FALL 2022 ISSUE

ADVANCES IN Cognitive Therapy newsletter

Publication of: The Academy of Cognitive & Behavioral Therapies (A-CBT) & The International Association of Cognitive Behavioral Therapy (IACBT)

The International Association of Cognitive Behavioral Therapy is a proud member of The World Confederation of Cognitive and Behaviour Therapies

IN THIS ISSUE:

EDITOR: Scott Waltman, PsyD, ABPP, A-CBT

A-CBT'S PRESIDENT'S COLUMN

Elaine S. Elliott-Moskwa, Ph.D.

It has been an eventful few months for the Academy. I am excited to report that the Academy has completed filming its CBT foundational course featuring a stellar lineup of some of our Trainer Consultants. I have had the chance to preview the videos and they are incredible. Many hours have been devoted to producing this professionally made course which will do much to further the Academy's mission of dissemination of CBT therapy to clinicians worldwide. I would like to shout-out a big thank you to everyone involved. Please stay tuned for a sneak preview trailer that will appear on A-CBT's website.

Speaking of websites – the A-CBT website will soon be updated and streamlined allowing us to integrate some new features that will facilitate our online training, education, credentialling and member experience. Thanks to our interim executive director, Matt Brooks and his team for shouldering this undertaking.

The Academy is busy planning it's "in-person" Annual Meeting and Member Reception during ABCT's November convention. Although online experiences and zoom are amazing, I think even the 50% of us who are introverts are happy that the ABCT convention will be "Live in New York!". Please look-out for your emailed invitation to our member reception. Here are a few of the highlights.

The Academy and IACBT boards are jointly presenting a Humanitarian Award. Thanks again to Bob Leahy for spearheading this initiative to honor the recipient. The winner will be recognized during the meeting. Additionally, you will have the opportunity to hear our Past-President, Lynn McFarr interview the recipient of the Lifetime Achievement Award.

At that event you will have the pleasure of meeting A-CBT's newest board members-at-large,
Mudita Bahadur and Scott Waltman. Both have dedicated countless hours of their time to the Academy. Mudita and Scott have served on the Diversity Action Committee. Scott, of course, has devoted enormous effort in pulling together the Advances in Cognitive Therapy Newsletter.

While at the ABCT convention, please attend the Diversity and Actions committee Clinical Roundtable: Moving forward during the challenges of the Double Pandemic: What we learned transitioning in a time of crisis while managing our vicarious traumatization.

Academy of Cognitive and Behavioral Therapies

Also say hello to Joel Becker who has stepped forward to head the Academy's Membership Committee. Joel, a Clinical Professor at UCLA, has been teaching CBT for decades and has been a steadfast member of the Academy.
Check-out Joel's mini workshop: Sexual and Gender Minority Stress: Pride and Prejudice in the Era of Covid and Increased Discrimination.

There are so many members of the Academy presenting at the convention and I have so little space to acknowledge all of you! This does not mean your contributions go unappreciated! Please attend A-CBT annual event to share your latest CBT passions and projects or find out how you may become more involved with the Academy. Look forward to seeing you in November!

IACBT'S PRESIDENT'S COLUMN

Advances in Cognitive Therapy
Summer 2022 Issue, Page 3

Lynn M McFarr, Ph.D.

Hello from a very warm California. I hope you are cooling down wherever you are.
The International Association of CBT has been hard at work this quarter. In addition to forming a joint committee with the Academy of CBT to further delineate our affiliation, we are ushering in a new era for our journal. John Riskind, Ph.D. will step down from the journal in a January 2023. Dr Riskind has served the IACBT for over 20 years and previously served as an editor and associate editor of multiple cognitive therapy journals. His distinguished service has seen us through challenges including changing publishers, names and fighting for an online submission portal (yes, you had to advocate for that back in the day). He raised the impact factor over 100% and was well known for creating a roster of exciting innovative research, including his own work on looming vulnerability. In short, Dr. Riskind has done tireless work for the journal and IACBT. We are deeply grateful for his service.

Please join me in offering a warm welcome to our new editor, Edward Selby, Ph.D. Dr. Edward A. Selby, Ph.D. is an Associate Professor and the Director of Clinical Training in the Psychology Department at Rutgers University in New Jersey, where he also directs the Emotion and Psychopathology Lab. Dr. Selby's work explores the roles of various forms of emotion dysregulation in the onset of adolescent and adult psychopathology, especially suicidal and self-injurious behavior, borderline personality disorder, and eating disorders. His work has been cited over 12,000 times and he is best known for his work establishing the Emotional Cascade Model of borderline personality disorder and self-injury, and more recently the Positive Emotion Amplification Model of anorexia nervosa. Dr Riskind will work closely with Dr. Selby, Ph.D., to ensure a seamless transition.

Speaking of transitions, we offer thanks and gratitude to Dr. Jung Hye Kwon who has served on the board of directors for several years, most recently as our delegate to the bylaws committee for the WCCBT. She has decided to step down from the board and we send her all best wishes. Our incoming Board member will be Dr. Dennis Tirch. Dr. Tirch is an expert in mindfulness, compassion and cognitive behavioral therapies. Dr. Tirch is President of the NYC-CBT Association and The Compassionate Mind Foundation USA; President Emeritus of The New York Chapter of The Association of Contextual Behavioral Science, Associate Editor of The Journal of Contextual Behavioral Science, Fellow and Certified Consultant and Trainer for The Academy of Cognitive Therapy and has served on the faculty of Weill Cornell Medical College and Albert Einstein Medical School. Dr Tirch joins us after having recently served as President of Association of Contextual and Behavioral Sciences. Please join us in welcoming our newest board member.

Finally, It is a great pleasure for me to announce that Iga Jaraczewska is the first recipient if the humanitarian award from the Academy of Cognitive Behavior Therapy and the International Association of CBT. During the last year, Iga Jaraczewska has been instrumental in organizing training for therapists in Poland and Ukraine who are dealing with refugees. This program is now online and will be available worldwide for free for anybody who's interested in learning about how to help refugees. Ina and her colleagues have been fortunate to be able to recruit some of the top people in the world in Cognitive Behavior Therapy.

Iga Jaraczewska is clinical psychologist, CBT supervisor of The Polish Association of CBT, certified trainer of the Motivational Interviewing Network of Trainers, chair of the Polish Association of Motivational Interviewing, and member of the EABCT and the Network for Psychotherapeutic Care in Europe. In addition to direct service, Dr. Jaraczewska also works as a counsellor to many organizations having published books, textbook chapters, and articles on CBT, motivation, dependencies, and communication in health care of CBT. She is accredited by the Polish Association of CBT and head of AMiE School evidence-based therapy methods and puts strong emphasis on strengthening students' skills of empathy, care, and respect to their clients. She also runs the AMiE's clinical service centre where Ukrainian psychologists have been employed to directly support refugees by offering them psychological assistance. We offer our sincere congratulations and gratitude for her efforts in this trying time.

CBT AND RELAPSE PREVENTION

John Ludgate, PhD

In psychotherapy research in general, not a lot of attention has been paid to the problems of relapse, which is common after therapy in substance abuse, recurrent depression and chronic conditions. A good deal of research has been done on drop outs, attrition from and non-response to acute therapy but the literature on the important issue of relapse prevention has been sparse either from a research perspective or on developing theoretical perspectives and clinical procedures to help prevent relapse and recurrence after successful treatment. While these observations are probably accurate concerning psychotherapy in general, the same cannot be said for CBT. In looking at depressive relapse Beck (1976) in his early writings suggested that since dysfunctional attitudes may predispose individuals to both initial and subsequent episodes of Major Depressive Disorder, Cognitive Therapy, which targets these, should be expected to reduce relapse. Blackburn et al (1986) argued that since CBT involves the acquisition of self-regulatory skills, this would be expected to prevent recurrence. Patients, who have undergone successful CBT will have learned skills (thought identification and challenging) that can be applied to new episodes of mood disturbance after treatment ends which gives them some form of protection from relapse. The earliest trials of cognitive therapy (CT) for depression included systematic follow-ups of 1–2 years (Blackburn et al., 1986; Evans et al., 1992; Kovacs et al., 1981; Simons et al., 1986) to examine CT's efficacy in sustaining recovery/remission. Results generally showed positive long-term effects.

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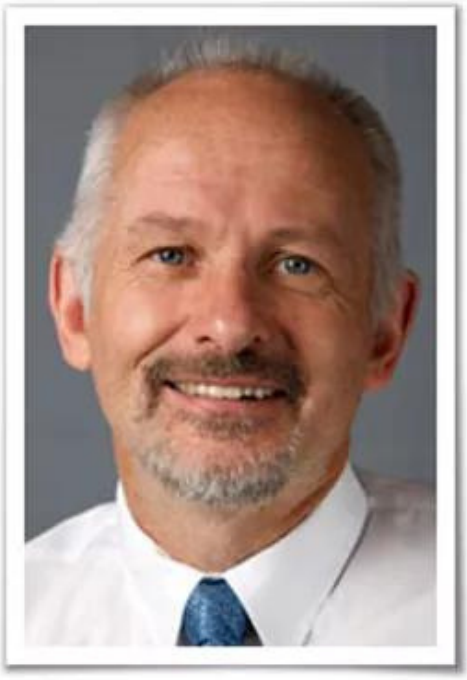


John Ludgate, PhD is a licensed psychologist, who has worked as a psychotherapist for more than 30 years. He currently works at the CBT Center of Western North Carolina, located in Asheville, NC. He specializes in treating mood, anxiety, relationship and psychosexual disorders. As well as having an active clinical practice, he is involved in training and supervision in CBT.

He obtained a Bachelor's degree in Psychology from Tr3inity College, Dublin, a Master's degree in Clinical Psychology from University of Edinburgh in Scotland and a Ph.D. from Trinity College, Dublin. He trained at the Center for Cognitive Therapy under Dr. Aaron Beck, the founder of Cognitive Therapy, obtaining a Post-Doctoral Fellowship in Cognitive Therapy from the University of Pennsylvania in 1986. He subsequently became Assistant Director of Training at Dr. Beck's Center. In the early 1990's Dr. Ludgate was a Research Clinical Psychologist at the University of Oxford in England and served as a cognitive-behavioral therapist in several outcome studies of panic disorder, agoraphobia, social phobia and hypochondriasis. He subsequently worked as a clinical psychologist in state agencies and private practice.

In 1988 he published the book Maximizing Psychotherapeutic Gains and Preventing Relapse in Emotionally Distressed Clients and was co-editor with Beck and others of Cognitive Therapy with Inpatients: Developing a Cognitive Milieupublished in 1990. He published Cognitive-Behavioral Therapy and Relapse Prevention for Depression and Anxiety in 2009 and Heal Yourself: A CBT Approach to Reducing Therapist Distress and Increasing Therapeutic Effectiveness in 2012. In 2014 he co-authored the book Overcoming Compassion Fatigue: A Practical Resilience Workbook with Martha Teater. In In 2016 he co-edited the book Teaching and Supervising Cognitive Behavioral Therapy published by Wiley. With Teresa Grubr he published the CBT Couples Toolbox in 2018. The book CBT Resources For Therapists: Handouts, Worksheets and Forms to Enhance Your Practice was published in 2021 by Professional resources Press. He has written numerous journal articles and book chapters in the field of Cognitive Behavior Therapy for Anxiety and Depression, most recently contributing a chapter on Relapse Prevention to the Handbook of CBT (2021) published by the American Psychological Association. He has presented many seminars and workshops on cognitive behavioral approaches, both nationally and internationally.
He is a Founding Fellow of the Academy of Cognitive Behavior Therapy (A-CBT)

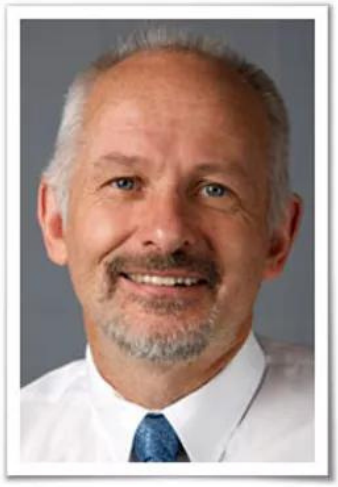
CBT AND RELAPSE PREVENTION (CONTINUED)

John Ludgate, PhD

In the seminal multicenter National Institute of Mental Health trial follow-up (Shea et al., 1992), relapse rates at 18 months were 36% for Cognitive Therapy (CT), 33% for Interpersonal Psychotherapy (IPT)and 50% for imipramine. The rate of return to therapy was significantly lower for patients who received CT compared to patients who were assigned to the other groups. Following these early findings CBT researchers continued to systematically explore long term effects of CBT in outcome studies. Hollon et al (2006) in a conclusive review of the literature found: (1) that CBT appears to have an enduring effect in the treatment of depression and anxiety disorders and reduces the risk for subsequent symptom return, (2) that clear documentation of reduced risk relative to medication exists for depression, panic, social phobia and OCD and (3) that there is also evidence of stability of gains for several other anxiety disorders.

As the 80s showed a number of exciting findings on the longer-term effectiveness of CBT for Depression from researchers using Beck's Cognitive Therapy for depression, some other independent work in this field also emerged. Around the same time period, in the field of substance abuse, considerable attention was given to relapse prevention by CBT researchers and practitioners, culminating in Marlatt and Gordon's (1985) seminal edited volume entitled Relapse Prevention: Maintenance Strategies in the Treatment of Addictive Behaviors. Since depression and substance abuse have high relapse and recurrence rates , these efforts were addressing a key clinical issue in the treatment of these disorders. Getting sufferers better is only part one of the therapeutic challenge, keeping these individuals well is also required.

Despite these early laudatory efforts, it seemed in the 1990s that some complacency might have set in by assuming that since 70% or so of depressed clients maintain symptom remission following CBT, there was little more to be done (Ludgate, 1994). However, the recent history of CBT and aligned fields shows considerable attention now being given to theorizing about and planning strategies for further reducing relapse rates in depression and other disorders. Evidence of this is Martin Antony and colleagues edited book, entirely dedicated to this topic, entitled Improving Outcomes and Preventing Relapse in CBT (2005) and the emergence of several specific guides on how to maximize relapse prevention in adult depression and anxiety (Ludgate, 2013), depression in children and adolescents (Kennard et al., 2016), substance abuse (Bowen & Chawla, 2011; Daley & Douaihy, 2015), posttraumatic stress disorder (PTSD; Duckworth & Follette, 2012), and sex offenders (Laws et al., 2000). Strategies that can augment relapse prevention and sustained recovery in depression, such as mindfulness (Segal et al., 2002) and maintenance CBT (Jarrett et al., 2001), have also been described in seminal articles.



The relapse-prevention therapy approach, named relapse-prevention therapy (RP) following Marlatt and Gordon's model, has received considerable empirical support. A meta-analysis conducted by Irvin et al. (1999) found RP to be efficacious both in the short and long term in treating alcohol abuse, smoking, and polysubstance abuse. Moreover, RP has also been shown to be efficacious for depression (Katon et al., 2001), sexual offending (Laws et al., 2000), bipolar disorder (Lam et al., 2003), and panic disorder (Bruce et al., 1999).

A series of important studies done by Robin Jarret and her colleagues examined relapse rates following remission in depressed patients treated with CBT. In a study that has important implications for clinical practice, Jarrett et al. (2001) found that adding 10 sessions of continuation CT, with a focus on generalization of skills and relapse prevention, over an 8-month period after remission reduced relapse rates from 31% to 18% over a 2-year follow-up. Vittengl et al. (2007), in a comparative meta-analysis of 28 studies that focused on CBT and relapse in major depressive disorder, found that (a) after discontinuation of acute phase treatment, many responders to CT relapsed (29% within 1 year and 54% within 2 years), and (b) continuation phase CT treatment reduced relapse by 21% at end of treatment and by 29% at follow-up compared to acute phase CT with assessment only after treatment.

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CBT AND RELAPSE PREVENTION (CONTINUED)

John Ludgate, PhD

IAnother important series of studies has empirically tested the efficacy of MBCT (Segal et al., 2002) in preventing relapse. This treatment combines mindfulness-based stress reduction (MBSR; Kabat-Zinn, 2013), usually administered in groups, with standard CBT treatment for depression. The results have indicated a significant effect on relapse using this approach. For example, Ma and Teasdale (2004) showed that MBCT reduced the relapse risk by half compared to treatment as usual. It was particularly striking in this study that the difference in the risk of relapse risk was 36%–37% for the MBCT group versus 67%–78% for the treatment-as-usual group in patients with three or more previous episodes of depression. In a subsequent study (Segal et al., 2010), patients in remission were assigned to continuation medications, MBCT, or placebo and outcomes were compared in two separate groups: (a) stable remitters (i.e., no symptom flurries during treatment) and (b) unstable remitters (i.e., symptom flurries or symptom fluctuations during treatment). Relapse rates were no different across treatment groups for stable remitters, but, in unstable remitters, maintenance medication with a 27% relapse rate and MBCT with a 28% relapse rate were both significantly lower than in the placebo group. It can be concluded that MBCT may confer a particular benefit over time, regarding relapse prevention/sustained recovery in both unstable remitters and in those with a history of several previous episodes of depression. This has important implications for treatment planning in the cognitive behavioral treatment of depression. There are a number of other studies showing that the MBCT approach can reduce relapse in anxiety disorders, which are reviewed by Segal and Ferguson (2018).

The literature also reveals a number of factors which predict relapse or longer-term outcome in different disorders (summarized in Anthony et al 2005) and since at least some of these are amenable to therapeutic interventions this growing literature has important implications for CBT clinical practice.

For example, studies done on dysfunctional attitudes and relapse (Jarrett et al, 2012) suggest that unless patients' maladaptive attitudes or beliefs are identified and modified in therapy, patients who have improved symptomatically may still be at risk for relapse after treatment. It may be that psychotherapy which produces symptom relief only is less than adequate treatment in terms of long-term outcome.

"Staying well" should be prioritized as much as "getting well" has been within the field of CBT.

Although cognitive behavioral approaches with or without a specific relapse-prevention focus appear to have reduced the relapse rates in emotional disorders, substance abuse, and other disorders, a significant percentage of patients (approximately 20%–35%) with depression and anxiety still experience a recurrence of symptoms (Ludgate, 2009). Also, research in the field of addictive behaviors, including cocaine dependence (McKay et al., 2007), smoking (Piasecki, 2006), and alcohol misuse (Hester & Miller, 2003), demonstrate that more than 50% of these patients do not maintain behavior change over time. This may be an even more significant problem in clinical practice, as usually patients treated in clinical practice will have more severe psychopathology than patients meeting the inclusionary criteria for research studies. Thus, it behooves clinicians and researchers to continue to develop methods to further reduce the significant problem of relapse in patients successfully treated with CBT.

Dismantling studies are needed to examine which components of a relapse-prevention package are most critical or lead to the most successful outcomes. Also, research needs to be carried out on the effectiveness of relapse-prevention approaches with other populations. Outside of substance abuse and depression, there is a paucity of empirical data on the incidence and predictors of relapse in CBT-treated patients and how relapse can be reduced or curtailed. Predictors of sustained recovery or relapse need to be identified that can aid clinical practice, and further research on factors such as self-efficacy, cognitive vulnerability, and motivation for change, which can be targeted in therapy, needs to be carried out.

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CBT AND RELAPSE PREVENTION (CONTINUED)

John Ludgate, PhD

Clinicians' use of systematic relapse prevention procedures such as ,for example with depressed clients, identifying early warning signs of lapse, planning for high risk situations, having an emergency plan for slipping back and including mindfulness and maintenance CBT with individuals at higher risk for relapse, is unknown but dissemination of information on relapse prevention has generally been poor with a developing but still meager number of resources to aid clinicians in the clinical application of relapse prevention within CBT practice. Workshops and training events in the area of relapse prevention at national and international conferences are often notable by their absence. Training programs at graduate and postgraduate levels should address the issues of relapse and maximize the acquisition of skills to prevent relapse and ensure maintenance of treatment effects.

"Staying well" should be prioritized as much as "getting well" has been within the field of CBT.

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TOWARD A CONSTRUCTIONAL EXPOSURE THERAPY

By T. V. Joe Layng and Awab Abdel-Jalil

Exposure therapy has become a CBT "gold standard" for treating many disorders, including anxiety disorders, obsessive compulsive disorder, and PTSD (Rauch et al., 2012). Though the delivery vehicle may vary, and the theoretical underpinnings may be debated, there is general consensus that many patients find the procedure uncomfortable, challenging, resulting in troubling drop-out rates (e.g., Eftekhari et al, 2020; Steenkamp et al., 2020). The emphasis with these procedures is often the elimination of the presenting complaint. Those approaches seeking the elimination of a problem have been characterized by Goldiamond as pathological approaches. In contrast, approaches that instead "establish behavior the absence of which is the problem" (Goldiamond, 1974/2002) have been characterized as constructional. Goldiamond's Constructional Approach was developed in the 1970s, but its full implications have not been explored until recently (Layng, 2009; Layng et al., 2022).

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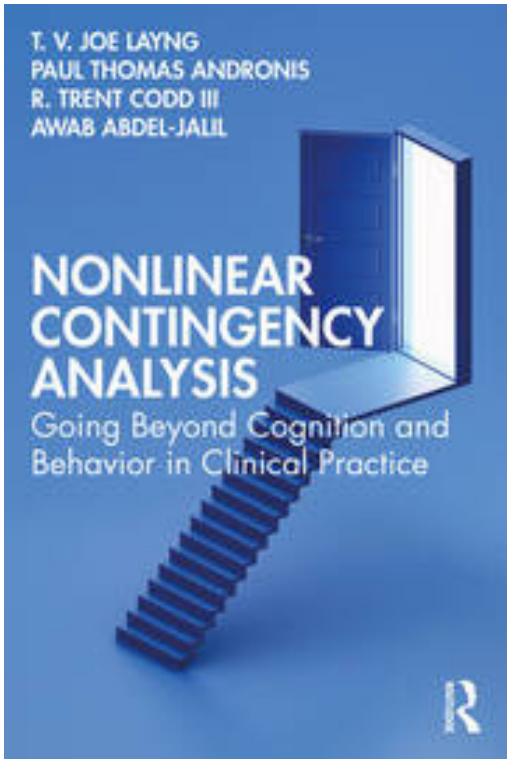

JT. V. Joe Layng is a Fellow of the Association for Behavior Analysis: International and has over 50 years of experience in the experimental and applied analysis of behavior. He earned a Ph.D. in Behavioral Sciences (biopsychology) at the University of Chicago. At Chicago, working with pigeons, he, along with Paul Andronis and Israel Goldiamond, investigated animal models of psychopathology, specifically the recurrence of pathological patterns (head-banging) as a function of normal behavioral processes, and the production of untrained recombinant, complex symbolic repertoires from simpler behavioral components, a process they described as contingency adduction. Joe has extensive clinical behavior analysis experience with a focus on ambulatory schizophrenia, especially the systemic as well as topical treatment of delusional speech and hallucinatory behavior. Joe has spent the last several years mentoring students, and interested investigators and practitioners in nonlinear contingency analysis. He has published approximately 60 articles or chapters, a range of software applications, coauthored a self-instruction book Decisions and Judgements in Ambiguous Situations: A Conceptual Introduction to Signal Detection Theory for behavior analysts and recently coauthored the book Nonlinear Contingency Analysis: Going Beyond Cognition and Behavior in Clinical Practice. Joe is an adjunct professor of Behavior Analysis at Endicott College and Partner, Generategy, LLC.

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TOWARD A CONSTRUCTIONAL EXPOSURE THERAPY (CONTINUED)

By T. V. Joe Layng and Awab Abdel-Jalil

One important feature of the approach is its reliance on a "nonlinear contingency analysis" (NCA). Layng et al.'s (2022) recent book, Nonlinear Contingency Analysis: Going Beyond Cognition and Behavior in Clinical Practice, provides a modern description of NCA and its application to a range of clinical phenomena, including those often found to be quite challenging. NCA describes how behavior that may appear to be maladaptive or dysfunctional may instead be quite adaptive, often in a sense heroic (see for example Layng & Andronis, 1984). In NCA, the outcomes of a behavior are analyzed in terms of their costs and benefits, as well as those of available alternative behaviors. When the costs and benefits of each pattern are considered, the behavior patterns comprising the presenting complaint are often found to be the most sensible patterns available.

Often the goal is to provide an alternative that results in the same or greater benefit, but at far less cost. In other words, patterns need be established, the absence of which is the problem (after Goldiamond, 1974/2002; Layng et al., 2022). When that occurs, the disturbing behavior is no longer the pattern of choice and decreases in frequency without being targeted for elimination. The emphasis is on establishing alternatives, not eliminating the disturbing pattern. The consequences that were maintaining the disturbing behavior are still available.

There are two nonlinear interventions: topical and systemic. Both can play a role in successful intervention. In nonlinear topical intervention, building alternatives to the disturbing behavior that provide the same or better benefits, but at less cost, is the target of intervention. In systemic intervention, establishing repertoires other than those that are a direct alternative to the disturbing pattern is the goal. That is, the problem presented may not, in fact, be the problem to be solved. A detailed discussion of both can be found in Layng et al. (2022). Here, we will briefly describe a nonlinear topical NCA procedure that is showing great promise as a new form of exposure therapy: Constructional Exposure Therapy (CET).

The primary consideration when choosing repertoires to establish is: Will the new alternative pattern provide the same or more benefits than the disturbing pattern or other available alternatives? Next, what precisely is the behavior to be established that will achieve that outcome? We then need to determine where the patient is now, and what strengths they may have upon which to build. What change procedures will be used to get from where the patient is to where they want to be, is the next step. Finally, determine the consequences that will maintain the patient's behavior through the change procedures, and how will progress be measured. Where possible, the same consequences maintaining the presenting complaint can be harnessed and used to maintain behavior through the change procedures (Goldiamond, 1974/2002; 2022).

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Awab Abdel-Jalil earned his MS in Behavior Analysis at the University of North Texas and is currently a doctoral student at the Institute for Applied Behavior Science of Endicott College. At UNT, with Jesús Rosales-Ruiz, he participated in streamlining and carrying out constructional programs for first-generation college students and students from low-income families. He is the Constructional Coach at Eastern Florida Autism Center and Great Leaps Academy where he trains staff, and works with parents on programs based on the constructional approach and nonlinear contingency analysis. Awab coauthored the book Nonlinear Contingency Analysis: Going Beyond Cogntion and Behavior in Clinical Practice.
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TOWARD A CONSTRUCTIONAL EXPOSURE THERAPY (CONTINUED)

By T. V. Joe Layng and Awab Abdel-Jalil

In the case of patterns associated with anxiety disorders, typical exposure therapy attempts to eliminate the debilitating effects of targeted S —> R or S — (mediating cognitive events) —> R relations that are thought to be responsible for, or a product of the often quite severe anxiety reported by the patient. Exposure brings the patient into progressively greater contact with the event as they overcome their fear or anxiety, and perhaps change their thinking, at each step in the program. Each closer approximation leads to an even closer approximation eventually removing the triggering S —> R relation. Some patients may find this distressful and abandon therapy as a result.

What separates CET from typical exposure therapies is that it is an operant or consequential approach, rather than one based upon a more reactive S —> R approach where the stimulus is considered to elicit or trigger certain emotions, thoughts, and escape behaviors. "This approach reformulates the temporally based S then R relation to include the consequences of behavior. Under this approach the initial S assumes a function differing from the eliciting one noted for the S —> R relation. Rather than a relationship between S and R such that S elicits a subsequent R, the relationship between the two is defined by the consequences that follow. ...Such a consequential analysis does not ignore stimuli or responses [or the emotions and thoughts], but attempts to evaluate them in the context of their consequences. When consequences can be related to behavior such that their occurrence is predicated on the occurrence of both the stimulus (or occasion) and the response (or behavior), a contingency is defined. When occasions and behaviors, both psychological and physiological, are investigated in such a contingent relation, different outcomes may be observed than if the occasions and behaviors are investigated alone" (Layng et al., 1999, p. 46, brackets added; also see Layng et al. 2022).

In the laboratory, the removal of, or escape from an aversive event has been shown to be a powerful reinforcer for the behaviors that produce such removal or escape (see Goldiamond, 1975a; Layng et al., 2022). Thus, one consequence that may maintain avoidance behavior of clinical interest is the distance created from the aversive event (Katz & Rosales-Ruiz, 2022).

CET harnesses this consequence and makes it contingent on other behaviors that occur when the participant is calm. Stated otherwise, the same consequence, distancing, is used as a (negative) reinforcer for behaviors other than those indicating fear or avoidance. In recent years, this NCA approach to exposure has resulted in replacing the fearful or aggressive responses of animals often considered untreatable with other behaviors that improve the animal's wellbeing and quality of life (Fernandez, 2020; Heidenreich, 2022; Katz & Rosales-Ruiz, 2022; Snider, 2018). Further, the procedures have been extended to humans who exhibit phobias and other strong fear responses, such as the fearful refusing of food and water. Using CET, Miller (2022) was able to re-establish eating in about one hour with an 11-year-old boy whose fear of food and water had led to his hospitalization. Some cases have also required a systemic intervention, where other consequential relations responsible for the pattern needed to be addressed (see Goldiamond, 1975b; Layng et al., 2022).

The procedures comprising CET were pioneered by Jesús Rosales-Ruiz and his students at the University of North Texas (see for example Snider, 2007; Rentfro, 2012). Briefly stated— and not intended as a guide— the stimulus is presented at a distance where the individual first simply "alerts" to it. If five seconds elapses without an attempt to escape or emotional response, the stimulus is removed, thus reinforcing the calmer behavior with that distancing. Subsequently, the aversive event is brought closer and removed, again, after 5 seconds. If there is an escape response, the stimulus is removed, and the program is reset to its last successful stimulus presentation. At no time is the consequence, distancing, withheld. In essence the participant has two ways of achieving the distance: 1) being calm or doing other things, or 2) indicating distress. This provides the participant with one degree of freedom (number of alternatives minus one, n-1; Goldiamond, 1976) at all times. In this way, the patient is never asked to give up a consequence important to them, providing genuine choice and some control over the situation (see de Fernandes & Dittrich, 2018; Goldiamond, 1974). Once close, and the constructionally defined behaviors are occurring, the time of presentation is extended. The targeted behaviors that occur in close proximity to the once aversive stimulus can be reinforced with a variety of positive reinforcers, both tangible and social. These behaviors are the outcomes that are constructionally targeted for establishment. Little distress is experienced.

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TOWARD A CONSTRUCTIONAL EXPOSURE THERAPY (CONTINUED)

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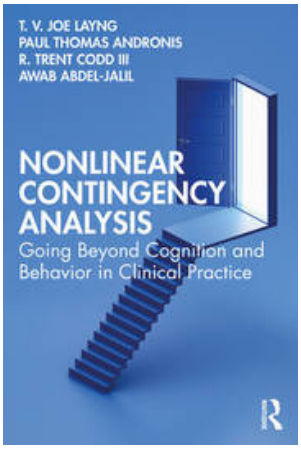

By T. V. Joe Layng and Awab Abdel-Jalil

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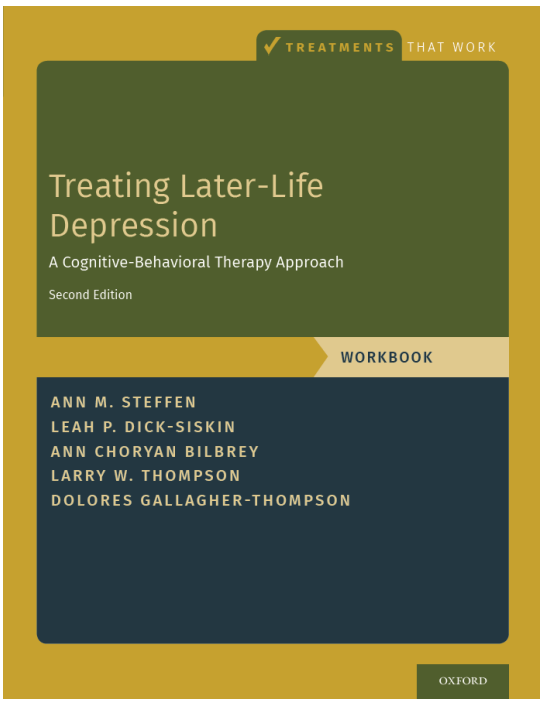
ASK THE EXPERTS: USE OF SESSION STRUCTURE WITH OLDER ADULTS

A question answered by
Dolores Gallagher-Thompson, PhD, ABPP
Professor Emerita and Board-Certified Geropsychologist: Stanford University School of Medicine
Co-Founder, Optimal Aging Center



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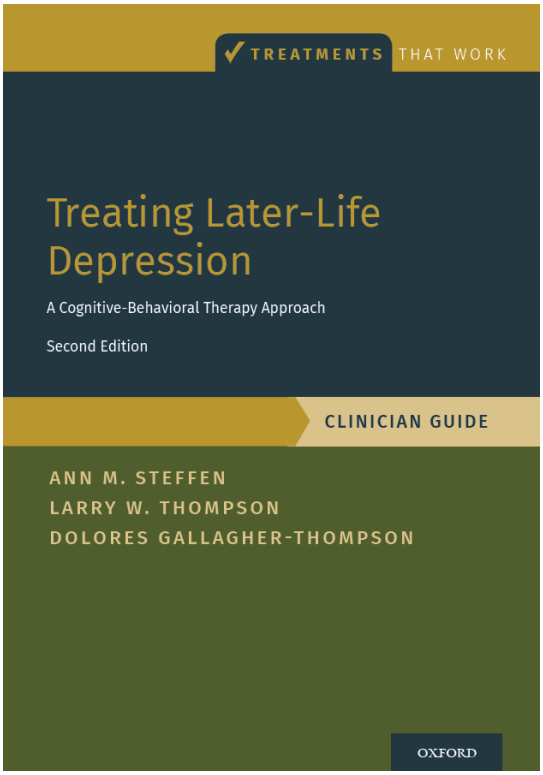

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Letter from the Editor to Dolores:

Dolores, I really enjoyed the article you wrote for our most recent newsletter. I was discussing the topic of your book with some colleagues and found myself receiving unclear messages about the topic of structure and older adults. Some of my colleagues believe that when working with older adults it is best to sit back and listen to their stories and other colleagues suggested that CBT session structure was just as (if not more) important with older adults as it is with any other client populations. I told my colleagues that I knew an expert on the topic, and I wanted to get your take. What are your views on the use of session structure when working with older adults and what practical recommendations do you have?

Answer:

Thanks, Scott, for this great question! It comes up all the time when I'm training clinicians who want to learn about how best to use CBT with older adults.

First, it's important to remember that older adults have years of life experience and many stories associated with those experiences that they want to share with anyone who will listen. Being a good listener and expressing accurate empathy are core counseling skills. With this population there is a significant risk of getting lost in storytelling and not having time for good use of CBT interventions and change strategies. There is a risk of older adults being satisfied in-session (while we we're being good listeners) but disappointed when session time does not translate to changes in their life, due to poorly structured sessions. As CBT clinicians, it's all about balance. We want to understand where they're coming from, we want to allow space for them to tell their story, and at the same time we have clear therapeutic goals we want to accomplish. Accomplishing these goals typically involves dedicating session time to goal setting, problem solving, skill use, and other cognitive behavioral endeavors.

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ASK THE EXPERTS: USE OF SESSION STRUCTURE WITH OLDER ADULTS

By Dolores Gallagher-Thompson, PhD, ABPP
Professor Emerita and Board-Certified Geropsychologist: Stanford University School of Medicine
Co-Founder, Optimal Aging Center

Second, we need to be aware of, and respect, the significant difference in age likely to be present between client and therapist. Many therapists are two or three generations younger than their clients. Most were taught to "respect your elders" and so they can have difficulty being directive in the therapy hour. It is important to acknowledge and make practical plans in relation to this age difference. A defining characteristic of cognitive behavioral therapy is that a CBT therapist is transparent. This allows for the clinician and the client to have an open and frank discussion about the different types of expertise present in the room. The older adult has decades of rich life experience to draw from in creating a collaborative plan of how to work with their depression. Similarly, the clinician has expertise in how to diagnose, formulate, and treat mental health problems of later life. In our experience, it's helpful to frame this in the context of a discussion of expectations. Expectations for the client are to come with an open mind, to be willing to try and learn new things, to participate actively in session, to give honest feedback, and engage in new cognitive and behavioral patterns (in and out of session). Expectations for the clinician are to be empathic and supportive, while also ensuring that session time is used in a way to maximize benefit to the client. This will allow for a collaborative relationship where evidence-based strategies can be used to reduce suffering and facilitate goals.

Third, a common practical strategy is to plan the intervention out-of-the-moment so it can be implemented when needed. For example, it is difficult to interrupt somebody mid story and explain to them that we might not have time to hear the whole story in-session because of other important items on the agenda. But if before the story starts, you talk with the client about the goal- and problem-oriented nature of sessions, then you can collaboratively problem solve how to address the challenge of being off topic. We find it useful to introduce a mutually-agreed-upon signal for interruption. This should be set up in an early session and repeated as needed throughout the therapy. Agreeing on such a signal allows for several things: the clinician feels comfortable interrupting, and the client understands this means they need to be redirected so they can get back on track. Typical signals include raising one's hand (like in a classroom) to get the other person's attention; using the "time out" signal (fingers of one hand into the middle palm of the other hand); or waving one or both hands in the air. We recommend asking the client what signal they'd be comfortable with and going with that. This signaling process is appreciated by most clients who realize that therapy time is precious and it's good to make the most of it.

Additionally, classic CBT strategies such as use of visuals, like a chalkboard or whiteboard to detail the collaborative agenda is generally recommended and helpful. There will be times where there is a lot of backstory to learn. Older adults have an abundance of experience and those stories might be important to understanding nuances of current beliefs or behavior patterns. One strategy to preserve session time is to have the older adult journal or write out the narratives of these stories so that the therapist can review them on their own. Of course, this does take up clinician time and will need to be planned for in clinic administration.

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ASK THE EXPERTS:
USE OF SESSION STRUCTURE WITH OLDER ADULTS

By Dolores Gallagher-Thompson, PhD, ABPP
Professor Emerita and Board-Certified Geropsychologist: Stanford University School of Medicine
Co-Founder, Optimal Aging Center

Bio
Dr. Gallagher-Thompson specializes in treatment of late-life depression and in working with persons with neurocognitive disorders (such dementia) and their family caregivers/ care partners. She provides individual psychotherapy, using a cognitive/behavioral framework (CBT) as part of the Geropsychiatry outpatient clinic at Stanford. She also leads psychoeducational workshops.as part of the Neuroscience Center's community educational programs..She is a board-certified specialist in Geropsychology (psychology of older adults) and is a licensed clinical psychologist who has been in practice for 25 years.

She received her degree in clinical psychology/adult development and aging from the University of Southern California and did her clinical training at UCLA. She has been an NIH funded researcher for the past 25 years and is most noted for her empirical studies on the efficacy of psychoeducational interventions to reduce stress and improve the psychological status of family caregivers of older adults with Alzheimer's disease or other forms of dementia. She has culturally modified, translated, and tailored programs for Chinese-speaking, Spanish-speaking, and Farci-speaking caregivers. In addition she works with an international advisory group, led by WHO, that has created an on-line web-based program to provide education and skill training globally to dementia family caregivers. The third edition of the edited book, Ethnicity and the Dementias, was published in 2019. Additionally, she is a Fellow of the Academy of Cognitive Therapy and a recognized Trainer/ Consultant/ Supervisor in CBT. In collaboration with others she is completing 2nd edition of the clinician guide and client workbook in the Treatments that Work series (Oxford). These focus on effective use of CBT with older adults. In addition, she has worked with colleagues to create an edited "primer" on geropsychology. All three books will be published in 2021.

At present she is Emerita Professor of Research in the Department of Psychiatry and Behavioral Sciences at Stanford University School of Medicine, and former Director of the Outreach, Recruitment and Education Core of the Stanford Alzheimer's Disease Research Center. The latter focused on recruiting Latino and American Indian persons with dementia and their family caregivers. She has authored over 200 papers in major journals in the field. She is co-founder and current member of the Diversity & Inclusion Committee of the local northern CA chapter of the Alzheimer's Association. She is an associate editor of the journal Clinical Gerontologist: The Journal of Mental Health, Diversity, and Aging.

Current active projects include: consulting on development and implementation of an internet-based programs for rural US caregivers of persons with dementia, and for family caregivers of older adults with any form of dementia in Thailand. She is currently working with collaborators at UCSF on the CARE project which aims to establish a research registry specifically for Asian Americans/Pacific Islanders who have been traditionally very under-represented in health-related research. Finally, she is working with a local technology company to develop a suite of apps for mobile phones and tablets, aimed at family caregivers.
www.optimalagingcenter.com

WELCOME TO ONE OF OUR NEWEST BOARD MEMBERS

Mudita Bahadur, PhD

I am humbly honored to be elected as a Board Member-at-Large to the Academy of Cognitive and Behavioral Therapies.I have been a Fellow with the Academy since 2003, and an active Trainer and Consultant with the Los Angeles County Rollout since 2014. I have conducted trainings and workshops on behalf of the Academy in California and Texas, and have been an active member of the Diversity Action Committee since 2020.My experience as a clinician and clinical supervisor in a Community Mental Health setting for over 20 years has been central to my professional work, and I am very committed to the Academy's goals of training and supporting mental health clinicians and organizations.

My introduction to CBT came back in the '90s while I was in graduate school in NYC. My training program was psychodynamically oriented, thus I sought out education and training in CBT outside my program. I was fortunate to find excellent training and mentorship with Dr. Bob Leahy and his team of colleagues. It was in those hallowed halls that I learned the fundamentals of CBT and developed an immense appreciation for the effectiveness of evidence based treatments. After moving to the west coast, where EBPs were already on the rise, my passion for CBT training and certification further developed as I served as a clinical supervisor and mentor for graduate and post-graduate trainees. Currently I'm in private practice using CBT for adults and children.

As a member of the Board, I seek to enhance the Academy's goals of training with a focus on diversity and inclusion, international applications, and cultural competence within the certification process. I hope to propose and support initiatives that will expand our membership with more diverse populations, and increase accessibility for marginalized populations. Lastly, I am certified as an Infant-Family and Early Childhood Mental Health Specialist and seek to expand our trainings for CBT with families and youth, and bringing a developmental lens to CBT treatment overall.

Outside of my professional work, I enjoy spending time with my husband and two adult children, whether we are traveling or just playing cards at home. I'm an avid reader and cook.

I look forward to being an active member of the Board and am excited to serve this vibrant professional organization.

HELPING MENTAL HEALTH WORKERS WHO ARE HELPING PEOPLE TRAUMATIZED BY WAR

Advances in Cognitive Therapy
Fall 2022 Issue, Page 16

Frank M. Dattilio, PhD

The past two years have been extremely challenging for most of us. For me, the backlog of cases due to the pandemic, the influx of patients affected by COVID-19, along with my active teaching schedule, not to mention the stress of all of the unfortunate deaths, several of whom were my close friends. I was unarguably "time bankrupt" when I received the long-distance call from a woman with a heavy accent. "Hello doctor, this is Ewa from Poland and we need your help. We are burned up here." (She meant burned out.)

Ewa is a middle-aged psychiatrist who remembered me from a lecture I gave in Warsaw years ago. She continued, "We need some of your strategies to help us keep our heads." She was referring to the deluge of Ukrainian refugees — some 3 million of them — who entered Poland and other neighboring countries in the flight from their native land.

Many of these refugees suffered terrible traumatic stress and grief over the loss of their homes and family members, not to mention their freedom and dignity. This request couldn't have come at a worse time for me, but I was moved by Ewa's stridency. She and a number of her colleagues arranged for my virtual seminar to be available to mental health professionals in Poland, Ukraine and surrounding nations.

Ewa's plea for help was not extraordinary. Many of my colleagues in the U.S. and elsewhere were experiencing what is known in our profession as burn out or compassion fatigue. Those of us who work in the trauma field all know (and often treat) professionals who experience symptoms similar to the ones they are attempting to treat in their own patients. Such "secondary effects" can happen when one takes on too many intense cases at a time, overwhelming their own capacity to maintain their emotional health and stay effective.

As a feature of their jobs, crisis workers are repeatedly exposed to extreme, psychologically toxic situations. The toll stress takes on crisis workers can be severe. Crisis workers are at risk for anxiety disorders, drug and alcohol abuse, other addictive behaviors, marital and family problems, depression and suicide.

Teaching professionals how to become aware of the warning signs that their work is undermining their health is not easy, because helpers are typically too focused on saving others to attend to their own needs. When I consult with such practitioners, the first thing I teach them is to take their own emotional temperature on a regular basis and to inquire about their colleagues' status as well. Recognizing when one is overwhelmed is essential and having a trusted colleague ask about that can normalize it, making it possible to examine one's status frankly.

The second step is to teach them to practice being mindful as a measure to prevent burnout rather than to wait to intervene after signs and symptoms have already set in. I remind them that they're as vulnerable as anyone else to developing untoward effects when exposed to constant stress.

HELPING MENTAL HEALTH WORKERS WHO ARE HELPING PEOPLE TRAUMATIZED BY WAR

Frank M. Dattilio, PhD

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Dr. Frank M. Dattilio, an Allentown resident, is on the faculty of psychiatry of the University of Pennsylvania Perelman School of Medicine and is also a teaching associate at Harvard Medical School.

https://www.mcall.com/opinion/mc-opi-helping-helpers-ukraine-dattilio-20220531-oykuq434ljfchird7oi3sreoqy-story.html

Then I delineate the first signs of overexposure to stressors such as: frequent fatigue, becoming irritated over minor issues, inability to relax, lack of patience or tolerance, lack of interest or time for socialization or engaging in recreational activities and a general sense of apathy. The tricky part is teaching them how to effectively compartmentalize or suppress their own emotions so they don't become overwhelmed. I use the analogy of being like a partially frozen sponge which only absorbs so much water, urging them to avoid becoming saturated. I teach them to psychologically inoculate themselves or build mental antibodies before they become inundated with emotion.

These things seem simple, but they are not easy to do, particularly when dealing with tragic situations like the ones that exist in Ukraine. One Ukrainian psychologist told me she was working with a 15-year-old girl who lost her house and her entire family when a missile struck her neighborhood. She was the sole survivor of the blast. She was subsequently trafficked and raped and became pregnant with the child of an unknown perpetrator. The girl was torn about giving birth to a child for whom she had mixed feelings, and still reeling from the death of her family members. She attempted suicide, later saying she felt it was the only way out for her. The psychologist told me she could barely remain stable and maintain her own focus in working with this young girl.

Faced with many gut wrenching stories such as this 15-year-old's can take its toll on any human being, no matter how tough they are.

The focus remains on aiding professionals to find the right pace and balance of their work, based on their tolerance level. And I try to help them to deal with feelings of shame if their tolerance levels are low and they are unable to do as much as some of their colleagues. To keep going, these committed professionals need reassurance that, even if they are able to help only a few survivors, they have already made an important difference in reducing human suffering.

Updates from the *International Journal of Cognitive Therapy*—the official journal of the International Association of Cognitive & Behavioral Therapies

Volume 15, issue 2, June 2022
6 articles in this issue

Espinosa, F., Martin-Romero, N. & Sanchez-Lopez, A. Repetitive Negative Thinking Processes Account for Gender Differences in Depression and Anxiety During Adolescence. J Cogn Ther 15, 115–133 (2022). https://doi.org/10.1007/s41811-022-00133-1

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Altavilla, A., Strudwick, A. Age Inclusive Compassion-Focused Therapy: a Pilot Group Evaluation. J Cogn Ther 15, 209–230 (2022). https://doi.org/10.1007/s41811-022-00132-2

Call for Proposals
for
International Congress of Cognitive Behavioral Therapy (ICCBT) 2024 or 2027

Due to shifting world circumstances our proposed 2024 site has shifted to 2027, therefore The Board of Directors of the International Association of Cognitive Behavioral Therapy (IACBT) is soliciting bids for bids for the International Congress of Cognitive Behavioral Therapy (ICCBT 2024). Bids will be considered at a meeting to be held in, January 17, 2023, and a successful host city and organization will be named at that time, or as soon as possible thereafter.

Interested parties should address the following issues in a proposal:
The name of the host professional organization and contact information for the proposed President of ICCBT 2024 or 2025 (if necessary).

1. The name and contact details for the company acting as conference organizers.
2. Proposed dates of the congress in June 2024 (or 2025).
3. The proposed city and conference venue.
4. The projected number of delegates and outline of marketing strategies to secure delegates.
5. The number of workshops, keynote addresses, symposia, open papers and poster presentations that can be accommodated and necessary to support the congress income.

A budget for the congress is also required, with the following specifications:

1. Early and late registration fees.
2. Fees are to include a 30 USD (or equivalent) per delegate and 20 USD per student paid to IACBT.
3. An advance payment of 3000 USD is to be paid to the IACBT.
4. Funded travel and accommodations should be budgeted for all IACBT Board members. IACBT Board members can be called on to provide invited addresses, panel discussions, and workshops. However, funded travel is expected for ICCBT Board members regardless of their acceptance of such invitations from the Scientific Program Committee.
5. Available accommodations for conference delegates, including a list of available hotels, residences and current sample rates.

Other information to include is as follows:

Call for Proposals for International Congress of Cognitive Behavioral Therapy (ICCBT) 2028

Due to shifting world circumstances our proposed 2024 site has shifted to 2025, therefore The Board of Directors of the International Association of Cognitive Behavioral Therapy (IACBT) is soliciting bids for bids for the International Congress of Cognitive Behavioral Therapy (ICCBT 2028). The 2028 site has the potential to serve as a backup alternate slot for the 2025 site. Bids will be considered at a meeting to be held in, January 17, 2023, and a successful host city and organization will be named at that time, or as soon as possible thereafter.

Interested parties should address the following issues in a proposal:

1. **The name of the host professional organization and contact information for the proposed President of ICCBT 2028 (or 2025 if necessary).**
2. **The name and contact details for the company acting as conference organizers.**
3. **Proposed dates of the congress in June 2028 (or 2025 if necessary).**
4. **The proposed city and conference venue.**
5. **The projected number of delegates and outline of marketing strategies to secure delegates.**
6. **The number of workshops, keynote addresses, symposia, open papers and poster presentations that can be accommodated and necessary to support the congress income.**

A budget for the congress is also required, with the following specifications:

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5. **Available accommodations for conference delegates, including a list of available hotels, residences and current sample rates.**

Call for Proposals
for

(Continued)

Other information to include is as follows:

1. Ease of travel to the proposed venue, including nearest major airport, and sample flight costs from each of New York, London, Hong Kong, Mexico City and Sydney.
2. Ease of local travel (e.g., metro, local train service)
3. Tourist opportunities available before or after the congress (not necessarily as part of the congress, but as attractions to delegates).

Please submit proposals electronically via email to the President (details below) and to the IACBT Administrative office (iacbtinfo@the-iacp.com) by January 12th, 2023. Questions or clarifications prior to or following the submission can also be addressed to the same address.

Sincerely,

Lynn McFarr, Ph.D.
President, International Association of Cognitive Behavioral Therapy
lmcfarr@cbtcalifornia.com

Note: The applicant organization must accept any decision by the IACBT as final, and its Board of Directors will not assign any liability to the IACBT or its Board, should its application be denied. It is recognized that the IACBT has no obligation to provide reasons or rationale for its final decision. The IACBT accepts no liability to the reputation or interests of an organization applying for consideration as a host for the ICCBT congress

Submissions to Advances in Cognitive Therapy are reviewed on an ongoing basis. Topic areas may include clinical issues, cultural considerations, 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.

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: Scott Waltman, PsyD, ABPP Editor: walt2155@pacificu.edu