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Jamie Schumpf, Psy.D.

ACT PRESIDENT'S MESSAGE

LATA K. MCGINN, PH.D.

As the incoming president of the Academy of Cognitive Therapy, I want to thank our Honorary President, Aaron T. Beck, our Executive Director, Troy Thompson, our outgoing president, John Williams, and our past-president, Dennis Greenberger, for their unflagging service to ACT and for their invaluable counsel and support as I start my term. We are indebted to John Williams for his work in creating an endowment for the Academy to ensure its long-term survival. I also want to thank Lynn McFarr (President-Elect), Elaine Elliott-Moskwa (Secretary), Allen Williams (Treasurer), Leslie Sokol (Board Member-at-Large), Trent Codd (Board Member-at-Large), Brad Richards (Board Member-at-Large), and Liane Browne (Lay member) for their tireless efforts to ensure that the Academy of Cognitive Therapy remains at the forefront of its mission to credential cognitive therapists and disseminate cognitive therapy. I also want to thank Simon Rego for his masterful efforts as editor of our newsletter. And finally, I would like to welcome Steve Holland as our new board member-at-large, and Jamie Schumpf as our incoming newsletter editor. I look forward to working with all of you to serve the Academy during my term as president.

I am eager to work with our Board of Directors to plan and organize our next strategic planning meeting this May and use the outcomes of our meeting to help ACT further its mission and strengthen its future. ACT continues to set the standard of excellence in cognitive therapy by credentialing cognitive therapists, and is now at the forefront of training future generations of cognitive therapists. Currently, ACT is providing training in cognitive therapy to well over a thousand clinicians in California, Texas, Iowa, North Carolina, and New York. Thanks to President-elect Lynn McFarr's Herculean efforts, our largest training project is the Los Angeles County Roll Out (LACRO-CBT), where almost a thousand clinicians have been trained to adherence under her guidance. I look forward to working with the board to expand our dissemination efforts and use research from Dissemination and Implementation science to augment the success of our training efforts. Educating professionals about the value of training and certification, and enhancing the visibility of the work done by the Academy is also a strong priority for me.

I am also excited to work with our Board of Directors to develop a close partnership with the International Association of Cognitive Psychotherapy so that we can work together to ensure that the legacy of cognitive therapy is unified and maintained for generations to come. Through its

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STANDING ON THE SHOULDERS OF GIANTS
DIANNE L. CHAMBLESS, PH.D.

Dianne Chambless is a Professor of Psychology and the Director of Clinical Training at the University of Pennsylvania. She earlier served on the faculties of the University of North Carolina at Chapel Hill, American University, and the University of Georgia. Her main research interest over the past 40 years has been the nature and especially the treatment of anxiety disorders. She and her colleagues developed questionnaires that have been translated into many languages and are in widespread use, including the Agoraphobia Cognitions Questionnaire (Chambless, Caputo, Bright, & Gallagher, 1984), the Body Sensations Questionnaire (Chambless et al., 1984), the Mobility Inventory for Agoraphobia (Chambless, Caputo, Jasin, Gracely, & Williams, 1985), and the Affective Control Scale (Williams, Chambless, & Ahrens, 1997). In addition, she has long been committed to the importance of promoting the use of empirically supported treatments and chaired the Division 12 Taskforce on Promotion and Dissemination of Psychological Procedures that launched the empirically supported treatments movement in the USA (e. g., Chambless et al., 1998). She has received numerous awards for her work, including the Aaron T. Beck Award for Significant and Enduring Contributions to Cognitive Therapy from the Academy of Cognitive Therapy in 2010, and the Mentoring Award from Section IV (Clinical Psychology of Women) of the Society of Clinical Psychology (Division 12 of the American Psychological Association) in 2002.

Influences on My Training: In some ways I think I was born to be a psychologist. My mother was devastated by becoming a widow at an early age, left with few resources to raise three young children. From the age of 7 it became my role in the family to help prop her up, and perhaps it is no coincidence that I study the role of the family in treatment of anxiety disorders today. I was very fortunate that our town had some excellent public schools and that with scholarships I was able to go to college at Sophie Newcomb (the women's college of Tulane University), the Institut d'Études Politiques de Paris, and the Sorbonne. Since I was a girl, my relatives didn't consider it necessary for me to attend college - surely I would marry and not need a college education. But school had always been my refuge, and I was determined to continue my education. In fact, you could say that by becoming a college professor I made sure that I would never leave school!

When I started college, I thought perhaps I wanted to be a journalist and was amused years later to learn that journalists and clinical psychologists share very similar profiles on vocational interest tests. I continue to think I would have been a good journalist. However, I had no idea how to go about it and wandered through a number of potential majors in college. I formed the vague idea that I might pursue psychology, but the rat- and perception-focused courses offered at Tulane didn't suit. A social psychology course was more to my liking, and while on my junior year abroad in Paris, I had the amazing opportunity to enroll in a doctoral seminar taught by the eminent American social psychologist Otto Klineberg, then residing in Paris and working at UNESCO. Prof. Kleinberg had conducted the original research on change in African-American children's IQs when they moved from the south to the north of the US, buttressing the idea that racial differences in IQ likely resulted from the poor education Black children received. He was committed to the idea that science could serve the social welfare. I was hooked. When I returned to the US, I moved to Philadelphia with my then husband, took some psychology courses to confirm that this was what I wanted, and entered graduate school at Temple University in 1971.

The early 70s were no picnic when it came to being a woman in psychology. There were faculty members in my department and on my internship who took as dim a view of a woman's getting a Ph.D. as my relatives had of my earlier decision to go to college. Since we would get married, have children, and drop out, why should we take up space men could use? Luckily, there were also sources of support. My first advisor, Thomas Karst, a social learning theorist, was one of those, although he left Temple soon after I entered graduate school. The women in my consciousness-raising group (the younger among you may have to Google that) were vital to my survival. But I still was missing the passion I had found for psychology in Paris, and I didn't find the research I was involved in compelling. I was well on my way to becoming a practitioner, focusing on women's issues in an organization for feminist therapy seven other women and I founded in 1972.

It was my great good fortune to find that passion again when I got permission to spend part of my internship at the Behavior Therapy Unit run by Joseph Wolpe in Temple's Dept. of Psychiatry. There in 1973 I met Alan Goldstein and Edna Foa, who combined outstanding clinical skills with research on anxiety disorders and their treatment. Alan and Edna became my mentors, with Edna serving as my dissertation advisor. These were heady days. I had loved my learning theory classes in graduate school (shout out here to Phil Bersh, father of Lauren Alloy and one of the best teachers I encountered in my education) and I took to behavior therapy with ease. I loved practicing a form of treatment based on science, and that love was bolstered when I saw my very disabled clients changing rapidly despite years of failed prior treatments. As a feminist, I particularly liked working with women with agoraphobia – a woman who can't leave the house without her husband is an oppressed woman indeed. In addition to our own excellent clinical researchers at the Behavior Therapy Unit, we had visits from outstanding people like Isaac Marks and Jack Rachman. Learning firsthand about the exciting development of exposure therapies across the Pond energized our work further. This was a period of tremendous advances in behavior therapy, and group lunches almost every

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IMPROVING ACCESS TO COGNITIVE-BEHAVIORAL THERAPY: LESSONS LEARNED FROM INTERNATIONAL, RESOURCE-CONSTRAINED SETTINGS

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DEPARTMENT OF PSYCHIATRY AND MENTAL HEALTH, UNIVERSITY OF CAPE TOWN

Dr. Lena S. Andersen is a Senior Research Officer in the HIV Mental Health Research Unit within the Division of Neuropsychiatry in the Department of Psychiatry and Mental Health at the University of Cape Town. She received her doctoral degree in Clinical Psychology from Hofstra University in 2009 prior to joining the Groote-Schuur Hospital HIV Mental Health Group in South Africa in 2010. Dr. Andersen specializes in cognitive-behavioral therapy (CBT) and has spent years working on adapting a CBT intervention for the treatment of depression and adherence for use in people living with HIV in South Africa.

The mental health treatment gap is a global burden that continues to exist even in the most highly resourced countries (Saxena et al., 2007). Often the most vulnerable populations in the US, such as children, the elderly, and racial and ethnic minorities, are not able to access the mental health care they need. Even when they are able to access mental health services, however, they are not guaranteed access to cognitive-behavioral therapy (CBT) or any empirically validated form of treatment.

The scientist-practitioner model in psychology has lead to great empirical advances in our understanding of effective forms of treatment, particularly CBT, for a wide variety of disorders. In fact, the National Treatment Guidelines in the US recommend CBT as a first-line treatment option for depression and other disorders (American Psychiatric Association, 1993). Despite this, there remains an unmet need for these interventions nationally and internationally.

The reasons for this are lengthy and complex and an in-depth discussion of this topic is outside the scope of this editorial. However, some of the contributing factors include constrained resources, limited mental health professionals in certain settings such as community health centers, and the lack of cultural adaptation of these interventions to the needs of racial and ethnic minorities (Beck et al., 2016). In order to overcome these barriers and to improve access to CBT and other evidence-based interventions, creative and novel strategies are needed.

Research conducted in resource-constrained, international settings are an untapped resource for such strategies. There are lessons to be learned from these international settings, who by the very nature of their resource constraints have needed to develop innovative ways of providing access to mental health care. The headed call of global psychiatry to expand access to mental health care has resulted in a surge of implementation and efficacy studies in international settings. These studies have formulated a number of ways of expanding access to mental health care in settings with few resources and limited funds. This includes, but is not limited to, task-shifting treatment administration to an available cadre of health care professional, reducing the lengths of CBT interventions, and culturally adapting CBT interventions to various racial and ethnic groups (Andersen et al., 2016; Chowdhary et al., 2014). Although by no means conclusive, these studies indicate the promising nature of these novel strategies.

This is an area of research that needs to be further developed and tested by CBT researchers both nationally and internationally. Further exploration is warranted if we want to ensure that all people in need are able to not only access mental health care, but are given the opportunity to engage in treatments such as CBT which are likely to be effective.

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INTEGRATING COGNITIVE-BEHAVIORAL THERAPY IN PRIMARY CARE

NATASCHA M. SANTOS, PSY. D.

Dr. Santos is a cognitive-behavioral psychologist who specializes in the treatment of Anxiety and Obsessive Compulsive Spectrum Disorders such as OCD, PANDAS/PANS, Body Dysmorphic Disorder and Hoarding. Dr. Santos provides workshops to schools, families, and community organizations to better serve children, adolescents, and young adults with anxiety and OCD. Dr. Santos also loves to mentor and teach students. She is an Adjunct Assistant Professor at Suffolk County Community College, SUNY Old Westbury and NYU Steinhardt School of Culture, Education, and Human Development. Dr. Santos recently did a TED-Ed Lesson on Debunking the Myths of OCD.

With the changing landscape of mental health care, access to effective psychotherapy is a timely and concerning issue for many individuals. Unfortunately access to equitable mental health care can be limited by systemic and individual factors such as lack of and/or poor insurance coverage or limited therapist availability and/or location. To further add to this issue, primary care settings are seeing higher rates of mental health issues and are commonly first line providers for conditions such as insomnia and anxiety. With the high prevalence of such disorders presenting in primary care, integrating evidence based psychotherapy into medical settings especially where mental health care providers are lacking seems to be a growing necessity (Combs & Markman, 2014).

Evidence-based psychotherapies like cognitive-behavioral therapy (CBT) are not only time-limited but cost effective at treating common disorders in the general population like anxiety, depression and sleep disorders. While psychological interventions such as CBT are effective, primary care clinicians are often limited in time and training in providing such treatment. Further, training primary care physicians in CBT is still under-examined as the research is limited on the effectiveness of training curricula and learning outcomes (Dorflinger, Fortin VI, & Foran-Tuller, 2016). To address this issue, teaching behavioral health consultants or members of the primary care team in how to adapt evidence-based CBT interventions for use in brief formats may be useful. Recommendations for integrating the application of CBT skills for use in a primary care setting are discussed.

Teaching CBT Interventions to Primary Care Professionals
Teaching health care professionals evidence-based psychotherapy modalities requires a simple and structured learning approach. Models, such as the Y-Model, have been used to teach evidence-based psychotherapy to mental health care trainees and has been adapted to teach psychotherapy to other providers in medical settings (Plakun, Sudak, & Goldberg, 2009). Conceptually, the stem of the Y-Model includes teaching common foundational principles shared across modalities such as empathic communication, active listening, reflection, identification of the presenting problem, support of self-efficacy, identification of goals, readiness for change, identification of past patterns, etc. The branches of the Y-Model represent specific psychotherapy modalities such as CBT and psychodynamic therapy (PT). Adapting models, such as the Y-Model, to teach CBT has been shown to be effective in a time-limited environment such as in primary care settings (Ramezani, Rockers, Wanlass, & McCarron 2016).

Applying the Y-Model to teaching health care professionals CBT offers a simple and concise manner in conceptualizing health issues. For instance, when teaching theoretical underpinnings (the stem of the Y-Model) such as the philosophy or etiology of symptoms, one can link those with the CBT principles of rational-empiricism and core beliefs and learning. Linking theory of personality and symptom mechanism to learned schemas of beliefs, emotion, and interpersonal roles and cognitive distortions would be another application (Ramezani, Rockers, Wanlass, & McCarron 2016). Adapting the Y-Model in teaching CBT, common core dimensions of psychotherapy (as reflected in the stem of the Y-Model) would include concepts such as psychoeducation; recognizing first signs of symptoms; principles that manifest symptoms; roots of symptoms; increasing awareness; strengthening internal resource; and teaching healthy relationships. Corresponding CBT techniques, as reflected by the "branch" of the Y-Model, would include teaching the relationship between thoughts, emotions, behaviors, and physical sensations; identification of automatic thoughts; identification of core beliefs; self-monitoring; cognitive restructuring; and communication skills training (Ramezani, Rockers, Wanlass, & McCarron 2016).

CBT Interventions in Primary Care
Integrating CBT in primary care settings can be quite advantageous. It can be cost-effective, increase access to mental health care, and can be effectively delivered in time-limited formats by those without specialist training. The effectiveness of brief CBT for insomnia delivered by people without specialist training in CBT compared to treatment as usual for insomnia delivered by mental health care professionals in a primary care setting was evaluated. Brief group CBT treatment for insomnia provided by mental health workers without specialist training in CBT had better sleep outcomes post-treatment (Cape, Leibowitz, Espie, & Pilling, 2016). Cognitive-behavioral interventions have also been successfully adapted in treating anxiety in by behavioral health consultants who were integrated into primary care settings (Sherpardson, Funderburk, & Weisberg, 2016).

Evidence based cognitive behavioral techniques such as psycho-

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COGNITIVE BEHAVIORAL THERAPY FOR INSOMNIA IS THE FRONTLINE TREATMENT FOR CHRONIC INSOMNIA, SO NOW WHAT?

KRISTIN MAICH, MA & COLLEEN CARNEY, PHD
RYERSON UNIVERSITY, TORONTO, CANADA

Kristin is currently completing her PhD in Clinical Psychology program at Ryerson University under the supervision of Dr. Colleen Carney. She received her Master's degree in 2013, with a thesis focused on arousal in individuals with insomnia. Specifically, she investigated the relationship between insomnia and subjective and physiological indices of startle in darkened conditions. Kristin is also a therapist in the ongoing SAD Lab clinical trial of Cognitive Behavioural Therapy for Insomnia, and recently completed her final clinical rotation at St. Joseph's Healthcare, Hamilton. Kristin completed her BA in Honours Psychology at The University of Western Ontario. She previously received a double major BA (English Literature and Political Science) from McGill University.

Dr. Colleen E. Carney is an Associate Professor in the Psychology Department at Ryerson University and the Director of the Sleep and Depression Laboratory. She is one of leading experts in the treatment of insomnia, particularly in the context of co-occurring illness. She has over 100 publications on the topic of insomnia, and is a passionate advocate for improving access to effective sleep treatments.

Cognitive Behavioral Therapy for Insomnia (CBT-I) has decades of support demonstrating clear efficacy and effectiveness in adults, including those with co-occurring health conditions (e.g., Morin et al., 1999; 2006). This year, the American College of Physicians (ACP; Qaseem et al., 2016), followed the lead of many other leading organizations such as the National Institutes of Health, the Academy of Sleep Medicine, and the British Association of Psychopharmacology, concluding that CBT-I should be considered the recommended frontline treatment for chronic insomnia in adults. Further, the ACP specified that sleep medication should be considered only in the event that a cognitive-behavioral treatment approach is unsuccessful in treating the sleep difficulties. This is a crucial recommendation, as medications are frequently prescribed as the first treatment approach when individuals present with sleep complaints in primary care settings; CBT-I is often only considered if pharmacological therapy is unsuccessful.

As a result, CBT-I and the diagnosis of Insomnia Disorder are receiving increasing attention. It is important to note that the conceptualization of "insomnia" has evolved recently. Perhaps most notably, insomnia is no longer considered merely a "sleep" disorder; rather, it is now a "sleep-wake" disorder. This revision reflects the importance of daytime complaints expressed by those with this disorder. The daytime complaints, and to some extent the sleep complaints as well, were previously attributed to comorbid mental health issues, but we now understand that insomnia in the context of comorbid psychiatric complaints is still a sleep-wake disorder meritorious of separate clinical attention. Thus, in nosologies like the DSM-5, insomnia "related to" or "due to" a mental disorder are no longer diagnostic entities. Whereas other mental health disorders certainly co-occur with Insomnia Disorder, there is no evidence to suggest that an Insomnia Disorder is different in the context of comorbidity. In other words, the three same causes of chronic insomnia (e.g., circadian dysregulation, an inadequate homeostatic drive for deep sleep and hyperarousal/conditioned arousal) are factors whether a comorbid condition is present or not. As such, we need a treatment that addresses these three causal factors for chronic insomnia. The core components of CBT-I (i.e., Stimulus Control, Sleep Restriction, and Cognitive Therapy) specifically address these factors. Not only do comorbid insomnias respond to CBT-I with improved sleep, CBT-I is associated with improvements in pain, depressed mood, anxiety symptoms, fatigue, and quality of life (e.g., Edinger et al., 2009; Manber et al., 2008; Wagley et al., 2013). Finally, the presence of an Insomnia Disorder is often predictive of treatment resistance or suboptimal outcomes unless the sleep disorder is addressed (e.g., Buysse et al., 2006; Carney et al., 2007; Thase, Simons, & Reynolds, 1996). Untreated insomnia in those who have been treated for a comorbid disorder is predictive that the other disorder will return post-recovery [i.e., residual insomnia is predictive of relapse (Karp et al., 2004)]. Thus, the presence of insomnia warrants clinical attention regardless of whether it occurs in a comorbid context. As Sateia (2014) aptly states: "insomnia is insomnia is insomnia."

The ACP recommendations clearly place an impetus on healthcare providers to consider cognitive-behavioral interventions for sleep difficulties, which effectively means that there will be increasing demand for CBT-I in future, as physicians increasingly seek referral sources. As such, it is now up to healthcare providers interested in providing CBT-I to acquire training in this protocol. Training is provided by a variety of sources including sleep societies (e.g., Society for Behavioral for Sleep Medicine, the Academy of Sleep Medicine), CBT conferences (e.g., www.abct.org or www.adaa.org) and individual expert trainers (e.g., www.drcolleencarney.com or www.med.upenn.edu). Further, limited access to CBT-I treatment as provided by qualified practitioners can be a barrier to widespread provision of this treatment. Thankfully, we have a long list of empirically-supported delivery modalities for providing CBT-I, including

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INTERPERSONAL EMOTION REGULATION: IMPLICATIONS FOR PRACTICE

KARA CHRISTENSEN, M.A. & AMELIA ALDAO, PH.D.

Kara Christensen is a fourth-year graduate student in clinical psychology at the Ohio State University in the Cognition and Emotion Lab. She completed her undergraduate work at the University of Chicago in 2011 and received her master's degree in 2015 from the Ohio State University. Her primary research interest is in interpersonal emotion regulation processes, in particular in examining the role of friendships in influencing levels of symptoms of psychopathology.

Amelia Aldao, Ph.D., former Assistant Professor and Director of the Psychopathology and Affective Sciences Lab at The Ohio State University from 2012 to 2016 (she is currently working in industry). Her research focused on the role of emotion regulation in anxiety and mood disorders, with a particular emphasis on identifying contextual influences on the adaptiveness (and maladaptiveness) of regulation processes. Dr. Aldao utilized an experimental psychopathology approach to identify mechanisms underlying the selection, implementation, and consequences of emotion regulation processes across contexts in healthy, anxious, and depressed populations.

A father comforts his crying child. A woman calls her partner after a difficult day at work. Two friends meet to discuss their worries. A key part of living with and around others is our reliance upon other people to help us manage our emotional experiences. Although much of the research in emotion regulation — the ways in which individuals manage the onset, duration, and/or intensity of their emotions (Gross, 1998) — has focused on how individuals manage their own emotional experiences (i.e., intrapersonal emotion regulation), there has been a growing appreciation for the importance of interpersonal emotion regulation (i.e., how people regulate with others) (Zaki & Williams, 2013) in daily life. This burgeoning research has important implications for cognitive therapy in several ways that may be of interest to the practitioner.

First, when working individually with clients, a therapist may wish to examine if the client is effectively utilizing interpersonal emotion regulation to reduce distress and impairment. As with other emotion regulation strategies, there may be times in which using certain strategies results in greater dysfunction. For example, an interpersonal process called co-rumination, in which a dyad repeatedly rehashes the past or dwells on negative affect, has been prospectively associated with increased levels of depression and anxiety in adolescent girls (Rose, Carlson, & Waller, 2007). This suggests that not all interpersonal attempts at regulation may be beneficial in the long-term. As such, in addition to examining if clients habitually rely upon maladaptive intrapersonal strategies such as worry, rumination, suppression, or adaptive ones such as reappraisal or problem-solving, therapists also may wish to assess how the clients recruits others to help manage their emotions and if these approaches are effective. To do so, they may help clients analyze the outcomes of their interpersonal emotion regulation attempts - are clients able to appropriately regulate their affect? How does using interpersonal strategies impact their relationships with their supports? Are they able to achieve their goals? Through these conversations, therapists may help their clients recognize what intrapersonal and interpersonal strategies are best for them in order to plan for skillful use in the future.

Second, interpersonal emotion regulation research may provide valuable insight for couples work. In one study examining long-term heterosexual married couples, interpersonal emotion regulation, as captured by the down-regulation of negative affect, was associated with marital satisfaction (Bloch, Haase, & Levenson, 2014). Specifically, the degree to which wives' negative affect was decreased during a laboratory conflict discussion was associated with concurrent marital satisfaction for both partners. Similarly, increased down-regulation of wives' negative behavior was associated with their longitudinal marital satisfaction. Taken together, these findings suggest that couples that are able to utilize interpersonal emotion regulation more effectively during conflict also report better relationships. As such, therapists may work with couples to examine how they regulate their emotions during conflict and help couples to establish which strategies escalate or de-escalate negative affect during these times.

Third, the work on interpersonal emotion regulation also has implications for forms of therapy that explicitly incorporate the family or other supports, such as family-based therapy for eating disorders or couples-based therapy for obsessive-compulsive disorder. In these therapies, the supports are often explicitly called upon to help manage the clients' emotional experiences; for example, parents may be required to help their child with anorexia nervosa consume a meal in spite of his or her high anxiety, or a romantic partner may be asked to help with exposures to a "contaminated" object. Laboratory-based work on interpersonal emotion regulation may influence these therapies by beginning to address questions such as the degree to which the supports should utilize certain strategies that may function as safety behaviors, such as providing reassurance (Neal & Radomsky, 2015).

The field of interpersonal emotion regulation shows great

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MEETING THE NEEDS OF OLDER ADULTS: WHAT COGNITIVE THERAPISTS NEED TO KNOW

KRISTEN H. SOROCCO, PH.D. & JORDAN HOFFMEISTER, B.S.

Kristen H. Sorocco received her Ph.D. in clinical psychology and a certificate in Gerontology from Oklahoma State University. She returned to Oklahoma after completing her clinical internship in California at the Palo-Alto Veteran's Administration Health Care System. During her internship year she received specialized training in geropsychology. She completed her postdoctoral training in biological psychology through the Department of Psychiatry and Behavioral Sciences at the University of Oklahoma Health Sciences Center. Currently, she is an Associate Professor within the Donald W. Reynolds Department of Geriatric Medicine at University of Oklahoma Health Sciences Center and Assistant Director of Geropsychology at the Oklahoma City VA Health Care System. Dr. Sorocco is the geropsychologist for the community living center and palliative care services and is actively involved in the clinical psychology internship and postdoctoral fellowship training program.

Overview

I recently sat next to an older couple, a wife who was 78 years young and her husband who was a mere 85, on the ski slopes who were the epitome of healthy aging. As a geropsychologist, I work with a smaller segment of the older population who are having difficulty living life to the fullest, so it is always refreshing to be reminded of the fact that most older adults successfully cope with late life challenges. However, as the population of older adults grows rapidly there is an increasing demand for more cognitive therapists who specialize in working with older adults. The purpose of this article is threefold 1) provide readers with basic information and resources on the older adult population, 2) Summarize why cognitive therapy is the key to helping older adults improve their quality of life, and 3) Highlight adaptations to cognitive therapy to best serve older adults.

Who are older adults?

Older adults are defined as individual's aged 65 years and older. According to the Administration on Aging the older population continues to grow at a rapid rate. In 2014 there were 46.2 million older adults or to put it differently roughly 1 out of 7 individuals you encounter will be an older adult. By 2060 this number is projected to be 98 million. In general, most older adults are in good mental health (APA, 2013). Despite this fact, there are many life stressors specific to older adults, such as retirement, physical decline, and multiple losses that place some older adults at risk for mental health problems. Roughly, 20-22 percent of older adults meet criteria for a mental health problem such as anxiety, depression, neurocognitive impairment, substance use problem, etc. (Karel et al., 2012). For this group of older adults cognitive therapy should be considered a first line treatment.

Why cognitive therapy for older adults?

Most importantly, we know cognitive therapy is efficacious for all age groups including older adults for a variety of mental health problems. Older adults are often on a number of medications that might prevent the use of a medication for mood management, but more importantly when surveyed and asked if they would prefer medication management or a non-pharmacological approach to improve mood, older adults prefer a non-pharmacological approach. Unfortunately, there is a paucity of mental health therapists to provide cognitive therapy (IOM, 2012; SAMSHA, 2007).

Adapting Cognitive Therapy to Meet the Needs of Older Adults

Older adults may need additional psycho education on the role of therapy (Wilkinson, 1997). In particular explaining the relationship between physical and mental health is important as symptoms are often intertwined. Interdisciplinary collaboration is often essential to properly address both the physical and mental health symptoms. Therefore getting a release of information to consult with an older adult's medical providers upfront is recommended. There are also several adaptations to consider when having older adults complete homework between sessions (Kazantzis, Pachana, & Secker, 2003). Involving support persons is often helpful particularly when neurocognitive deficits exist.

CBT relies heavily on the use of many diverse neurocognitive functions (e.g., learning new information, problem solving, naming emotions and thoughts, completing homework). Although age related changes in cognition are mild and do not significantly impede learning new skills, some older adults do experience declines in cognitive functioning (APA, 2013). Therefore, it

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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 May 15th, 2017. Submissions should be 350-900 words with no more than five references (using APA style and as an MS Word document). In addition, please include a brief (50-100 word) author bio and high quality photo/headshot with your submission!

Submissions and/or suggestions for how to improve the newsletter and/or topics that should be considered should be sent to: Jamie Schumpf, PsyD, Editor: jamie.schumpf@einstein.yu.edu.

I look forward to hearing from you all!

BOOK REVIEW
CINDY J. AARONSON, MSW, PHD

STOPPING THE NOISE IN YOUR HEAD: THE NEW WAY TO OVERCOME ANXIETY AND WORRY (HCI BOOKS—MAY 2016--$16.95) BY REID WILSON

Cindy is an Assistant Clinical Professor of Psychiatry at Icahn School of Medicine at Mount Sinai in New York City, a part-time clinical researcher and part-time clinical practitioner. She supervises psychiatric residents on CBT treatment at Mount Sinai. She is currently Secretary of the Board of Directors of Anxiety and Depression Association of America (ADAA), as well as a scientific member of the Academy, a member of Association of Behavioral and Cognitive Therapy and a member of New York City CBT.

There are so many self-help books written for the public on the topic of anxiety, panic and stress that when I tried to count them on Amazon.com, I gave up after more than 70 (that was only on the 23rd page of over 100). Of that large number, there were some written by laypeople who experienced panic and or anxiety and wanted to share their secrets to successfully overcoming their problems. The rest were written by professionals who suggested CBT techniques and mindfulness techniques and other techniques for overcoming, managing or reducing panic and anxiety. So here I am reviewing a new book for the public on treatment of anxiety and worry by Reid Wilson called, "Stopping the Noise in Your Head: The New Way to Overcome Anxiety and Worry" (Health Communications Inc.), which raises the questions, what's different or new in this book and why should I recommend this one to my patients, friends or family?

I haven't read that many of the over 70 books on my Amazon search, which makes answering those questions intelligently a bit challenging. I have read Wilson's book and what I have found is that it combines much of what is out there in one very easy to read, understandable book that is filled with humorous examples and metaphors. It's all in there: neuroscience and brain anatomy, intolerance of uncertainty, approach/avoidance, safety behaviors, exposure, mindfulness and resistance to change (inertia).

This very engaging book uses competition as the metaphor in overcoming anxiety, "playing the game and winning or losing against anxiety." Worrying is described as noise in one's head and the reader (or anxious person) is instructed to determine whether their thoughts are signals of real danger or just noise. If the signal is real, then the reader moves into problem solving mode. If the signal is noise, then the reader is taught to "step back" (calling on elements of mindfulness, gaining perspective, using breathing and relaxation). This is the first of four stages presented.

Wilson then proposes the reader "want it" (second stage) which incorporates elements of acceptance of the anxiety (distress) and making a conscious decision to change the way in which the reader has typically behaved (often using avoidance and safety behaviors or increased worrying). The "want it" is a means to help the reader accept and believe in the need to confront situations that make him/her anxious (what is typically avoided). "Step forward" (step three) is the metaphor for doing exposures to anxiety provoking situations. He addresses the underlying doubt that most anxious, avoidant people experience, especially the doubt about their ability to manage. The game metaphor is used here to tell one's anxiety to "bring it on and give me more." This directly opposes the doubt without a conscious thought correction of "I am able to manage." Wilson continually urges the reader who is avoidant to move toward the feared situation and challenge their opponent, anxiety, in order to win the game.

The answer to the question, is Reid Wilson's Stopping the Noise in Your Head just another self-help book about anxiety or something new: It may not be radically different, but it is a very readable, engaging and helpful tool for those suffering from panic, anxiety and worry. I would recommend this book.

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

peer-reviewed journal and triennial conference, IACP's mission to facilitate research and education in cognitive therapy perfectly complements ACTs mission to train clinicians to conduct adherent cognitive therapy, and to credential clinicians who achieve the standards of training excellent set by the Academy. Working in tandem, I believe that both organizations will achieve greater heights by integrating efforts to create and disseminate the science and practice of cognitive therapy.

Please visit our website (www.academyofct.org) to learn more about what the Academy can do for you and what you can do for the Academy and for our field. I want to thank the members for giving me the opportunity to serve the Academy. I look forward to serving you. Please contact me if you have suggestions or comments about the Academy, or to learn more about the Academy's Institutional Training Program.

Sincerely,

Lata K. McGinn, Ph.D.

President, Academy of Cognitive Therapy

STANDING ON THE SHOULDERS OF GIANTS CONTINUED FROM PG. 2

day were exciting opportunities to exchange ideas about cases and research plans. I found my calling in clinical research, and I've had it for life.

Also in 1973 while on my internship, I attended a seminar with Tim Beck and was very excited about his ideas and his clinical work with depression. Tim kindly invited me to his supervision and discussion groups and encouraged my nascent ambitions to become a clinical researcher. That one-time seminar encounter led to a lifetime of kindly guidance and friendship. Still excited about his latest research at age 95, Tim is my role model for prolonged engagement in science. With the cognitive therapy influence from Tim and the behavior therapy influence from Alan and Edna, perhaps it's no surprise that when Alan and I published our 1978 paper introducing the concept of fear of fear as the basis for panic disorder and agoraphobia (Goldstein & Chambless, 1978), I hypothesized that fear of fear resulted from maladaptive cognitions about the consequence of panic and also from interoceptive conditioning to bodily sensations associated with panic. I still believe that today.

There was one other important relationship formed in those early years at the Behavior Therapy Unit – that with my fellow trainee Gail Steketee. Gail served as a therapist in my dissertation research (warning to graduate students – do not do a treatment study for your dissertation!) and years later we teamed up to conduct research on expressed emotion and treatment outcome for agoraphobia and obsessive-compulsive disorder (Chambless & Steketee, 1999). Gail moved on to hoarding research, but my students and I continue to examine the family relationships of people with anxiety disorders, the impact of those relationships on treatment outcome, and the utility of a couples/family based intervention adjunctive to CBT. I continue to be fascinated by this line of research, and without Gail I might never have gotten there.

So how does this all come together, that passion I found in Paris in the 60s with Otto Klineberg for psychological research as a path to social service and the love of clinical research I found at the Behavior Therapy Unit in the 70s? Perhaps now my commitment to promulgating empirically supported treatments will make sense. In my view, making sure that students are trained in the development and application of science-based treatments, encouraging established professionals to become proficient in such treatments, and continuing my own work in developing better treatment strategies provide not only an intellectual high but also a way to serve the public good.

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INTEGRATING CBT IN PRIMARY CARE CONTINUED FROM PG. 4

education, relaxation training, exposures, cognitive restructuring, and behavioral activation can be successfully applied to improve overall health outcomes in a medical setting. For instance, psychoeducation can be used to help develop health related cognitions; relaxation skills can be taught to increase healthy behaviors and manage stress related to chronic health conditions; self-monitoring is a tool that can improve awareness of and adherence to healthy behaviors; and cognitive restructuring can be used to change maladaptive beliefs about health to health-conscious cognitions. Chronic pain patients may also be taught CBT techniques such as those used in exposure and response therapy to work on their fear of movement while other techniques such as those used in behavioral activation can help improve mood and increase physical activity (Shepardson, Funderburk, & Weisberg, 2016).

Integrating CBT into medical settings can be quite beneficial, however, the methodology in how to best employ this remains unclear. Possibilities include teaching health care professionals a brief form of CBT for common disorders, adapting CBT interventions for health conditions, and/or integrating behavioral health consultants into primary care settings. Integrating CBT into primary care would not only improve access to mental health care but improve overall health outcomes. What remains clear is the need to conceptualize health from a holistic approach and simultaneously treat its physical and mental health counterparts. Incorporating evidence based psychotherapy such as CBT into

medical settings is one way to address this.

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CBT-I, NOW WHAT?

CONTINUED FROM PG. 5

web-based and smartphone applications (e.g., Ritterband et al., 2009; 2016), teletherapy (Arnedt et al., 2013; Bastien et al., 2004), and self-help books (e.g., Morin et al. 2005), including CBT-I self-help books targeting comorbid insomnias (Carney & Manber, 2008). We will have to do a better job with dissemination of the effective components of CBT-I, as research tells us that sleep hygiene is the most commonly disseminated treatment on the internet and the most frequently used treatment for insomnia outside of sleep specialty clinics (Lachowski, Moss, & Carney, 2013) even though it is not empirically supported as a monotherapy (Morin et al., 1999; 2006). In fact, sleep hygiene is increasingly used as a control/sham condition in RCTs that test CBT-I, since it has face validity but is not effective on its own (e.g., Bjorvatn, Fiske, & Pallesen, 2011; Espie et al., 2016). As interest to evidence-based approaches for sleep increases, we will need to ensure that information about constitutes an empirically supported approach, is disseminated carefully and widely.

In sum, the endorsement of CBT-I as a frontline treatment by yet another major organization and the shifting focus in DSM5 have several important implications for insomnia treatment. The realization that comorbid insomnia deserves its own treatment and improves comorbid symptoms will increase the need for treatment providers to add CBT-I to their clinical toolbox. Similarly, the recommendation that CBT-I be provided first to individuals presenting with sleep-wake insomnia will undoubtedly see a rise in demand for CBT-I trained practitioners. Disseminating evidence-based protocols (i.e., not sleep hygiene as a monotherapy) to clinical care providers as well as augmenting the public's access to this treatment (i.e., by making it accessible via different platforms) is thus a crucial next step in increasing access to care for patients with insomnia.

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INTERPERSONAL EMOTION REGULATION

CONTINUED FROM PG. 6

promise for refining our existing treatment approaches. As the research advances, we hope that experimental findings from the interpersonal emotion regulation literature can be effectively incorporated by clinicians into treatment. By bridging the gap between basic affective science and clinical practice we may be able improve the lives of individuals experiencing impairment.

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OLDER ADULTS, WHAT COGNITIVE THERAPISTS NEED TO KNOW

CONTINUED FROM PG. 7

is essential to consider clients' neurocognitive functioning in treatment planning and implementation, especially for older adults. Major neurocognitive domains to be considered when adapting CBT for older adults are: 1) sensory and perception functioning, 2) motor functioning, 3) attention and concentration, 4) executive functioning, 5) speed of processing, 6) memory and learning, 7) language functioning, and 8) intellectual functioning. Due to various neurocognitive deficiencies that older adults experience, adaptations can be made to maximize treatment success. These adaptations include, modifying material to compensate for visual deficits, breaking CBT concepts into simple concrete steps, and teaching mnemonic strategies (Dreer, Copeland, & Cheavens, 2011).

Definitions and Resources:

Older adults – Typically refers to individuals 65 years of age and older

APA Guidelines for Psychological Practice with Older Adults (2013) http://www.apa.org/practice/guidelines/older-adults.aspx

Mental and Behavioral Health and Older Americans Fact Sheet
http://www.apa.org/about/gr/issues/aging/mental-health.aspx

Professional Geropsychology – According to the APA Education Directorate, Geropsychology is a ***specialty within professional psychology that applies the knowledge and methods of psychology to understganding and helping older persons and their families to maintain well-being, overcome problems and achieve maximum potential during later life.***
http://www.apa.org/ed/graduate/specialize/gero.aspx

Profile of Older Adults
https://aoa.acl.gov/Aging_Statistics/Profile/index.aspx

To Further Develop Competency in Geropsychology - The Council of Professional Geropsychology Training Programs has developed the Pikes Peak Geropsychology Knowledge and Skill Assessment Tool can be used to assist in developing or enhancing geropsychology competencies. There are also Recommended resources associated with the Pikes Peak Model Competencies available on the copgtp website. http://copgtp.org/

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Table 1. Potentially affected neurocognitive domains and examples for adaptation in CBT.

Neurocognitive Domain	CBT Adaptation
Sensory and perception	Modify materials to compensate for visual deficits.
Motor functioning	Implement different homework recording strategies.
Attention and concentration	Break CBT concepts into simple concrete steps.
Executive functioning	Create structured homework with concrete steps.
Speed of processing	Simplify concepts, materials, and homework.
Memory and learning	Teach mnemonic strategies.
Language functioning	Check for understanding.
Intellectual functioning	Match information to client's education and reading level.
Note: Table adapted from Dreer, Copeland, & Cheavens, 2011 p. 334-340.	