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EDITOR
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IACP PRESIDENT'S MESSAGE

First of all, I would like to wish all of the distinguished members of IACP and ACT a healthy, more peaceful and a meaningful new year. As the incoming president of IACP, I would like to express my gratitude to our Honorary President Aaron T. Beck, who kindly sent me his greetings to promote IACP further during my presidency. I would like to extend my gratitude to our past president Stefan Hofmann and all of our past and present board members for their invaluable contributions to IACP and for their support in electing me as the incoming president. I would also like to express my sincere thanks to the prior editor, Simon Rego, who has done a great job in publishing this excellent newsletter and wish Jamie Schumpf every success in taking over the responsibility of a hard task as the new editor.

It is a great honor, pleasure and responsibility to be the president of IACP. No doubt, this will sometimes be an exhausting but mostly a very rewarding task. Knowing that our past president, my dear friend and colleague Stefan Hofmann is irreplaceable in very many different ways, I do not see him as an outgoing president but as a reliable partner to collaborate with in order to achieve IACP's ultimate goals. I am also very happy to work in close partnership with Lata K. McGinn, one of the past presidents of IACP, who is now the president of ACT. This partnership will certainly help bridge a closer liaison and collaboration between IACP and ACT, the two distinguished communities, that I have always found to be supportive, encouraging and compassionate to each other. Being a member of the IACP board and being a certified supervisor, trainer and diplomate of ACT for long enough, I have no doubt that the collaboration efforts of the two giant societies will end up with mutual benefits while preserving the unique character and function of each individual society. Working together will certainly lead to further success in facilitating reduction of human suffering through better training of professionals working in the area of mental health that aim to promote service given in clinical and non-clinical contexts.

IACP'S mission to disseminate the science and practice of CBT through its peer-reviewed journal edited by John Riskind and by organizing truly international congresses regularly held with three year intervals in different parts of the world perfectly complement ACT's mission to train clinicians to the level of recognized and accredited CBT therapists. The merging of the two societies that share similar goals can only be done through cooperation, communication, respecting different needs and interacting in mutual multidimensional efforts.

In this issue of the newsletter, I would like to say a few words about one of the

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ACT PRESIDENT'S MESSAGE

It has been a year since I began as President of the Academy of Cognitive Therapy. As I look back at what we have accomplished over the last year, I want to begin by giving thanks to the people whose skill and dedication make these achievements possible. Many thanks to the rest of the board for their immense service to the Academy, and in particular, to our outgoing board members, Dr. Leslie Sokol and Liane Brown, Esq. I am filled with gratitude to Dr. Leslie Sokol for her unparalleled contributions to the Academy of Cognitive Therapy. In addition to her numerous accomplishments in the field, Leslie has served on the board of the Academy for 18 years. She has been instrumental in the success of the Academy and even though she retired from her position on the board at the end of last year, she continues as chair of the credentialing committee and continues to serve as the lead trainer in our training efforts. So rather than bidding her goodbye, I want to welcome Leslie to her continued role in the Academy. I also want to give thanks to Dr. Jamie Schumpf, who is the editor for Advances in Cognitive Therapy, the newsletter that we co-publish with the International Association of Cognitive Therapy. And finally, a big thanks to our Executive Director Troy Thompson whose skills, dedication, and hard work make it possible for the Academy to execute its mission successfully. We wouldn't be where we are without him.

We continue to be successful in fulfilling our mission - to ensure quality control in training and certifying clinicians to conduct high level principle based evidence based practice. The Academy launched its new website in 2017, and our dissemination efforts have been extremely successful. To date, we have credentialed over 1,350 clinicians and trained over a thousand clinicians in LA County alone. These efforts come at a time when the need for high quality clinicians is more pressing than ever. The World Health Report tells us that one out of every four individuals is expected to experience mental health problems during their lifetime. Costs of poor mental health have been estimated to account for between 3-4% of GDP in developed countries. Anxiety, depression, suicide, and substance abuse are some of the most common illnesses today, and are occurring at a greater pace, among adults and especially among children and adolescents than ever before. These illnesses come at a huge cost – to the person who suffers, to their family and friends, and to the society at large. Collectively, anxiety disorders are the most common illnesses today - they cost our society over 42 billion dollars in the United States alone. Depression is the leading cause of disability in the world, costing our society upwards of 1 trillion dollars across the globe - more than heart disease, asthma, diabetes and other chronic health conditions. Given the scope of the problem, the Academy's efforts are important and yet, a reminder that more work needs to be done.

A few more highlights from this past year. As president, I convened our strategic planning meeting for our board this past May, where we discussed key developments in the field and the future of our organization. We had many productive discussions, which led to some important decisions. One key decision made by the board is for the Academy to broaden our umbrella to represent all forms of cognitive behavior therapies in the future and to use cutting edge research to ensure that our certification and training represents all the evidence based advances in the field. Relatedly, another key decision we made is for the Academy to closely partner with the International Association of Cognitive Psychotherapy or IACP, and in doing so, integrate the science and practice arms of the field. We are very much looking forward to a strong and productive relationship with IACP and to ensuring that the field is strong and unified. The board and I look forward to working with the president of IACP, Dr. Mehmet Sungur, and with the rest of the board – Past-president Stefan Hofmann, David A. Clark, Nik Kazantzis, Lynn McFarr, and John Riskind.

We had a productive and enjoyable members' meeting and social at the ABCT convention. I enjoyed meeting and getting to know all over wine and hors d'oeuvres. The 2017 Aaron T. Beck Student Achievement Award winner was presented to Amy Sewart. Amy is a fourth-year graduate student in clinical psychology at the University of California, Los Angeles. Under the mentorship of Dr. Michelle Craske, Amy's research aims to: 1) contribute to and advance human models of fear learning, and 2) translate this knowledge to inform evidence-based treatment of anxiety disorders. Her research and writings on anxiety disorders and their treatment have been published in many journals and she has won awards from the Anxiety Disorders Association of America and UCLA, as well as a fellowship from the National Science Foundation.

The 2017 Aaron T. Beck Lifetime Achievement award winner was presented to past- president Dr. Keith Dobson who went on to engage in a lively conversation with past-president Dr. Judith Beck at the meeting. Dr. Dobson is a Professor of Clinical Psychology at the University of Calgary in Canada. His seminal research has focused on both cognitive models and mechanisms in depression, and the treatment and prevention of depression, particularly using cognitive-behavioral therapies. Dr. Dobson has recently been engaged in the examination of psychological approaches and treatments for adults with a history of childhood abuse and neglect in primary care. He is also a Principal Investigator for the Opening Minds program of the Mental Health Commission of Canada, with a focus on stigma reduction related to mental disorders in the workplace. Dr. Dobson's efforts have resulted in over 250 published articles and 80 chapters, 13 books, two DVD series, and numerous conference and workshop presentations in many

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STANDING ON THE SHOULDERS OF GIANTS
STEVEN HOLLON, PH.D.

Steven D. Hollon, Ph.D. is the Gertrude Conaway Vanderbilt Professor of Psychology at Vanderbilt University. His research focuses on the nature and treatment of depression, with a particular emphasis on the enduring effects of psychosocial treatments. He is a past president of the Association for Behavioral and Cognitive Therapies and the former editor of Cognitive Therapy and Research. He is the recipient of awards for Distinguished Scientific and Distinguished Professional Contributions to Clinical Psychology from the Society of Clinical Psychology of the American Psychological Association. He has over 250 publications and mentored over 20 doctoral and post-doctoral advisees.

My parents were both high school dropouts who went on to become marvelously cultured and literate role models. My father was a boxer who left school to pursue a professional career before going back to get his doctorate in psychology. He spent forty years in independent practice serving as president of the state psychological association along the way and founding a center for the treatment of victims of political torture. My mother left school a credit short of graduation because she refused to apologize to a teacher she upbraided for belittling a student with a speech impediment. She returned to school after I was grown and got involved in politics.

We always had books around the house and I was encouraged to read whatever took my fancy. I was an indifferent student (high test scores and mediocre grades) largely because I tended to follow my own interests rather than what was assigned in classes. I was fascinated by ethology and spent more time in college watching the Barbary apes at the National Zoo than I did showing up for classes. I tried my best not to go into psychology (too close to what my father did) and was in the midst of applying to law schools when I decided that that was silly and applied instead for graduate study in psychology. The ten programs I applied to were not impressed and I returned to my hometown and got a job as a therapist at a community mental health center where I saw a full patient caseload and manned the suicide hotline.

I applied to fifty graduate schools the following year and was lucky to get wait listed at two. Jack Hokanson was my advisor at Florida State and he was terrific but I grew bored with the larger program and I stopped by to let Jack know that I planned to drop out. He was in a meeting at the time and gave me a preprint of a chapter by Marty Seligman on learned helplessness to read while I waited. I went to a nearby café to read the chapter and was transfixed. This was just what I wanted to study.

The people that I read the most in graduate school were Seligman and Beck. I spent hours in the stacks sharing journals with classmate Judy Garber and talking about our mutual interest depression. One thing led to another and we ran off together to Philadelphia to see if we could cure depression. Judy was able to cut a deal with Marty to run his lab while he was on sabbatical in London and I was able to work my way into the Beck research group by volunteering to fill in for others on vacation.

During my second year at Penn I applied for a job at the University of Minnesota for which I was wholly unprepared but the visit went well and it was clear that they were going to make me an offer. I flew back to Philadelphia very much wanting to accept but also very much aware that I had promised Tim before I left that I was just going on the interview for practice and that I would stay at Penn to run the grant that he had just gotten funded. I went in to see Tim as soon as I got back and he released me from my pledge before I could say a word. Judy very much wanted to stay at Penn and continue working with Marty (she had just been accepted to graduate school there) but after much deliberation she decided to come with me to Minnesota where she completed her doctoral work with Paul Meehl as her advisor.

It was at Minnesota that I fell in with Rob DeRubeis who, along with Judy, has been my closest friend and colleague over the years. We were convinced that it was good to treat depression but better to prevent it. Rob and I have shown that you can do both with depressed adults and Judy with at-risk adolescents. I had my own history of depression in my youth (it runs in the family) but I have not had another episode since I started teaching cognitive therapy to my clients. Depression rarely mellows with age and I have benefited as much from the approach as any of my clients. Tim Beck has been my mentor in life and work and I admire him more than I can say.

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.

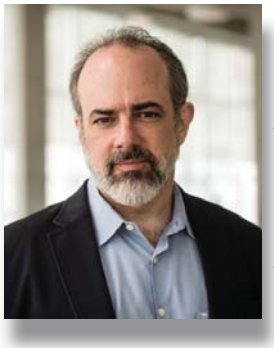
The next deadline for submission is May 15th, 2018. Submissions should be 350-900 words with no more than five references (using APA style and as an MS Word document). In addition, please include a brief (50-100 word) author bio and high quality photo/headshot with your submission.

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.

INDECISIVENESS IN HOARDING DISORDER: IS IT REALLY PERFECTIONISM?

HANNA MCCABE-BENNETT AND MARTIN M. ANTONY, PH.D.

Hanna McCabe-Bennett's research interests are in perfectionism, anxiety, and hoarding. Her doctoral dissertation investigated information processing and emotional factors involved in problematic hoarding using virtual reality technology. Her Master's thesis examined behavioral expressions of perfectionism, including identifying specific behaviors that may be associated with elevated levels of perfectionism, the contexts and domains in which they occur, their interference in daily life, and their emotional consequences. Hanna is currently completing her predoctoral clinical internship at St. Joseph's Healthcare Hamilton.



Martin Antony, Ph.D. is Professor in the Department of Psychology at Ryerson University in Toronto. Dr. Antony has published 30 books and more than 250 scientific articles and book chapters, mostly on the nature and treatment of anxiety related disorders and perfectionism. He is a past president of the Canadian Psychological Association, and a fellow for the Royal Society of Canada, as well as several professional associations in Canada and the United States. He is a founding fellow of the Academy of Cognitive Therapy.

Hoarding disorder is characterized by difficulty discarding objects of little value, excessive acquisition of objects for which there is little space or use, and severe clutter that limits the functionality of certain areas of the home. There are many factors involved in the development and maintenance of hoarding problems, one of which may be fear of decision making. Research has shown that indecisiveness is elevated in hoarding samples and is a significant predictor of hoarding symptom severity (e.g., Grisham, Norberg, Williams, Certoma, & Kadib, 2010; Shaw, Llabre, & Timpano, 2015;). The problems associated with increased levels of indecisiveness are most salient during sorting and discarding tasks (e.g., Tolin et al., 2012). Not only are these tasks reported as being more difficult for individuals with hoarding problems, but they also trigger more intense negative emotions such as sadness.

It has been suggested that this indecisiveness stems from perfectionistic beliefs about the negative consequences of making mistakes. Indeed, indecisiveness and perfectionism are positively correlated with one another (Frost & Shows, 1993), and perfectionism has been shown to predict acquisition (Frost, Rosenfield, Steketee, & Tolin, 2013). New findings from our lab sought to examine the relationships between indecisiveness, perfectionism, and hoarding (McCabe-Bennett, 2018). This study included two groups of participants, either with hoarding disorder (n = 36) or without hoarding disorder (n = 40).

Results of this study indicated that, controlling for the effects of general distress variables (i.e., depression, anxiety, and stress), indecisiveness was positively correlated with perfectionistic doubts about actions in both groups. When comparing between groups, the hoarding group reported significantly higher indecisiveness scores than the nonhoarding group. They also reported higher perfectionism scores, specifically in the areas of concerns over mistakes, doubts about actions, organization, and socially prescribed perfectionism (i.e., believing that others have high standards for one's own performance). Furthermore, follow-up analyses showed that when controlling for the effects of perfectionism, the group difference on indecisiveness became nonsignificant; however, all group differences on perfectionism (excluding concern over mistakes) remained significant when controlling for the effects of indecisiveness.

These preliminary findings suggest elevations in indecisiveness for individuals with hoarding problems may be explained by elevations in perfectionism. The specific facets of perfectionism also provide interesting insights into certain problems faced by individuals with hoarding problems. First, the hoarding group reported elevated doubts about actions, which may contribute to fear of decision making and decision making difficulties in everyday life. Second, and unsurprisingly, the hoarding group reported significantly lower scores on organization. Finally, the hoarding group reported elevated scores on socially prescribed perfectionism. This elevation makes sense given the higher rates of social isolation and social anxiety that commonly co-occur alongside hoarding problems. In the current study, 33% of the hoarding group compared to 5% of the nonhoarding group had a comorbid diagnosis of social anxiety disorder (McCabe-Bennett, 2018).

Research questions and findings such as these highlight the diverse ways in which perfectionism can manifest clinically. It may seem counterintuitive that individuals who hoard may have elevated perfectionism, especially given the cluttered state of their homes. Although one should not assume that a client with hoarding problems likely has problems with perfectionism as well, it is important to investigate perfectionism as a possible mechanism that can be targeted directly. In the context of cognitive-behavioral therapy for hoarding disorder, this may include planning exposures to purposefully making the "wrong" decision about discarding an object and tolerating the distress that follows, behavioral experiments to test predictions about feared negative consequences

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IMPLEMENTING SUCCESSFUL COGNITIVE BEHAVIORAL THERAPY FOR EATING DISORDERS

TARYN A. MYERS, PH.D.

Taryn A. Myers, Ph.D. is Batten Associate Professor and Chair of the Department of Psychology at Virginia Wesleyan University. Her research examines risk and protective factors for body image disturbance and disordered eating. She received her Ph.D. in clinical psychology from Kent State University. She is currently serving as President of the Obesity and Eating Disorders Special Interest Group of the Association for Behavioral and Cognitive Therapies. She is the 2017 recipient of an Early Career Achievement Award from the American Psychological Association.

Cognitive Behavioral Therapy (CBT) has been well established as an empirically supported treatment for eating psychopathology, particularly Bulimia Nervosa and Binge Eating Disorder, both in randomized control trials (e.g., Hay, 2013) and examinations of CBT implementation in routine clinical practice in residential (Calugi et al., 2016), outpatient (Rykos et al., 2013; Waller et al., 2014), and even primary care settings (Rose & Waller, 2017). The Society of Clinical Psychology, Division 12 of the American Psychological Association, which has become the unofficial gatekeeper of empirically supported treatments, states that "CBT has the strongest scientific evidence of all the tested psychological treatments for bulimia nervosa" (Division 12, 2016). Research support is also building for use of CBT in treating Anorexia Nervosa; however, the findings are only modest at this time, and some studies have found no differences between CBT and other types of therapy for this disorder (e.g., Carter et al., 2011).

Several factors can influence how successful CBT will be for a client with an eating disorder. One is adherence to the treatment on the part of the therapist delivering the therapy. Waller, Stringer, and Meyer (2012) found that when clinicians were asked which CBT techniques they actually used in their practice with eating disorder clients, none of the widely supported techniques were used by half the clinicians routinely. Therefore, many clinicians who self-identify as using CBT are in fact not administering CBT techniques.

Another factor that can potentially influence the outcomes of any type of therapy for eating psychopathology is the therapeutic alliance. Waller, Evans, and Stringer (2012) found that CBT clients rated the therapeutic alliance as strong early in therapy but that these ratings were not related to symptom reduction. However, when Waller and colleagues (2013; 2014) examined CBT for Anorexia Nervosa, weight gain predicted the strength of the alliance later in therapy, indicating that it may be more pressing to focus on symptom change initially and that a strong alliance might follow. A recent meta-analysis by Graves and colleagues (2017) showed small to moderate effect sizes for the relationship between the quality of the therapeutic alliance and reduction of symptoms in treatment of eating disorders using any therapy modality. However, the alliance early in therapy was not related to subsequent symptom change for clients engaged in CBT.

This evidence is particularly important to consider in light of the fact that clinicians may avoid or delay using CBT techniques in session in part due to their concerns about the potential consequences of these techniques. For example, Brown, Mountford, and Waller (2013) found that those clinicians who are concerned about the therapeutic alliance and who believe more strongly in its influence on therapeutic outcomes are less likely to, for example, push for weight gain in clients with Anorexia Nervosa. In turn, attrition is much higher for those clients who gain less weight. Therefore, ironically, by trying to keep the client in therapy by protecting the alliance, the clinician instead can cause early termination in addition to problems in symptom reduction. Clinicians do self-report anxiety related to treating clients with eating psychopathology, particularly related to body image work, behavioral experiments, and ending treatment (Turner et al., 2014).

The findings related to body image work are particularly troubling given that Fairburn (2008) emphasizes that cognitive distortions about weight and shape are among the most important and the most difficult to change in treating eating disorders. In addition, the apprehensions about behavioral experiments are concerning given the growing body of research supporting the importance of use of exposure and response prevention in treating eating psychopathology (e.g., Steinglass et al., 2014; Trottier et al., 2015), even extending to promising findings using virtual reality as means of exposure (de Carvalho et al., 2017).

Adherence to techniques and overcoming anxiety on the part of the clinician related to disrupting the therapeutic alliance, particularly early on in therapy, is imperative, as research by Raykos and colleagues (2013) shows that those who respond more quickly to CBT for eating disorders require fewer treatment sessions and are more likely to achieve remission from their disordered eating symptoms. Similarly, Rose and Waller (2017) found no added benefits to clients who engaged in CBT for eating disorders in a primary care beyond the 12th session of therapy. Therefore, engaging in empirically supported CBT techniques from the earliest session of therapy to directly address disordered eating behaviors and related factors, such as body image, is imperative.

Recent research illustrates that the anxieties and hesitancies of clinicians to engage their clients in CBT techniques is a hindrance to clients' progress and symptom reduction. Based on the current data available, clinicians can implement these techniques without worry about rupturing the alliance. Instead, they can be confident

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GENDER IDENTITIES IN CASE CONCEPTUALIZATION

DEBRA A. HOPE, PH.D.

Dr. Hope is a Professor of Psychology at University Nebraska Lincoln She received her Ph.D. in clinical psychology from the University at Albany-State University of New York in 1990 and joined the department in the same year. Her current research interests follow two broad themes: (a) assessment and treatment of anxiety disorders (particularly social anxiety disorder) and (b) the impact of stigma and discrimination on mental health and health services, particularly for individuals who identify as transgender, lesbian, gay, or bisexual. Dr. Hope is the director of the Anxiety Disorders Clinic and the Rainbow Clinic, both speciality services within the Psychological Consultation Center. Her work on psychopathology emphasizes information processing models that describe the role of attention and memory in social anxiety disorder and the impact of these cognitive processes on interpersonal functioning. Dr. Hope also has ongoing research on both the outcome and process of psychotherapy, with a most recent emphasis on using technology to make evidence-based treatment more available, especially in underserved rural areas. The LGBT line of research is examining how stigma and discrimination impact mental health. Our current major collaboration is developing a culturally sensitive model of care for individuals who identify as transgender and reside in areas with few specialty resources. Dr. Hope also has a teaching and research interest in the psychology of women. Dr. Hope teaches a course in behavior therapy fundamentals and supervises practicum at the graduate level. She teaches psychology of diversity, abnormal psychology, introductory psychology at the undergraduate level.

Therapists-in-training often hear the dreaded phrase "it depends" in response to a query to a supervisor about what to do in a particular circumstance with a client. The "it depends," of course, refers to the case conceptualization. How should a therapist handle a client who is late to session? It depends on whether the case conceptualization suggests the client has difficulty prioritizing their own self-care or has core beliefs about perfectionism. Models of case conceptualization typically include an understanding of the antecedents of the problem and a theory of the mechanism(s) (e.g., cognitive factors, family relationships, past experiences, behavioral deficits, biological mechanisms, environmental influences) hypothesized to cause the problem(s). Treatment plan naturally flows from the case conceptualization. For example, if a client's interpersonal difficulties are attributed to lack of social skills rather than anxiety, then improving social skills is a more logical intervention than challenging cognitions that over-estimate risk.

A multicultural approach to case conceptualization means that various contextual or identity factors such as socioeconomic status or race/ethnicity are combined with the clinical presentation to build a complete understanding of the case. Recent work that my colleagues and I have undertaken to address health disparities with transgender and gender non-conforming communities (TGNC) has highlighted both the complexities and importance of including gender in case conceptualization.

Gender is commonly included in case conceptualization, though often only implicitly. For example, a client is depressed, having difficulty being patient with two young children and is avoiding them by spending more time at work. The other parent is picking up more of the responsibility for the children. Although we might strive for an egalitarian society, most therapists will see this problem differently, perhaps as more urgent, if the client is the mother than if the client is the father in a two-parent heterosexual family. An explicit inclusion of gender in this case conceptualization would include a discussion of gender roles, both for this particular couple and their culture in general.

The experiences and gender presentations of the TGNC communities are far too varied to have a generic "transgender/gender non-conforming" case conceptualization. As a therapist comes to understand a client's gender at a given point in time, the therapist must also understand the meaning of the gender the client is owning, how gender will be enacted, how others are likely to perceive and react to the client's gender and gendered behaviors, and the client's experience of those reactions. The reactions of others including both people within the family and social network as well as society at large and the therapist themselves. This is not the entire case conceptualization for most TGNC clients but is a crucial context for understanding any presenting problems such as anxiety, depression, or substance abuse, or decisions such as social, medical, or legal transitions. I would argue that while this aspect of case conceptualization may appear more complex for TGNC clients, this is due to our default assumptions and experience with a traditional binary gender. A similar process could be used to incorporate a deep understanding of gender in all case conceptualizations.

There are, however, two ways in which TGNC clients differ from cisgender clients when considering gender in the case conceptualization. The first difference is the near universal experience of marginalization for TGNC individuals. Although a case conceptualization for a cisgender individual may include the experience of marginalization or privilege for women and men, respectively, consideration of marginalization stress due to a TGNC identity is crucial. Understanding a client's challenges and resiliency in the face of negative cultural messages, experiences of exclusion, and physical danger can provide useful information for the case conceptualization. This may be especially acute for gender queer/gender non-conforming clients who do not fit the cultural narrative of gender as binary. The second difference is consideration of

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COGNITIVE AND BEHAVIORAL THERAPIES FOR PSYCHOSIS AND THE SCHIZOPHRENIA SPECTRUM: DOES THE ARC OF HISTORY BEND TOWARD COLLABORATION?

JEROME YOMAN, PH.D. LIFE SKILLS RESOURCE, LLC

Jerome Yoman, Ph.D., ABPP, clinical psychologist, has served persons with serious mental illnesses for 35 years. He is board certified in Cognitive and Behavioral Psychology, a Fellow of the Association for Cognitive & Behavioral Therapies, and Leader of ABCT's Schizophrenia and Other Serious Mental Disorders Special Interest Group. He has been a program creator and director, supervisor, consultant, adjunct faculty member, and trainer. He has published on functional analysis, functional assessment, and problem solving skills. He has a private practice, Life Skills Resource, LLC, with clinical interests in cognitive therapy for psychosis, social skills training, and family therapy.

Cognitive-behavioral interventions for psychosis and the schizophrenia spectrum (abbreviated hereafter as PASS), have a half-century-long history (e.g., Ayllon & Azrin, 1968). CBT practitioners for other disorders, and newcomers to working with this disorder, may be unaware of this extensive evidence base. Readers of Advances in Cognitive Therapy may well be aware of Donald Meichenbaum's (Meichenbaum & Cameron, 1973) early case study, "Training Schizophrenics to Talk to Themselves" and research on cognitive therapy for schizophrenia (see for example, Dickerson, 2004). They are less likely informed of the groundbreaking work of individuals such as Gordon Paul (Paul & Lentz, 1977) and Robert Liberman (e.g., Liberman, King, & DeRisi, 1976), who laid the cornerstones of our evidence base for CBT with PASS. Paul's work led to the first evidence-based behavioral intervention, the token economy, which has been often replicated and continues rather anonymously in a number of active treatment programs (see Dickerson, Tenhula, & Green-Paden, 2005; Glynn, 1990). Liberman's work, largely drawing on Bandura's social learning theory, established behavioral family therapy (the CBT intervention for PASS with the strongest evidence base; Mueser & Glynn, 1999) and social skills training (Wallace, Liberman, MacKain, & Eckman, 1992; Kopelowicz, Liberman, & Zarate, 2006). Mueser et al. (2006) have subsequently elaborated Liberman's work with the illness management and recovery intervention. Cognitive remediation (Twamley, Jeste, & Bellack, 2003) is another evidence-based CBT intervention.

The above is just a cursory introduction to the rich history of research and associated clinical technique under the umbrella of CBT for PASS, yet there are surprising limits to our understanding. Each of our evidence based interventions contains multiple components, but the literature provides little insight on which of these are the mechanisms of action. This admittedly difficult line of research is essential if we are to develop the most efficient and effective interventions for the often disabling problems encountered by people with PASS. Also, more so than for other mental health problems, a great deal of work remains to determine their generalizability and disseminability if the promise of these findings is to be fulfilled. Though many policymakers and members of the public are unaware of our work, there is already a great shortage of well-trained practitioners and complex barriers to accessing care (Thomas, 2015; van der Gaag, 2014).

Even in the face of these great challenges, it is easy for researchers to function in separate silos, and for clinicians to cling to the intervention or theory they know best. Building new clinical skills can be daunting, and competition stiff for grants, publications, and presentations. We tend to settle into camps and champion a particular theory, in the absence of strong evidence for the superiority of its purported mechanism of action. We set career-long programs of research in relative isolation. We replicate far more than we innovate. On the other hand, we sometimes reinvent the wheel.

Greater collaboration and awareness of each other's work might better serve both our clients and the knowledge base. This includes more collaboration with clients in developing, studying, and refining interventions. Cognitive-behavioral therapies hold in common a reliance on the evidence base; data is our universal language. Working together we can best integrate findings to answer Paul's (1967) enduring question: "What treatment, by whom, is most effective for this individual with that specific problem, and under which set of circumstances?". Better collaboration may move us more quickly to consensus on such issues as the content validity of outcomes measures for research and practice, and the necessary competencies for therapists treating PASS.

I invite interested readers to join our ABCT Special Interest Group (SIG) that focuses on PASS, and to participate in the ABCT convention in November 2018 in Washington, DC. Many of the researchers cited below have attended. ABCT presents fertile opportunities to come together in service of more effective treatments for people with PASS.

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SCHOOL-BASED INTERVENTION FOR SOCIAL ANXIETY DISORDER: CURRENT STATUS AND FUTURE DIRECTIONS

DEVANTE CUNNINGHAM, MELISSA SITAL, CARRIE MASIA WARNER, PH.D., & JEREMY K. FOX, PH.D.

Carrie Masia Warner, Ph.D. is Professor of Psychology at Montclair State University in their Ph.D. program in Clinical Psychology. Dr. Masia Warner completed an NIMH postdoctoral fellowship in the Department of Child Psychiatry at Columbia University after which she served on the faculty in the Department of Child and Adolescent Psychiatry at New York University's Langone Medical Center for 13 years. Dr. Masia Warner specializes in pediatric anxiety disorders. Her research has been funded by NIMH, AKFSA, and ADAA, and has focused on enhancing access to services for children and adolescents with anxiety disorders by training frontline professionals to implement interventions in schools and pediatric medical settings. Dr. Masia Warner is best known for developing a school-based intervention for social anxiety disorder that has been used nationally and internationally. The program, referred to as Skills for Academic and Social Success (SASS) is available as a Guilford book entitled, Helping Students Overcome Social Anxiety.

Jeremy Fox, Ph.D. is an Assistant Professor in the Psychology Department at Montclair State University. He received his Ph.D. in Clinical Psychology from the University at Albany, State University of New York and subsequently completed his predoctoral internship at the University of Washington, School of Medicine and Seattle Children's Hospital and postdoctoral fellowship at the New York University Child Study Center. His research interests focus on the developmental psychopathology, screening, and early intervention of childhood anxiety, as well as school mental health and dissemination issues. He is also the Director of Clinical Training for MSU's Psychology Department, where he directs the PhD Program in Clinical Psychology.

DeVanté Cunningham is a first-year Ph.D. student in the Clinical Psychology program at Montclair State University (MSU). Prior to beginning this program, DeVanté (DJ) spent the last 6 years at the University of Virginia (Charlottesville, VA) where he completed his B.A. in Psychology and Sociology and Master's in Public Health with a concentration in Health Policy, Law, and Ethics. His master's thesis was entitled "I'm in the dope Black people group": The educated and stressed minority, in which he conducted qualitative research on the stressors and coping strategies of Black graduate and professional students at a predominantly white institution. DJ has spent years mentoring minority and under-resourced youth and has a desire to work both as a professor and clinician. At MSU, DJ is being mentored by Dr. Carrie Masia Warner. His research and clinical interests are primarily focused on minority populations and trauma and anxiety related disorders.

Melissa Sital is a first-year Ph.D. student in the Clinical Psychology program at Montclair State University (MSU). Prior to her work in the program, Melissa earned her B.A. in Psychology at Trinity College (Hartford, CT). There, she completed an honors thesis investigating the relationship between cultural framework and distress tolerance, and the influence of this relationship on support-seeking behaviors. Melissa then served as a Research Assistant at the Nathan Kline Institute (Orangeburg, NY), providing support for several studies aimed at creating a large scale (N>1000) community sample of healthy participants across the lifespan (aged 6 to 85). Now at MSU, Melissa is studying under Dr. Jeremy K. Fox. Her doctoral research is focused upon anxiety and depression in childhood and adolescence. In the future, Melissa aims to contribute to the development of evidence-based treatments and interventions for these disorders, with an emphasis on cultural sensitivity.

Social anxiety disorder (SAD), characterized by excessive fear and avoidance of social and performance situations, is highly prevalent in adolescents, affecting an estimated 9.1% (Merikangas et al., 2010). SAD is relevant to the mission of schools because of its association with increased risk for absenteeism, school refusal, and premature withdrawal from school (Heyne, Sauter, Van Widenfelt, Vermeiren, & Westenberg, 2011; Stein & Kean, 2000; van Ameringen et al., 2003; see Fox, Masia Warner, & Drew, in press). Youth with social anxiety demonstrate lower academic performance (Van Ameringen, Mancini, & Farvolden, 2003) and greater problems with learning and concentration in the classroom (Bernstein, Bernat, Davis, & Layne, 2008). Common social fears, such as speaking in front of the class and asking questions, may directly interfere with classroom performance. In addition, students who feel less engaged and connected at school tend to experience greater social anxiety and degree non-completion (Blum & Libbey, 2004; Bond et al., 2007; Resnick, Harris, & Blum, 1993; Shochet, Dadds, Ham, & Montague, 2006). Undoubtedly, these consequences of social anxiety indicate a growing need for identification and treatment of symptoms, particularly in schools. However, SAD has one of the lowest rates of service utilization among adolescent psychological disorders (12%; Merikangas et al., 2011), underscoring a need to enhance detection and access to intervention.

Schools are uniquely positioned to address treatment challenges specific to SAD. For one, SAD appears less responsive than other pediatric anxiety disorders to individual cognitive-behavioral therapy (CBT; Ginsburg et al., 2011). Clinical settings, unlike schools, have difficulty forming groups of children at similar developmental levels with specific clinical disorders. School-based group treatment is especially relevant to social anxiety because many social fears manifest in school; thus, schools are uniquely suited for addressing these fears in real life contexts (e.g., school

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cafeteria, library) with multiple individuals (e.g., peers, teachers). In sum, by supporting a group structure and integrating treatment within a natural environment, school-based intervention maximizes opportunities for treatment effectiveness.

Masia Warner and colleagues have systematically developed and evaluated a school-based, cognitive-behavioral intervention for SAD, Skills for Academic and Social Success (SASS), which has demonstrated effectiveness (Masia et al., 2001; Masia Warner et al., 2005; Masia Warner et al., 2007). SASS involves 12, 40-minute (one class period) group sessions, two brief individual meetings, two booster sessions, two parent meetings, teacher meetings as needed, and four social events with prosocial school peers (Masia Warner, Colognori, & Lynch, 2018). Most recently, in a randomized clinical trial of 138, 9th through 11th graders from three public high schools (Masia Warner et al. 2016), SASS was shown to be effective when implemented by school counselors with benefits comparable to care delivered by psychologists. These findings support the potential to disseminate SASS to schools more broadly.

In the doctoral program in clinical psychology at Montclair State University, we are conducting research to move this work ahead in significant ways. There is a paucity of intervention research for anxiety in racial/ethnic minorities (Huey Jr. & Polo, 2008). This is concerning because rates of SAD and other anxiety disorders are high among racial/ethnic minority students (Beidas et al., 2012; Merikangas et al., 2010; Yeh et al., 2002). In addition, minority youth are more likely to receive mental health services in schools than community clinics (Cummings, Ponce, & Mays, 2010; Jaycox et al., 2010). Therefore, an important direction for our research will be to extend school-based intervention efforts to students with SAD from minority backgrounds in underserved communities. One approach may be to enhance the cultural and structural applicability of SASS, as well as to develop strategies to engage minority students in school-based intervention. Adapting evidence-based anxiety interventions to be feasible and effective in diverse school environments will help to address unmet mental health needs of underserved youth with anxiety.

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NATIONAL CONFERENCE ON COGNITIVE BEHAVIORAL THERAPY 2017 CETTAD-UNAM. MEXICO

JUAN M. BRAVO SIERRA, MD, ERIKA M. ZAMORA G., ANGELICA GUTIERREZ CHAVERO, KAREN A. CERRILLO A., MD, ANA B. ZALAZAR V., THALÍA ALDAPE CHAVEZ, BEATRIZ HERNÁNDEZ RAMÍREZ, & VICTOR J. TREJO T., MD

The Centro Especializado en el Tratamiento de los Trastornos Ansiosos, Depresivos y de la Personalidad S.C.1 (known in Spanish as CETTAD S.C.) opened its gates for the first time in 2009, México City. CETTAD is staffed by a team of four psychiatrists and six psychologists trained as cognitive behavioral therapists. Its mission is to be a center dedicated to dissemination of and treatment with Cognitive Behavioral Therapy (CBT), and, therefore serves both clinical and academic functions. The clinical arm of the center assists people of all ages with a wide variety of psychopathology. The academic arm provides CBT training, endorsed by the National Autonomous University of Mexico (known as UNAM in Spanish)—Mexico's most important university, and one of the most relevant in Latin America.

In November of this year, CETTAD—with UNAM's support—held the National Conference on Cognitive Behavioral Therapy 2017 (www.congresotcc2017.com). A description of the program follows:

The Conference included workshops, round tables, and plenary sessions. The workshops were "Handling Depression with CBT," "Applying the Intolerance of Uncertainty Model in the Handling of Generalized Anxiety Disorder," "Mindfulness' Basic Techniques Training," and "Training for Parents." The round tables covered: "The Cognitive Model, Challenges and Proposals for its Clinic Deployment," and "The Future of CBT." The plenary sessions were divided into three main sections. First, the theoretical category included "Case Formulation in CBT," and Dr. Donna Sudak's "Learning to be an Expert in CBT." Second, the clinical category included sessions about the most updated treatment models for particular diagnoses, and Dr. Sudak spoke about "Combining CBT and Medication." The third category covered expanding CBT, CBT in novel ways, with remarkable videoconferences including "Trial Based Cognitive Therapy" by Dr. Irismar Reis de Oliveira, and "Emotional Schema Therapy" by Dr. Robert L. Leahy. The majority of the national speakers were from CETTAD's group.

The level of satisfaction of the Conference's audience—according to a survey conducted by the UNAM—was high. CETTAD plans to hold this event annually, and hopes to draw more participants and presenters to increase the quality of CBT training and implementation in Mexico.

As part of its deployment and disclosure program of CBT as an evidence-based model, for which is calling on other CBT groups in Mexico and freelance professionals to join this endeavor.

More information about CETTAD can be obtained at www.cettad.com.

1 CETTAD is a specialized center that focuses on treating patients with anxiety, depressive, and personality disorders in México City.

Juan M. Bravo Sierra, MD, is a psychiatrist and cognitive behavioral therapist certified by the Academy of Cognitive Therapy. He holds a master's degree in researching from Barcelona University. He is a psychiatrist-psychotherapist at the CETTAD and the academic coordinator and professor of the cognitive behavioral therapy degree course provided by UNAM-CETTAD. His clinical work focuses on personality disorders.

Erika M. Zamora G. is a psychologist and cognitive behavioral therapist endorsed by the National Autonomous University of México (Known as UNAM in Spanish), which is the most recognized university in our country. She holds a Master's degree in Criminology and Legal Psychology and a Doctoral degree in law by the University Institute of Puebla. She is a psychotherapist at the CETTAD. Her work focuses on domestic violence and crisis intervention.

Angelica Gutierrez Chavero is a psychologist and cognitive behavioral therapist endorsed by the National Autonomous University of México. She is a mindfulness trainer and a psychotherapist at the CETTAD. She also is a professor of the cognitive behavioral therapy degree course provided by UNAM-CETTAD. Her clinical work focuses on the Mindfulness Based Cognitive Therapy and as an Executive Coach.

Karen A. Cerrillo A., MD, is a psychogeriatrician and cognitive behavioral therapist endorsed by the National Autonomous University of México. She is a psychiatrist-psychotherapist at the CETTAD and

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professor of the cognitive behavioral therapy degree course provided by UNAM-CETTAD. Her clinical work focuses on the mental disorders in older adults.

Ana B. Zalazar V. is a psychologist and cognitive behavioral therapist endorsed by the National Autonomous University of México. She is a psychotherapist at the CETTAD. Her clinical work focuses on anxiety disorders in children and adolescents. Thalía Aldape Chavez is a psychologist and cognitive behavioral therapist endorsed by the National Autonomous University of México. She is a psychotherapist at the CETTAD and professor of the cognitive behavioral therapy degree course provided by UNAM-CETTAD. In addition, she is a professor of the cognitive behavioral therapy for children and adolescents course provided by UNAM-CETTAD. Her clinical work focuses on the externalizing disorders in children and adolescents.

Beatriz Hernández Ramírez is a psychologist and cognitive behavioral therapist endorsed by the National Autonomous University of México. She is a preventive and social rehabilitation center psychology area coordinator in Cuautitlán, Estado de México. She is a psychotherapist at the CETTAD and professor of the cognitive behavioral therapy degree course provided by UNAM-CETTAD. Her clinical work focuses on anxiety and obsessive-compulsive disorders.

Victor J. Trejo T., MD, is a psychiatrist and cognitive behavioral therapist endorsed by the National Autonomous University of México. He is a psychiatrist-psychotherapist at the CETTAD and a professor of the cognitive behavioral therapy degree course provided by UNAM-CETTAD. He is also a professor of the medicine degree at the UNAM. His clinical work focuses on combining cognitive behavioral therapy and medication.

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IACP PRESIDENT'S MESSAGE
CONTINUED FROM PG. 1

present challenges regarding the future of CBT. Having had the honor and responsibility of being the president of the last EABCT (European Association for Behavioural and Cognitive Therapies) Congress, I had the privilege to give an opening keynote regarding the theme of the congress which was "Bridging dissemination with good practice". The theme of the congress and my opening keynote was chosen on the opinion that dissemination of CBT is no doubt highly important but dissemination without caring about its good and ethical practice may discredit its prestigious status. As evidence for efficacy and effectiveness of CBT became evident an initial and important question emerged about its provision: "Can we make effective therapies more accessible and available?" In other words, when problems were identified as suitable for CBT, CBT was not readily available which lead researchers and clinicians to disseminate evidence based therapies, by different delivery methods ranging from internet- based to face to face treatments. As CBT became more available and accessible a further important question emerged: "When CBT is available, is it really CBT?" Relying only on dissemination may result in discrediting of the approach due to lack of "competent adherence". Many studies do not adequately describe their treatment procedures and processes and therefore, cannot reliably be measured in terms of adherence and competence. It is our major need and perhaps our duty today to emphasize the significance of "dissemination of good and ethical practice" which requires defining the optimum pre-requisites that constitute the key principles of an acceptable practice of CBT. Clinicians' self report of doing CBT may not always be a reliable predictor of their adherence and competence in pursuing good practice. Adherence and competence are core variables of treatment integrity, securing that treatment is implented as intended. How much and how well (skillful) therapists do what they are expected to do certainly has an ultimate impact on the outcome. To sum up, the quality of CBT offered remains to be better analysed and this analysis can be meaningful only when client/ patient perceptions of what was done in treatment match with well defined procedures of what should have been done in treatment sessions and in between sessions. Further studies need to be conducted to find out the gap between effectiveness obtained in randomized clinical trials and during its dissemination to routine clinical practice and how to improve transferability of efficacious CBT protocols into daily practice.

I would also like to draw attention to the fact the term "CBT" is losing its specifity. Therefore, it is now more accurate to view CBT as a maturing discipline that is not a single approach but a broad set of psychotherapies that continually evolve and change as more knowledge is accumulated. Perhaps CBT today can be seen as a scientific enterprise with openness in translating and accommodating new developments and new empirical findings into its flexible structure.

IACP's distinguished board members and I will aim to improve communication and liaison with other CBT societies around the globe that share similar interests and goals to promote and disseminate good practice of CBT. These collaboration efforts will hopefully conclude by establishing a truly inclusive and integrative World Federation of CBT. We will need to work harder as a wave is alive only by its motion and when it comes to rest, it is not existent anymore.

Please visit our new website which is under reconstruction to learn more about IACP. I will carry on discussing further challenges that CBT is likely to face in the upcoming issues. I would like to thank you all for giving me the opportunity to take a leading role in this distinguished and highly esteemed CBT community.

Our board members and I am looking forward to serving you in the

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most appropriate and desirable way over the next years. Please do not hesitate to guide us to serve you in the best way possible.

Mehmet Sungur, MD
President, IACP

ACT PRESIDENT'S MESSAGE

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countries with many more to come. He has received three awards from the Canadian Psychological Association, is a van Ameringen Scholar of the Beck Institute, and the recipient of the Aaron T. Beck Award from the Institute for Cognitive Studies. Dr. Dobson is a Past-President of both the Academy of Cognitive Therapy, and the International Association for Cognitive Psychotherapy, and has served on the ABCT Board of Directors. He is the current President-elect for the Canadian Association of CBT.

Before I end, I want to welcome Drs. William Sanderson and Robert Leahy to the board. I look forward to working with them and with the board, with our Executive Director Troy Thompson, our new administrator, Mr. Kenneth Cobbs, and with our newsletter editor, Dr. Jamie Schumpf for another productive year.

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 am honored to continue serving all of you for another year. Please continue to recommend deserving colleagues to the Academy for credentialing and if you haven't done so already, consider applying to become a fellow and/or trainer-consultant. Please contact me if you have suggestions or comments about the Academy, or to learn more about the Academy's Institutional Training Program.

Lata K. McGinn, Ph.D.
President, Academy of Cognitive Therapy

INDECISIVENESS IN HOARDING DISORDER

CONTINUED FROM PG. 4

of sorting objects imperfectly, and cognitive restructuring to target black-and-white thinking related to discarding objects or other aspects of hoarding. Interventions targeting the possible underlying mechanism of perfectionism may lead to positive effects on hoarding symptoms (i.e., difficulty with making discarding decisions), though this hypothesis remains to be studied.

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GENDER IDENTITIES IN CASE CONCEPTUALIZATION

CONTINUED FROM PG. 6

the TGNC client's experience of change in their gender, if it is occurring. This could include both positive and negative aspects of their own sense of self and self-identity, positive and negative reactions from others, and the experience of gaining or losing cultural privilege related to perceived gender.

Much of the clinical literature on working with TGNC clients focuses on transition care. Less attention has been paid to evidence-based care for general behavioral health problems. As our societal acceptance and understanding of variation in gender identities expand, more TGNC clients will arrive at clinicians' offices seeking good evidence-based therapy. Thinking deeply about the meaning of gender and challenging our assumptions will help prepare therapists to work with TGNC clients but also enrich work with all of our clients.

IMPLEMENTING SUCCESSFUL CBT FOR EATING DISORDERS CONTINUED FROM PG. 5

that using CBT techniques will lead not only to symptom reduction in the short term but also a stronger therapeutic alliance as treatment progresses. By adhering to CBT, we can best treat the dangerous symptoms of eating psychopathology.

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SCHOOL-BASED INTERVENTION FOR SOCIAL ANXIETY DISORDER: CURRENT STATUS AND FUTURE DIRECTIONS

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