based Cognitive Therapy* (MBCT; Segal, Williams, & Teasdale, 2013) and its adaptation for children, *Mindfulness-Based Cognitive Therapy for Children* (MBCT-C; Semple & Lee, 2011).

First, despite the name, MBCT is not a traditional cognitive therapy. MBCT integrates elements of cognitive therapy into a complementary mindfulness-based paradigm that was originally grounded in Buddhist meditative practices (Semple & Hatt, 2012). Buddhism, however, is less a religion than it is a way of being the world and a practice of living our lives with mindful awareness and acceptance. Alan Watts (1961) suggested, “If we look deeply into such ways of life as Buddhism we do not find either philosophy or religion.... we find something more nearly resembling psychotherapy...” (p. 3).

Mindfulness and cognitive theories agree that suffering may arise when thoughts *about our experiences* are not differentiated from the direct perceptions *of our experiences*. For our clients (and sometimes ourselves), depressed or anxious thoughts may feel more real than the experiences themselves. When practicing mindfulness, changes can occur in how our clients relate to their own thoughts. Realizations may arise that what they infer is not necessarily true, what they fear is not necessarily real, and that their thoughts are “just thoughts.” The cultivation of metacognitive awareness (i.e., decentering from one’s own thoughts) may be the central component of change in mindfulness-based interventions.

At first glance, MBCT might appear antithetical to CBT because mindfulness is about accepting things just as they are, while cognitive therapy aims to change the thoughts and behaviors that we don’t like. The cognitive model is based on the idea that inaccurate or distorted thoughts create, maintain, or exacerbate emotional suffering, and that changing those thoughts (cognitive restructuring) can reduce suffering. In traditional CBT, we teach our clients to

change *what* they think. On the other hand, MBCT assumes that the way we relate to our thoughts, emotions, and body sensations is what increases suffering. Consequently, finding different ways to relate to these intrapsychic events can reduce suffering. In other words, mindfulness practices increase awareness—and acceptance—of the thoughts, feelings, and body sensations that contribute to our felt experiences. Mindfulness is simply the practice of paying careful, nonjudgmental attention—in the present moment—to the rich and complex inner and outer worlds that Jon Kabat-Zinn refers to as the “nowscape.”

In some ways, these models work very well together. One central component, however, can seem paradoxical. As I noted, cognitive therapy is focused on change while mindfulness is focused on acceptance. Because of its focus on acceptance, even discussing mindfulness-based “interventions” might sound a bit odd. In reality, mindful therapists seek to promote change by accepting things just as they are. The word *acceptance* in MBCT does not mean a passive resignation to fate, but is rather a recognition and active engagement with what *is* in any given moment. What *is*, however, changes from moment to moment. So, in order to accept what *is* in this moment, we must let go of the previous moment—and continue to do so—moment by moment. As clients cultivate greater awareness of their experiences, compassionate acceptance for themselves and empathy for others tends to increase. In practice, as acceptance grows, profound changes may occur in thoughts and behaviors. When we practice mindful acceptance, we experience our worlds in different, more kindly, and perhaps more helpful ways. Clarity of seeing what *is* informs clear intentions, with which we can choose to make changes—moment by moment. Curiously, our letting go of the desire for therapeutic change may in itself catalyze significant changes. By empowering our clients to accept themselves exactly as they are, we are fertilizing the ground and planting the seeds from which changes will grow. As Carl Rogers (1961) observed, “the curious paradox is that when I accept myself just as I am, then I change” (p. 17). With acceptance, our automatic, habituated, often unhelpful patterns of thinking are interrupted. We begin to replace automatic thoughts with intentional cognitive processing, which allows for greater consideration of response choices and potential outcomes. Mindful awareness provides opportunities for each of us to act with greater intention, compassion, and awareness.

Mindfulness, however, is not a quick fix; it requires commitment and discipline. Mindfulness teaches us to pay attention to life as it is. This sounds simple, but often isn’t easy. For most people, mindfulness practices themselves are not difficult. Remembering to practice, making room in your life to practice, and cultivating the daily discipline of practice is the real challenge. The facilitation of mindfulness is always be grounded in experience and practicing mindfulness in your own life is an essential precursor to becoming a

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GROUP CBT FOR HEALTH PROMOTION IN PUBLIC SCHOOL SETTINGS

CARMEM BEATRIZ NEUFELD, MSC, PHD & SUZANA PERON

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When considering interventions aimed at children and adolescents, there is evidence which points to positive results for the use of Group Cognitive Behavior Therapy for various demands and disorders. It is observed in the scientific literature that the psychological treatment of children and adolescents has been considered as a form of prevention and health promotion, as well as a therapeutic measure (Petersen & Wainer, 2011).

There are several CBT-based programs that use the school environment as a place of intervention for various demands, with promising results. Furthermore, groups have been perceived as ideal scenarios for children and adolescents to come into contact with various growth opportunities, experimenting with new behaviors, identifying their own and other's feelings and behaviors, and learning how their behaviors affect others and the environment. (Reddy, 2012).

(Neufeld et al., 2014) has been applied and improved in public schools in the city of Ribeirão Preto since 2009. PRHAVIDA is based on the knowledge of Group Cognitive Behavioral Therapy and on the literature on Life Skills Development, aiming to further health promotion actions with children and adolescents in groups. This program is applied in its version for children (8 and 9 years old) and in its version for adolescents (12 to 14 years old). PRHAVIDA consists of 11 sessions of about 60 minutes each, which take place weekly at the children's or adolescents' school, and is conducted by psychology students, who receive prior training and weekly supervision. The sessions follow the structured and directive model, consisting of the presentation of the agenda of the day, the review of the action plan, the presentation of the focus content of that specific session, trainings, reflections, practical activities aimed at training the skill in question, a summary of what has been learned, and the discussion of the new action plan.

The contents covered in each session are based on the 10 Life Skills recommended by WHO as a health prevention and promotion tool for intervention programs aimed at these populations. These skills promote adaptive and positive behavior which enable individuals to deal effectively with the demands and challenges of everyday life, as follows: Self-awareness; Interpersonal relationship; Empathy; Coping with emotion; Coping with stress; Effective communication; Critical thinking; Creative thinking; Decision making; Problem Solving (WHO, 1997). In this way, effective Life Skills training can increase individuals' awareness by providing greater self-knowledge and allowing them to use these skills to solve problems and improve aspects of their lives, as well as to improve interaction with their environment and others, thus providing higher life quality (Abbasi, Sajedi, Hemmati, & Rezasoltani, 2014).

For the development of these skills, cognitive-behavioral theoretical assumptions are used, such as: directivity and structure; collaborative empiricism; guided discovery; and cognitive restructuring. The sessions include psychoeducation, emotional regulation strategies, problem solving, cognitive distortion identification, evidence-based reasoning, social skills training, role plays, relaxation and breathing training, mindfulness practices, and specific skills training. In continuity, life skills are approached from situations of difficulties brought by the participants themselves, anchored in group therapeutic factors such as universality, imitative behavior, development of socialization strategies and group cohesion. The children and adolescents are encouraged to adopt a reflective attitude based on guided discovery and collaborative empiricism, customizing solutions for each specific reality while developing generalizable learning for different contexts.

Preliminary data from this program indicated a decrease in depression, anxiety and stress symptoms, as well as increased interrelational skills of the children and adolescents (Nardi,

TRANSDIAGNOSTIC TREATMENT FOR IMPULSIVE AND ADDICTIVE BEHAVIOR: MINDFULNESS AND MODIFICATION THERAPY

PEGGILEE WUPPERMAN, PH.D, JACQUELINE DOUGLAS, M.A., JENNY EM MITCHELL, M.A., & CATHERINE HARRIS, M.A.



Peggilee Wupperman, PhD, is Associate Professor and Director of Doctoral Practicum Training at John Jay College/City University of New York, as well as Assistant Clinical Professor at Yale School of Medicine. Dr. Wupperman is author of the book Treating Impulsive, Addictive, and Self-Destructive Behavior: Mindfulness and Modification Therapy (Guilford Press).

Her research is focused on improving understanding and treatment of dysregulated behaviors and emotions, and her work has appeared in numerous journal articles and book chapters. Dr. Wupperman has presented at multiple national and international conferences, and she regularly conducts workshops, trainings, and consultations for mental-health practitioners at all levels. She is a licensed psychologist in the state of New York.



Jacqueline Douglas, MA, is a doctoral student in the Clinical Psychology program at John Jay College/City University of New York. Jacqueline received her bachelors degree in Experimental Psychology from the University of South Carolina and her masters degree in Clinical Psychological Science from the University of Maryland. Her research interests lie in the development and

implementation of mindfulness-based treatments for emotional and behavioral dysregulation. Through her clinical work, Jacqueline has gained experience treating individuals with a variety of dysregulated emotions and behaviors in community, college, inpatient, and outpatient settings.



Jenny "Em" Mitchell, MA, received her bachelors degree from Johns Hopkins University and her masters in Clinical Psychology from American University. Currently pursuing her doctoral degree at John Jay College of Criminal Justice/City University of New York, Em's research is focused on improving interventions for intimate partner violence and complex trauma, particularly through the

evaluation of third wave therapies and through mitigating the impact of socialized biases in therapy.

Catherine Harris, BS, is a doctoral student in the Clinical Psychology program at John Jay College/City University of New York. She received her B.S. from Tulane University, where she conducted research on depressive symptoms in HIV-positive individuals who use crack. She has worked on multiple grant-funded research projects related to trauma and substance use among low socioeconomic status minority populations. Catherine's research focuses on emotion dysregulation and posttraumatic stress as mechanisms underlying the development of externalizing psychopathology after childhood trauma.



By the time most clients enter treatment for dysregulated (impulsive/addictive) behavior, they already have experienced substantial negative consequences. Despite these consequences, clients often feel as though the behavior is impossible to resist. As a result, clients often display fluctuating motivation, difficulty engaging in treatment, and high drop-out rates. They may also have trouble attending session consistently or engaging in therapeutic tasks (inside or outside of session). What's more, clients with one dysregulated behavior are likely to have another. (For example, a client with substance use issues has an increased likelihood of aggression, binge eating, gambling, compulsive sex, etc.; e.g., Goodman, 2008). Consequently, therapists treating these clients may feel like they are treating a moving target, and outcomes are often disappointing (McFarlane, Olmstead, & Trottier, 2008; Olver, Stockdale, & Wormith, 2011; Stevens, Verdejo-García, Goudriaan, Roeyers, Dom, & Vanderplasschen, 2014).

To address these issues, Mindfulness and Modification Therapy (MMT; Wupperman, 2019) was developed by integrating strategies from six therapies with evidence for treating dysregulated behavior: Motivational Interviewing (Miller & Rollick, 2012), Mindfulness-Based Relapse Prevention (Bowen, Chawla, & Marlatt, 2010), Dialectical Behavior Therapy (Linehan, 1993), Cognitive-Behavioral Therapy (e.g., Witkiewitz & Marlatt, 2007), Acceptance and Commitment Therapy (Hayes, Strosahl, & Wilson, 2011), and Mentalization-Based Psychotherapy (Bateman & Fonagy, 2004). MMT is a transdiagnostic treatment that includes methods for addressing (1) multiple dysregulated behaviors; (2) related clinical difficulties with motivation, engagement, and retention; and (3) broad psychological constructs underlying this spectrum of behaviors. The ultimate goal of MMT is to help clients break free of dysregulated behavior and begin building lives that feel more meaningful and fulfilling.

Background

Dysregulated behaviors are widely viewed as efforts to avoid or

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regulate negative emotions and urges (e.g., Witkiewitz & Bowen, 2010). However, the emotions and urges may not be the primary drivers of the behaviors. Instead, a primary driver may be the perceived inability to experience and tolerate the emotions and urges.

By integrating mindfulness with other empirically supported methods, MMT addresses this difficulty by helping clients process and habituate to negative emotions and urges, thus reducing the perceived need to avoid the emotions or act on the urges (Wupperman, Marlatt, Cunningham, Bowen, Berking, Mulvihill-Rivera, & Eason, 2012; Wupperman, Cohen, Haller, Flom, Litt, & Rounsaville, 2015). MMT's practices are also designed to help clients (1) gain awareness of conditioned reactions, and (2) tolerate their affect long enough to choose adaptive strategies for regulating emotions and behaviors. In addition, mindfulness is integrated with techniques designed to decrease interpersonal conflict and increase awareness of positive emotions and values, which may also reduce the perceived need to engage in dysregulated behaviors.

Evidence

The main evidence for MMT's clinical utility is the fact that it systematically integrates components from evidence-supported interventions for dysregulated behavior. Additional support is provided by findings from four small trials and multiple case studies conducted with culturally diverse clients. Trials have included (1) women court-referred for aggression and alcohol abuse (Wupperman et al., 2012), (2) adults self-referred for drug/alcohol problems and anger issues (Wupperman et al., 2015), (3) community and college adults self-referred for binge eating and depression (Wupperman, Burns, Edwards, Pugach, & Spada, 2019), and (4) adults with mild manic and/or psychotic features self-referred for opioid addiction (Wupperman, Burns, Pugach, & Edwards, 2019). Results have shown significant decreases in all of the targeted dysregulated behaviors, with large effect sizes and retention rates greater than 80% across studies. Similarly, clinical case studies of MMT have demonstrated decreases in bulimic episodes, trichotillomania, checking behavior, smoking, shopping, computer gaming, and compulsive texting (unpublished data). Despite their preliminary nature, these findings—combined with MMT's integration of empirically supported methods—provide a promising evidence base. Of note is that clients across studies have rated MMT as highly helpful ($M=8.67-9.62$ on a 10-point scale).

Implementation

MMT has been conducted in individual and group formats. Initial sessions focus on building rapport and motivation, clarifying values, and improving the client's ability to mindfully experience neutral stimuli (e.g., physical sensations). In later sessions, clients visualize distressing situations and intentionally experience resulting emotions, thoughts, and urges, without engaging in habitual behavior. Ensuing sessions target additional issues pertinent to overcoming

dysregulated behavior, including (1) flexible coping and regulation of emotions; (2) communication, refusal skills, and understanding/acceptance of others; and (3) customization of strategies to help clients move toward valued goals.

Mindfulness and related skills are practiced in every session; home assignments include: audio-guided mindfulness practice (5 times weekly), daily informal practice (2-3 minutes each), and further assignments to extend daily practices. Clients also complete daily logs of emotions, urges, and dysregulated behaviors, which are reviewed at the beginning of each session. If needed, therapists nonjudgmentally help clients understand antecedents to lapse(s), recommit to treatment, and plan future coping. MMT also includes a strong focus on the therapy relationship, with active validation and affirmation throughout treatment.

Depending on need, MMT can be:

1. Delivered as a stand-alone treatment,
2. Delivered as a "first step" treatment to decrease dysregulated (and treatment-interfering) behavior prior to further therapy (e.g., for social anxiety), or
3. Integrated with empirical treatments for disorders comorbid with dysregulated behavior.

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BOOK REVIEW: AMY WENZEL'S COGNITIVE BEHAVIOR THERAPY FOR BEGINNERS: AN EXPERIENTIAL APPROACH
SCOTT WALTMAN, PSYD, ABPP



Scott Waltman, PsyD, ABPP, is a clinician, trainer, and practice-based researcher who specializes in providing Case Conceptualization-Driven CBT. He is certified as a qualified Cognitive Therapist and Trainer/Consultant by the Academy of Cognitive Therapy. He also is board certified in Behavioral and Cognitive Psychology from the American Board of Professional Psychology.

Amy Wenzel's *Cognitive Behavior Therapy for Beginners: An Experiential Approach* was released earlier this year as part of Routledge's Clinical Topics in Psychology and Psychiatry Series. What follows is a brief review of that text. The question likely to be on the mind of any CBT practitioner is: How well does this book stack up against other introductory CBT texts? Judith Beck's (2011) *CBT: Basics and Beyond* has long been the gold-standard of introductory and texts, the basics and beyond focus makes it informative and useful for clinicians at all levels. Another book to compare Dr. Wenzel's new book to is Bennett-Levy and colleagues (2014) *Experiencing CBT from the Inside Out Workbook*. Dr. Wenzel's book is a worthy contender and fits comfortably as a mix between the two comparators. In comparison to *Basics and Beyond*, it is pretty exclusively focused on just the basics; however, it is written in a way that it is just like attending one of Dr. Wenzel's in-person trainings. It is direct, practical, and parsimonious. The book actually has a phenomenal amount of charm, and if you are familiar with Dr. Wenzel, it will feel just like you're having a conversation with her. She is a well-seasoned trainer and she knows how to present complex ideas in simple and accessible terms. The experiential components of the book mostly consist of reflection, though there are some homework assignments for the reader. This is less heavy in experiential components than Bennett-Levy et al. (2014), but the amount of reflection covered in the current text are appropriate to an introductory audience.

Each principle is grounded in both a simple and difficult case examples. She covers core elements such as treatment structure, case conceptualization, therapeutic relationship, cognitive restructuring, basics of behavioral interventions, so-called third-wave CBT strategies, and relapse prevention. This would make a great introductory CBT text for grad students or well-trained therapists who are new to CBT, especially to a reader who is short on time and needs a quick read (total page count 229). This book would probably be best paired with ongoing case supervision or clinical case consultation, possibly provided by one of the Academy of Cognitive Therapy's Certified Trainer/Consultants.

The back cover states, "Cognitive Behavior Therapy for beginners provides a guided tour for delivering top-flight CBT steered by a master clinician," and that is an incredibly accurate description. Really, it felt just like attending a workshop, and that speaks to the personality of the book. If you remember the cult classic movie, *Being John Malkovich*, this text offers the experiential component of being Amy Wenzel. She helps you see if from her well-experienced perspective, she walks you through what to do and why to do it. She reflects on meaningful conversations with Dr. Aaron Beck on various topics, and she wraps it in her clinical experiences with case examples.

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STANDING ON THE SHOULDERS OF GIANTS CONTINUED FROM PG. 5

a common language, grounded in empiricism, to discuss how mindfulness meditation could be offered inside MBCT and his repeated invitations for me to start my own mindfulness practice led to an entirely different appreciation of the types of skills we were offering our patients.

I have been very fortunate to work alongside exceptional mentors and colleagues and, together, we have managed to catalyze promising circumstances into concrete outcomes that have improved the lives of people living with a mood disorder. I don't think I could have asked for more when I was starting out can only look back at my career with thanks and gratitude.

MINDFUL ACCEPTANCE VS. COGNITIVE CHANGE CONTINUED FROM PG. 6

mindful therapist. In return, your own commitment to mindfulness is likely to bring about positive transformations within yourselves as well as in the clients you serve.

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GROUP CBT FOR HEALTH PROMOTION IN PUBLIC SCHOOL SETTINGS CONTINUED FROM PG. 7

Ferreira & Neufeld, (2017). In addition, the qualitative changes in the interaction of participants with their peers, teachers and parents must be highlighted. From this, it can be suggested that the application of cognitive behavioral therapy knowledge, beyond the clinical and therapeutic intervention contexts, deserves more attention and may help promote a healthier development for children and adolescents.

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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, 2020. 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@yu.edu.

sponsored conference, The International Congress on Cognitive Psychotherapy which will take place in Rome June 2020. You can learn more about the conference at <https://www.iccp2020.com/>.

Here's a great thing about being an IACP member. You get an excellent journal for free. AND you get 150 euros off of the attendance fee for ICCP. That is a lot of euros. So here's what we were able to do. For all of the Academy Members, for a limited time only, all of our get to join IACP for \$25! You can exercise this option when you renew your Academy certification or reach the membership page directly here: https://www.academyofct.org/group/IACP_Member

A New Name, A New Direction

You spoke, we listened. A while back our membership voted about including 'behavioral' in our name. In a landslide decision, The Academy of Cognitive Therapy has been officially renamed '*The Academy of Cognitive and Behavioral Therapies (A-CBT)*.' We are so excited to be part of this collaborative, inclusive community focused on the future of CBT.

Comings and Goings

Dr Robert Leahy, my dear friend and colleague and the reason I am even an Academy Member, let alone President, will transition off the board as of Jan 1, 2020. Dr. Leahy is a Distinguished Founding Fellow of the Academy and has served the board for a total 17 years in a multitude of roles. Thank you for your service, wisdom and leadership, Dr. Leahy.

In this spirit we hope to build bridges to the larger CBT community, by electing people to our board and committees that represent the larger focus of CBT. We also want to welcome new diplomates to committees. Scott Temple a CBT and DBT psychologist with expertise in adolescent DBT who has also served as a consultant on LACROCBT has been elected to the board as Member-at-Large. Welcome, Scott! Additionally, Lauren Jackson, a CBT, DBT, PE, CPT and CBASP therapist who also serves on LACROCBT, Lynn Martin, a clinical nurse specialist and the head of the Northern California CBT Network and Julia Hale, social worker and Diplomate, joined our membership committee. Look forward to committees, projects, trainings and events that celebrate our new inclusive organization.

It is a brand new era for CBT and for the Academy. I am so happy to have you on board with me.

