ADVANCES IN Cognitive Therapy newsletter

February, 2019

IACP Vol 19, Issue 1 / ACT Vol 20, Issue 1

Publication of the Academy of Cognitive Therapy (ACT) and the International Association of Cognitive Psychotherapy (IACP)

EDITOR
Jamie Schumpf, Psy.D., ACT

ACT PRESIDENT'S COLUMN

LYNN MCFARR, PH.D.

I am delighted to be writing my first column as President of the Academy. Although the position carries with it tremendous responsibility, I rest easy knowing that I am preceded by the stellar leadership of Lata McGinn, Ph.D., who saw us through some of our biggest challenges as an organization since our inception. My plans for the presidency include strategic planning that includes both the Academy and the International Association for Cognitive Psychotherapy (IACP) to create a seamless partnership that encompasses both the practice and science arms of CBT. I am also interested in broadening our umbrella as a welcoming place for CBT practitioners of all stripes while still honoring our cognitive roots. Our ability to offer a rigorous yet flexible measure of competency makes the Academy especially suited to rate fidelity across multiple settings, treatments, and disciplines.

With respect to disciplines, I am delighted to welcome our first Social Worker to the board. Lizbeth Gaona, LCSW joins us as the first social worker and first Latina to serve. She comes to us from USC's doctoral program in Social Welfare with a commitment to dissemination and implementation of CBT in marginalized populations and is proud to represent her discipline on the board.

Over the years one of the most helpful experiences on the board was the members meeting we held to get feedback on our organization. I was thrilled to hear how happy, in general, the members are with the Academy and even more happy to receive feedback of things we could improve. I am hoping to schedule a general members meeting at least twice a year to get your input and ideas on how to make the Academy even better. I look forward to the journey we will on be on together for the next two years.

Lynn McFarr, Ph.D.
President, The Academy of Cognitive Therapy
President-Elect, International Association of Cognitive Therapy

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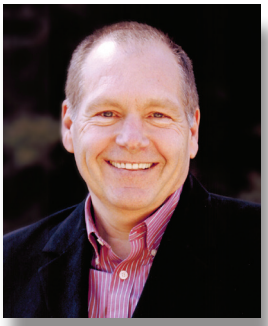
STANDING ON THE SHOULDERS OF GIANTS
KEITH S. DOBSON, PH.D.



Keith Dobson, Ph.D. is a Professor of Clinical Psychology at the University of Calgary in Canada, where he has also served in other roles, including Head of Psychology and Director of the Clinical Psychology program. His research has focused on both cognitive models and mechanisms in depression, and the treatment of depression, particularly using cognitive-behavioural therapies. . Dr. Dobson's research has resulted in over 250 published articles and 80 chapters, 15 books, and numerous conference and workshop presentations in many countries. His recent books include Evidence-based Practice of Cognitive-behavior Therapy (2017, with Deborah Dobson, Guilford Press), The Therapeutic Relationship in Cognitive-behavioral Therapy (2017, with N. Kazantzis and F. Dattilio, Guilford Press), and the Handbook of Cognitive-behavioral Therapies (4th Edition) (2019, Guilford Press). Further, he has written about developments in professional psychology and ethics, and has been actively involved in organized psychology in Canada, including a term as President of the Canadian Psychological Association. He is a Past-President of both the Academy of Cognitive Therapy and the International Association for Cognitive Psychotherapy, and is the current President of the Canadian Association of Cognitive Behavioral Therapies. Dr. Dobson is also a Principal Investigator for the Opening Mindsprogram of the Mental Health Commission of Canada, with a focus on stigma reduction related to mental disorders in the workplace. This work includes evaluations of a number of programs, and spans a variety of types of employers (e.g. police, oil and gas industry, manufacturing, colleges and universities) across Canada. Among other awards, he has been given the Canadian Psychological Association's Award for Distinguished Contributions to the Profession of Psychology, the Donald O. Hebb Award for Distinguished Contributions to the Science of Psychology, and the CPA Award for Distinguished Contributions to the International Advancement of Psychology.

It is my distinct honor to have received this invitation to write this retrospective review of my development and its influences. For those readers who do not know me, I am the second of five sons, mostly raised in rural Alberta. I finished high school and left home at the age of 17 to pursue university in Edmonton, Alberta, where I completed my BA in Psychology in 1975 before heading off to graduate school at the University of Western Ontario and ultimately earning a doctoral degree there in 1980. The other important developmental factor for me was my marriage, when I was 19 to my current wife Debbie, who also completed her Ph.D. in clinical psychology at the University of Western Ontario (in 1984, due to some delays associated with having two wonderful children and my career).

My first true giant was Brian Shaw (of Beck, Rush, Shaw & Emery, 1979) who was at the University of Western Ontario and my doctoral dissertation supervisor. He introduced me to cognitive-behavioral therapy (CBT), as well as Dr. Aaron Beck, the latter of whom graciously invited me to attend sessions at the University of Pennsylvania. These were the early days of what became CBT, when it was still almost revolutionary to opine that cognitive change could modify behavior! Randomized trials were just beginning to shape the landscape of what would today become common knowledge. In this regard, I was most fortunate when Brian Shaw became the lead trainer for the Cognitive Therapy component of the NIMH Treatments of Depression Collaborative Research Program (TDCRP; Elkin, et al., 1989) and I was situated to become a trainer in that process. I met some of the lead people at NIMH and in the field of depression through that work, which quickly accelerated my career trajectory.

In 1982, I moved to the University of British Columbia, the same year as Jack Rachman arrived there from London (another giant in the field). I became involved in my research program, training issues, as well as professional psychology (e.g., I was the President of the provincial licensing organization in 1986-87, when I was all of 32 years old). While at UBC, I had the great fortune to meet Neil Jacobson who was at the University of Washington. This collaboration resulted in three NIMH funded depression trials, and many further opportunities. Neil was a true iconoclast, and a giant in the field, and someone who was able to negotiate many diverse interests. He also was an empiricist, and although by the time I had met him I had already "drank the elixir" of empiricism, his conviction in science was truly inspirational. I have wondered where his and my careers might have gone, except for his untimely death in 1999.

In 1989 my wife and I made a dual career move to Calgary, where we have been since. As I noted above, she obtained her degree in Clinical Psychology in 1984 and we lived in British Columbia at an unfortunate time, as there were cuts to public health and very few career options for her. I became the Director of a nascent Clinical Psychology program (accredited in 1993), and eventually the Head of Psychology on three different occasions. I stayed active in professional psychology and served on many committees in the Canadian Psychological Association as well as its President (1995-96). I also served on the boards and executive of a variety of CBT organizations, including ABCT, IACP, the Academy of Cognitive Therapy, the World Congress committees and the Canadian Association of CBT- ACTCC. Through these associations, I have had the wonderful experience of standing of the shoulders of many committed, brilliant and hard working professionals who have given of their time and knowledge to move the field forwards. I am extremely reticent to name names in this regard, as there have been so many people from whom I have learned and with whom I have worked. I will not be able to name them all here, but these giants include Judith Beck, Leslie Sokol, Bob Leahy, Mehmet Sungur, Lata McGinn, and David M. Clark.

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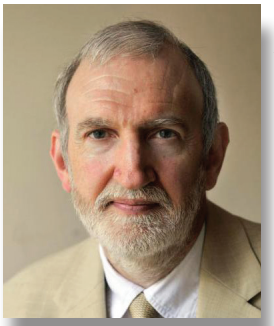
RECOGNIZING AND TREATING VOICE-HEARING IN PTSD

CHRIS R. BREWIN, UNIVERSITY COLLEGE LONDON, U.K.



Chris Brewin, FMedSci FBA is Emeritus Professor of Clinical Psychology at University College London. He has a particular interest in intrusive memories and flashbacks and has been centrally involved in developing the dual representation theory of PTSD. He has contributed to recent international changes to the diagnosis of PTSD in DSM-5 and ICD-11, and to the implementation of outreach programs to ensure survivors of terrorist attacks have access to evidence-based treatment. In 2013 he was given the Robert S. Laufer Memorial Award for Outstanding Scientific Achievement by the International Society of Traumatic Stress Studies.

A little over ten years ago I was treating a patient with what seemed to me to be irrational self-blame over a traumatic experience in which another person was killed. When I asked him why he was so convinced he was responsible he described hearing a voice that told him so in no uncertain terms. This was very intriguing – the voice frequently criticized him and played a major part in his negative thinking. But this was more than just a thought – the voice had sensory characteristics that intensified its impact and made it more than usually compelling. The literature on PTSD was, and remains, almost entirely silent on this symptom, apart from a few studies conducted with military samples. So Trishna Patel and I replicated these findings with both a military and civilian sample in the U.K., finding about half our group of people with reasonably complex PTSD reported regularly hearing one or more voices. They were occasionally positive but more usually highly critical. Many patients heard the voices daily and were strongly affected by them.

Voice-hearing is traditionally regarded as a psychotic symptom, but some psychosis researchers such as Eleanor Longden and colleagues propose it is actually a trauma-related dissociative symptom. Apart from epidemiological research tying trauma exposure to voice-hearing it is also one of the items on the Dissociative Experiences Scale. Certainly in our study voice-hearing was related to other current and peri-traumatic reactions. In my experience voice-hearing in PTSD is usually restricted to one or two voices – patients with greater numbers of voices may be better described as suffering from a comorbid dissociative disorder or as being farther along a spectrum ending in dissociative identity disorder.

Psychosis research is illuminating in demonstrating that often people relate to their voices in ways that mirror other human relationships. This is the key difference with the familiar phenomenon of negative thoughts – the content may be similar but the thoughts are being delivered in a way that activates responses associated with a personal relationship. In our study PTSD patients often reported being intimidated or terrorized by their critical voices and felt unable to question them or answer back. PTSD therapists may be surprised to hear that a number of patients have voices that will comment on their therapeutic capabilities (by no means always in favorable terms) and advise patients not to answer key questions. If therapy is to be successful, therefore, it is obviously necessary that such an important mental experience be identified as early as possible and included in the treatment plan.

In experimenting with how to treat voices in my clinical practice I have travelled along a relatively well-trodden path, even though it is one that will be unfamiliar to many CBT therapists. The vast majority of patients will never have revealed the presence of the voice to anyone and are likely to be greatly reassured by a therapist who treats the phenomenon in a matter-of-fact way rather than, as so often feared, a sign of madness. The primary aim is to alter the relationship with the voice so that patients are no longer intimidated by them. This can usually be achieved by a combination of psychoeducation/ normalization and having patients interact with them in a neutral way, for example by internally asking them questions and exploring their goals. For most patients this will be their first experience of taking an active role towards the voice and some may wonder if they are 'allowed' to do this. Although some voices will not respond, others will. The more active role helps to make the patient feel empowered and rebalance the relationship.

Interventions concerning the voice can follow traditional CBT lines of having the patient question its assertions, consider if they are supported by evidence, note counter-examples where the voice's predictions were wrong, and so on. A curious attitude is encouraged just as with any other unwanted mental experience, with Socratic questioning allowing the patient to avoid challenging the voice in favour of interacting with it in an effective but more neutral way. Usually it will be easy to identify predictable patterns in the voice's utterances, just as one does with negative thoughts. Many patients find it helpful to give the voice a name, sometimes a humorous one, as a way of achieving greater distance from it.

As noted by therapists aligned with the Hearing Voices movement, such as Dirk Corstens and colleagues, even highly negative voices may give an account of themselves that suggests they are trying to protect the patient from danger, making mistakes, etc., goals that are entirely plausible when seen in the context of the patient's trauma history. This functional value means that patients may be unwilling to engage in therapy that appears to belittle or discredit their voices. This is another difference from standard CBT, which seeks to abolish negative thoughts. A more effective approach is to acknowledge the function of the voice but question its prominence, moderating its influence and rebalancing the different parts of the personality. This kind of intervention may not totally abolish

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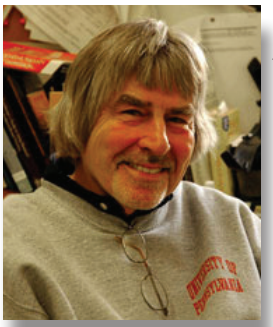
TEEN THOUGHT RECORD

THOMAS TREADWELL & DEBORA DARTNELL



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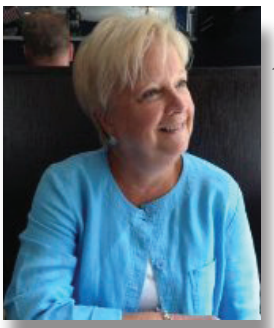

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Abstract:
There is a paucity of research on teenagers thought records thus this article reviews the history of thought recording for children along with automatic and dysfunctional thought records for adults. The objective is to simplify the steps to create a thought record in which the language would be more relatable for adolescents. Making CBT user friendly to adolescents involves the integration of existing cognitive behavioral techniques with innovative approaches. A discussion of teenager's hierarchy of needs is addressed along with reviewing negative self-thoughts and common thinking distortions for teenagers. Lastly, we focus on the administration of the teen thought record.

Keywords: **Automatic Thought Record, Dysfunctional Thought Record, Cognitive Distortion, Negative Automatic Thoughts**

Very Brief Thought Record History

Cognitive Behavioral Therapy (CBT) Automatic Thought Records (ATRs) were initially developed for use with adults (Beck, Rush, Shaw, & Emery, 1979). Aaron T. Beck and colleagues (1979) developed the first dysfunctional five column (CBT) thought record; Padesky (1983) changed the terminology of Beck's Thought Record (e.g., from "rational response' to balanced and alternative thinking") and expanded the thought record into her seven-column version of the thought record published in Mind over Mood, (C. Padesky, personal communication, December 8, 2017). De Oliveira (2015) developed the Trial-based thought record (TBTR) designed to restructure unhelpful core beliefs with adults. However, little has been done to design a thought record with terminology that reflects that of a teenager between the ages of 13 and 17.

In developing the Teen Thought Record, the goal is to simplify the steps to create a thought record in which the language would be more relatable for adolescents. Making CBT user friendly to adolescents involves the integration of existing cognitive behavioral techniques with innovative approaches. According to Friedberg et al. (2000) the challenge for this integration is maintaining theoretical integrity and adhering to the empirically endorsed basic principles within the approach. In order to preserve theoretical integrity and the basic principles of CBT, the Teen Thought Record language has been modified to reach the same objective as the previously validated thought records.

As teenagers experience grief, obstacles, or worry, thoughts can easily become negative. Frequently, negative self-thoughts (NSTs) can take over and dominate feelings about one's self worth and life in general. Thought records are one strategy to address negative thinking.

There is great value in learning what teenagers think and care about and the Teen Thought Record allows one to notice their moods, thoughts and feelings. For the most part, many adults think they understand what it is like being a teenager and assume they understand the issues teenagers are experiencing. It is not uncommon to hear an adult say; "After-all, I was a teenager."

These issues may include: social relationships, family dynamics, school problems, peer pressure, along with many others.

Teenagers' Hierarchy of Needs

- To be taken seriously.
- Success.
- Structure.
- Protection.
- Comfort.
- Identity.
- Fitting in, peer acceptance.

Negative Self-Thoughts (NSTs)

Teenagers may struggle to identify both short and long-term goals due to negative thinking. Negative Self-thoughts are how teenagers explain or justify behavior, or life's outcomes. As a result, teenagers usually interpret negative thoughts as the truth and believe they are doomed.

A few common thought patterns teenagers experience and

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RECENT DEVELOPMENTS IN RESEARCHING COGNITIVE THERAPY FOR PSYCHOSIS

ANTHONY MORRISON, CLINPSYD & NIKKI DEHMAHDI, BSC.

Anthony Morrison, ClinPsyD, is a Professor of Clinical Psychology at The University of Manchester and director of the Psychosis Research Unit at Greater Manchester Mental Health NHS Foundation Trust. He has published over 150 articles on cognitive approaches to understanding and treating Psychosis, as well as several treatment manuals which have been evaluated in clinical trials. He was a member of 2 National Institute for Health and Care Excellence in England guideline development groups (for adult schizophrenia and psychosis, and psychosis in children and young people).

Nikki Dehmahdi, BSc, is an assistant clinical psychologist working for the Psychosis Research Unit at Greater Manchester Mental Health NHS Foundation Trust. She is currently working across a number of trials which include research investigating the feasibility and acceptability of a new therapy known as Talking with Voices and research examining the feasibility of family CBT alongside individual CBT for individuals at risk of Psychosis.

Psychosis is a mental health problem whereby an individual's perceptions and interpretations may differ from those around them. Some of the common symptoms of psychosis include unusual beliefs (often called delusions) and unusual experiences such as auditory and visual hallucinations. These symptoms are often associated with significant distress and disability. There is considerable evidence that antipsychotic medication can be helpful for these problems and is usually the first line of treatment, but there are often serious side effects and people often stop taking their medication due to some combination of inefficacy or unwillingness to tolerate side effects. Our research unit (see www.psychosisresearch.com) prioritises several key research themes: early intervention and prevention, promoting recovery, reducing stigma and increasing treatment choices. We emphasise coproduction of research, involving people with psychosis in all stages of our research via a service user reference group (consisting of ten people with personal experience of psychosis), and employing several graduate and post-doctoral researchers who have experienced psychosis.

We have attempted to increase treatment options for people with psychosis by investigating cognitive behavioural therapy for people with psychosis (CBTp) as an alternative choice to antipsychotics. We have conducted several randomised controlled trials that attempt to explore this issue. The ACTION trial (Morrison et al., 2014) aimed to investigate the feasibility and effectiveness of cognitive therapy as an intervention for individuals diagnosed with schizophrenia spectrum disorders who had chosen not to take antipsychotic medication. From the 74 participants recruited from two locations in the UK, half continued with their treatment as usual, whilst the other half received up to 26 sessions of cognitive therapy in addition to their usual treatment for a maximum of up nine months with the option of an additional four booster sessions offered in the subsequent nine months. The intervention adhered to our manualised treatment protocol for the delivery of cognitive therapy for individuals experiencing psychosis (Morrison, 2017). Results from this study revealed cognitive therapy to be effective in significantly reducing psychiatric symptoms as captured by the positive and negative syndrome scale (PANSS) and significantly improving personal and social functioning. However, whilst the findings indicated that cognitive therapy was an acceptable intervention for this population, a larger definitive trial is required in order to confirm clinical effectiveness.

Another gap in the literature was any head-to-head comparison between CBTp and antipsychotic medication. The COMPARE study (Morrison et al., 2018) recruited 75 participants who were experiencing psychosis to a randomised control trial, comparing CBTp alone with antipsychotic medication alone and with a combination of both. Although this was another pilot trial, there were suggestions that combined intervention was more effective than the monotherapies. There was no suggestion that CBT monotherapy was detrimental in comparison to antipsychotic monotherapy. However, CBT monotherapy appeared to have less side effects than the conditions involving antipsychotics. Psychiatric symptoms were significantly reduced over time across all conditions.

The National Institute for Health and Care Excellence (NICE) in England, UK have provided guidelines for recognising and managing Psychosis and Schizophrenia in children and young people which highlights the element of choice in selecting antipsychotic medication and/or psychological interventions (National Institute for Health and Care Excellence, 2013). However, they identify a need for research comparing the different interventions amongst adolescents experiencing first episode psychosis. The MAPS trial (ISRCTN), led by our research unit, is currently underway at multiple sites across England. It is examining the effectiveness of CBTp plus family intervention, antipsychotic medication or a combination of both within this population. The data derived from this trial should generate evidence specific to children and young people regarding the safety and acceptability of CBT in the absence of antipsychotic medication, which can be utilised in guiding informed decisions regarding treatment for this

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TENDENCIES TO RESPOND TO EMOTION STATES IN AN IMPULSIVE MANNER: WHAT TOOLS MIGHT WORK?

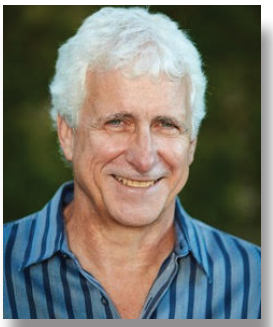
SHERI L. JOHNSON, MACKENZIE R. ZISSER, DEVON B. SANDEL, EPHREM FERNANDEZ, & CHARLES S. CARVER

Sheri L. Johnson, Ph.D. is a clinical psychologist and the Director of Clinical Training at the University of California Berkeley. She is a fellow of ABCT and APS. She has published more than 200 manuscripts and 8 books. Her work has been funded by the National Institute of Mental Health, the National Science Foundation, the National Cancer Institute, and the National Alliance for Research on Schizophrenia and Depression. With the other authors of this article, she recently completed a wait-list control trial testing an online intervention for impulsivity.

Mackenzie Zisser is a project coordinator at the CALM Program and a research associate at the Berkeley Psychophysiology Lab at the University of California, Berkeley.

Devon B. Sandel is a doctoral student in the Clinical Science Program at University of California Berkeley, advised by Dr. Sheri L. Johnson. Her research focuses on understanding emotion-related impulsivity in the context of self-harm and suicide.

Ephrem Fernandez, Ph.D. is professor of clinical psychology at the University of Texas at San Antonio and Director of the Emotion Sensation Lab at UTSA. He is the author of more than 80 scholarly publications, including Treatments for Anger in Specific Populations: Theory, Application, and Outcome (Oxford University Press, 2013). His clinical workshops on assessment and treatment of anger have been frequently presented at the American Psychological Association, and at other venues including Canada, Australia, New Zealand, Latin America, and Asia. His research has been funded by the National Institutes of Health and private foundations.



Charles S. Carver, Ph.D. is Distinguished Professor of Psychology at the University of Miami. His work spans topics in personality, social psychology, health psychology, and experimental psychopathology. He is author/co-author of 9 books and over 400 articles and chapters.

A growing body of work indicates that tendencies to respond impulsively to states of high emotion are distinct from other forms of impulsivity (see Carver & Johnson, 2018). Findings of more than 100 studies indicate that emotion-related impulsivity is closely related to many different syndromes, including externalizing disorders, aggression, depression, anxiety, self-harm, and suicidality, with effect sizes larger than those observed for other forms of impulsivity (Berg, Latzman, Bliwise, & Lilienfeld, 2015). Emotion-related impulsivity also predicts the onset of alcohol and substance use problems, depression, self-harm, and suicide attempts (reviewed in Carver & Johnson, 2018).

Given the range of adverse outcomes tied to this trait, clinical intervention seems desirable. We have been struck by the distress that people with this form of impulsivity express about their actions during states of high emotion, and their motivation to address these patterns. We recently designed an intervention to help address emotion-related impulsivity.

To plan our intervention, we began by considering findings regarding the neurocognitive correlates of emotion-related impulsivity. We and others have argued that emotion-related impulsively is shaped by relative weakness of top-down control from the reflective system versus the strength of momentary emotion and motivation states (Carver & Johnson, 2018). Across studies, emotion-related impulsivity has been tied to deficits in the ability to exert cognitive control to over-ride a prepotent response, as measured using tasks such as the go/no go, Stroop and stop-signal tasks (Johnson, Tharp, Peckham, Sanchez, & Carver, 2016). Accordingly, coping techniques that depend on cognitive control (e.g., reappraisal), may be difficult for people with high emotion-related impulsivity to implement. This presents a challenge for some cognitive therapy techniques.

Other strategies, though, appear helpful. One approach that may be helpful is teaching behavioral techniques to recognize emotion

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states and their triggers. Another may be strategies for directly reducing arousal, such as relaxation techniques. A third strategy is to use implementation intentions (Gollwitzer & Sheeran, 2006). Implementation intentions consist of a plan to use a given behavior or strategy (e.g., relaxation skills) in a specific context (e.g., when angry), usually in the form of an "if-then" statement.

Implementation intentions have been shown to be effective in improving emotion regulation, and in lowering impulsive behavior, including impulsive behaviors that occur during intense emotion states. Once constructed, implementation intentions are executed automatically, thereby lowering demands on cognitive control (Gollwitzer & Sheeran, 2006). Accordingly, implementation intention interventions may be particularly well suited for persons who struggle with deficits in cognitive control by automating effective responses at high risk moments.

We recently developed a brief online intervention. The intervention contains modules to help recognize signs of high emotional arousal and to teach strategies for reducing arousal. Participants engage in two weeks of daily monitoring to practice recognizing their arousal, to use self-calming strategies, and to rate the effectiveness of different approaches. Personalized feedback from the daily monitoring data is provided, and participants are then taught to form implementation intentions based on the feedback.

To test our intervention, we worked with individuals who endorsed high emotion-related impulsivity (as assessed using a self-report measure described here http://local.psy.miami.edu/faculty/ccarver/CCimpulsivity.html) and who also reported at least 6 instances of aggression in the past 12 weeks. In the first 91 participants, emotion-related impulsivity and aggression declined significantly from baseline to post-treatment, effects that were not observed in the waitlist control group.

In sum, emotion-related impulsivity has serious clinical consequences and can be difficult to quell. A growing body of work indicates that people who struggle with this form of impulsivity show deficits in cognitive control that could interfere with some cognitive therapy interventions. Behavioral interventions that help individuals learn to recognize arousal, to learn self-calming techniques, and to preplan and rehearse coping strategies for use during high arousal moments show promise.

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STANDING ON THE SHOULDERS OF GIANTS

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I am compelled to name two other giants. One is a collective, who are the large number of students, trainees and junior colleagues I have worked with over the years. I have often said that the best part of my job as a professor is to work with brilliant graduate students, and I will say that again here, but add to the long list of 37 doctoral students I have supervised to completion, so far, the people I have also worked with in other supervisory roles. I am hesitant to name names for fear of offending those whose names do not appear here, but in particular I think about my work with Nikolaos Kazantzis, David Dozois, Yang Fahui, and Andrew Szeto.

Finally, I must acknowledge my fortune to be partnered with a wife who is diminutive in stature but enormous in intellect, compassion and wisdom. I have said before that my best ideas have come from her and although that statement is a sophistry, I have certainly relied on her uncountable times over my career to bounce ideas around, test out the validity of my thinking, or simply encourage her to call me out when I was misguided. She and I have published together (Dobson & Dobson, 2017, for example) and so this has been an unusual and yet completely rewarding relationship.

In summary, and as is true for most successful people, I have stood on the shoulders of many giants. I would like to believe that I have also given back to many of these people and to the field at large, but that conclusion is not for me to reach. One of the truisms that I have repeated over the years is that it is not only the opportunities that we get that define life's outcomes, but it is also what we do with the opportunities we are given. Given my start in life, I believe that I have made much of my circumstances, but will take this

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opportunity to thank those around me for these opportunities.

RECOGNIZING AND TREATING VOICE-HEARING IN PTSD
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symptoms, but it is likely to be highly effective at reducing patients' distress and confusion, helping them to understand their mental life, and equipping them with greater resilience for the future. I recommend that all patients with PTSD be assessed at the outset for the presence of voices and attempts be made to understand their impact and, where necessary, to engage with them.

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MY CBT TRAINING AND EVOLUTION
CONTINUED FROM PG. 9

interpret negatively:

- NSTs are exaggerated: 'People never like me'.
- NSTs make us feel bad, hopeless: 'I can't do anything right'.
- NSTs can be comforting because they excuse our mistakes: 'I am so stupid, THAT'S why this (bad thing) happened'

A few Common thinking distortions for teenagers

- All or Nothing Thinking or Black and White Thinking
- Catastrophizing/Blowing out of proportion
- Mind Reading

These negative thought patterns cause to lose sight of the positives in our world and hinder reasonable thought processing. Thought records help remedy inaccurate thinking patterns.

Completing the Teen Thought Record

When completing Teen Thought Record with your teen-age clients, instruct them to turn their attention inward and notice immediate thoughts and feelings. Very often teen clients feel overwhelmed with themselves and have no idea what they are really thinking or feeling. This process helps them slow down and identify what's going on. Completing a Teen Thought Record in a more reflective state of mind will help clients to put their thoughts on trial and gain a more balanced perspective of the situation.

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The authors thank the following graduate and undergraduate students for their assistance in developing the teen thought record: Erin Matthews, Alexis Tarsnane, Joyce Romero, Gabrielle Kennedy, Noah Lessner, and Brittni Gettys.

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population (Morrison, 2019).

Despite the recommendations regarding offering choices of treatments to people with psychosis and schizophrenia, there are significant discrepancies in the proportion of people who have received antipsychotic medication as opposed to CBT. Carter et al. (2017) found that antipsychotic medication was prescribed by clinicians to 85% of clients, whereas CBT was only offered to 40%. Whilst the lowered percentage in CBT being offered may have been attributable to unsuitability, one of the main reasons for this was due limitations in resources to deliver the therapy. In addition to the research trials, our research unit is also involved in efforts to increase access to CBTp, including delivery of training courses and clinical supervision. However, there is much more work to be done, both in terms of large scale, definitive research trials and further development of effective approaches to dissemination and

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implementation of CBTp.

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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, 2019. Submissions should be 350-900 words with no more than five references (using APA style and as an MS Word document). In addition, please include a brief (50-100 word) author bio and high quality photo/headshot with your submission.

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