ADVANCES IN Cognitive Therapy newsletter

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

EDITOR
Scott Waltman, Psy.D., ACT

A-CBT'S PRESIDENT'S COLUMN

ELAINE S. ELLIOTT-MOSKWA, PH.D.

IACP Vol 21, Issue 1 / A-CBT Vol 22, Issue 1

Happy 2021! As incoming President of the Academy of Cognitive and Behavioral Therapies my heart goes out to all in our community who have been touched by the challenges and losses of the pandemic and racial injustice.

Events of the past year have given me the opportunity to ask, "What do I value and how do I step toward what I value?" I value the Academy's mission as "a global community of mental health professionals dedicated to upholding excellence in the dissemination, implementation, and practice of cognitive behavior therapies."

Members of our international community have sustained our mission by confronting 2020 challenges. Facing the pandemic, the Academy stepped forward to provide COVID resources to mental health professionals and consumers. A wealth of materials that encompass our commitment to disseminating cognitive and behavioral therapies were assembled on our website. Thank you to Robert Leahy for his series on coping with the pandemic and to Shireen Rizvi, David M. Clark, Leslie Sokol and the many others who posted information and offered support.

With the pandemic shutdown, the Academy pivoted quickly from in-person to online CBT training of LA County Department of Mental Health Clinicians. The training program, born from Lynn McFarr's vision, continues to arm these clinicians with state-of-the-art practices to deliver services to underserved populations in LA.

The Academy also grappled with the issues of racial injustice and diversity. Special thanks to board member, Scott Temple for leading the Task Force and Leide Porcu, Jodi Hickey, Scott Waltman, and Hollie Granato who helped craft the final statement endorsed by the board on June 4th, 2020. My appreciation goes to board member Lizbeth Gaona for heading our new diversity committee. Thanks also to all our members who expressed their opinions, perspectives and proposals.

As President of the Academy, I am fully conscious of the responsibilities and possibilities.
I am indebted to Lynn McFarr's leadership and am excited to work closely with her to promote the Academy's affiliation with IACP. I would like to acknowledge Lata McGinn for her tireless contributions as she leaves the board. I welcome Stefan G. Hoffman, who has made stellar contributions to CBT research, to the board as President-Elect.

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IACP'S PRESIDENTS COLUMN

LYNN MCFARR, PHD

Happy New Year to our wonderful Academy and IACP communities. This is my final column as President of the Academy, but I am happy to say I will continue to write one as President of IACP until June 2023. As I close out my presidency, I want to reflect on the past two years, offer some well-deserved props, and a welcome our new leaders.

My Academy presidency has been marked by both Covid-19 and Civil unrest here in the US. For Covid, I am in awe of the community that has rallied to provide resources, pivoted swiftly to telehealth to continue to provide services, and have largely borne witness with our patients, to the horror of losing almost 2 million fellow humans. I am hopeful that the vaccines will provide much needed protection from this devastating illness. I am also, once again, reminded of the debt we owe to science. The mental health aftermath will no doubt be vast. This community will be there to meet it. Again, science will help us identify and evaluate the best practices to treat a grieving planet. Wherever you are, I hope you are safe and healthy.

With respect to the civil unrest in the United States and Black Lives Matter, I cannot thank our Board enough for all of the work that went into our statement and the actions we have taken since. In particular, I want to thank Dr. Scott Temple for leading our discussion and providing the basis of our statement. Although we still have a long road towards anti-racism in the US, in particular, I am hopeful that that one silver lining in this whole discussion is that the discussion of culture is more prominent in our understanding and evaluation of evidence- based practices. To that end, I am particularly impressed with the newly formed Diversity Action Committee, led by Dr. Lizbeth Gaona, who have recently developed and refined the diversity item for the Cognitive Therapy Rating Scale and corollary items for our case conceptualization rating scale. These items are currently in beta testing for the LA County Roll Out of CBT (LACRO-CBT). They have also worked on a Fact Sheet for Race Based Trauma that is included in this issue. We look forward to providing you updates on this committee as they occur.

With respect to LACRO-CBT, I am proud to say we have cohorts scheduled through 2021. We hope to hit the 3000-clinicians-trained mark by the end of the current contract. Like many you, we will be evaluating the impact of Covid on our practices. In particular, we will be evaluating the impact of Covid and moving to an exclusively tele based training model.

Now onto the comings and goings of the Academy and IACP boards. We have been busy! First and foremost, I want to communicate my deep, abiding gratitude to Dr. Lata McGinn who rolled off the board as of Jan 1,2021. We simply would not be where we are as an organization without her. Dr. McGinn joined us as president and led us through one of the largest periods of growth and change. We came out stronger, larger, and more inclusive as a result. It is my deep belief that this set the stage for our ability to weather any strife that has come our way. Dr. McGinn has the rare ability to attend to the micro (including what the menu should be for meetings when we were still able to meet in person) while not only keep an eye on the marco, but also having a strong vision for it. Under her leadership, we officially joined forces with IACP, and the IACP officially became part of the newly formed World Confederation of Cognitive Behavioral Therapy, the United Nations of CBT organizations. The WCCBT was the brainchild of Dr. McGinn who steadfastly worked for its creation (for over seven years!), bringing all of the key players into agreement and helped to form the first board. It was such a feat of excellence that it warranted the ABCT Service award for 2020. On a personal note, it has been my true delight to serve with Lata, a fellow Beatles fanatic, and trusted friend. Thank you so much for your service, Dr. McGinn.

I am also delighted (and relieved) to hand the reigns over to Dr. Elaine Elliot-Moskwa. Dr. Moskwa joined our board in 2014 and swiftly became known as a quiet voice of reason and calm. Having served with Dr. Moskwa on several committees and projects, I can assuredly say that the Academy in great hands. She has this singular ability to listen to all of the feedback, synthesize it in an understandable way, and suggest a common path than honors all of the input. Although I have never had the privilege of listening to one of her therapy sessions, I am certain she is fantastic at Socratic Questioning! Her background in both institutions (Harvard) and private practice, make her ideal at representing a wide array of our members interests. She has served as the chair of the Membership Committee and has listened to the feedback of members and will no doubt bring that to any initiative.

With Dr. Moskwa as President of the Academy, that leaves me to introduce our President-Elect. Dr. Stefan Hofmann will be re-joining the Board as President-Elect. Although Dr. Hofmann really needs no introduction, having published over 400 articles and 20 books, and being one the world's foremost experts in CBT. Most recently he was awarded the Alexander von Humboldt Professorship, one of the highest honors in Psychology in Germany. https://en.wikipedia.org/wiki/Alexander_von_Humboldt_Professorship. We are delighted he will bring his expertise, commitment, and crackling humor back to our board.

With respect to the IACP, we have been busy there as well. I did not have to wait long to work with Dr, Lata McGinn since she

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REFLECTIONS ON TREATMENT FOR SOCIAL ANXIETY: AN INTERVIEW WITH RICHARD HEIMBERG

DEBRA A. HOPE
UNIVERSITY OF NEBRASKA-LINCOLN

Debra A. Hope is Aaron Douglas Professor in the Department of Psychology at University of Nebraska–Lincoln. Her research includes assessment and treatment of anxiety, especially social anxiety. More recently, her work has shifted to mental health disparities, especially for sexual and gender minorities through the community–based participatory research group, Trans Collaborations (go.unl.edu/transcollaborations). Prof. Hope teaches CBT and supervises practicum students. She also maintains a small private practice

Richard G. Heimberg has announced that he will retire in 2021 from his long career devoted to understanding and treating social anxiety disorder. I took this opportunity to interview my mentor and friend to celebrate his many accomplishments and document his wisdom for practitioners who are working with socially anxious clients. In full disclosure, this article refers to the client workbook and therapist guide for Managing Social Anxiety: A Cognitive-Behavioral Approach from which we both receive royalties.

Richard G. Heimberg is the Thaddeus L. Bolton Professor of Psychology at Temple University. He is past president of the Association for Behavioral and Cognitive Therapies (ABCT) and the Society for a Science of Clinical Psychology and recipient of Lifetime Achievement Awards from ABCT, the Academy of Cognitive-Behavioral Therapy, and the Philadelphia Behavior Therapy Association. He has published over 485 articles and chapters and a dozen books on understanding and treating anxiety, mostly about social anxiety.

What is the most important thing you have learned about the nature of social anxiety over the years that you think the average frontline clinician should know?

Social anxiety presents in many forms. We used to think that social anxiety was equivalent to shyness, timidity, or behavioral inhibition. That is certainly true in many cases, but not all. It is possible that someone who presents with an angry demeanor, for instance, may have adopted that stance to drive people away or keep them at enough of a distance that the other people cannot see "what they are really like." Similarly, someone who is involved in risky, or even criminal, behavior, may do so for fear of negative evaluation from others. All that takes is a social group that will accept you if you drink, use drugs, or engage in risky sexual behavior, and their negative evaluation then becomes something to be feared and it drives the problematic behavior. In summary, social anxiety can rear its head in almost any case, whether the client looks like our stereotype of the socially anxious client or not.

What are a couple of "pro tips" you always share with your graduate students when they are first learning the MSA intervention?

Keep in mind that your clients are socially anxious in interaction with you! This has a number of implications. First, they may be hesitant to answer questions (or talk at all) because they are afraid that you will negatively evaluate them. Alternatively, they may talk a lot because they are afraid of being judged for silences or to keep the conversation from getting to the thing that makes them fear your evaluation. Second, beware your desire to fill silences (because they are uncomfortable for you too!), as you teach your client that if they wait long enough, you will rescue them. In other words, you will be training them to engage in social avoidance in the therapy room, and that is not something you want to do. Third, since a number of your clients fear positive evaluation as much as they fear negative evaluation, you should endeavor to be positive and supportive, but if you are too effusive in your praise of your client's efforts, you may be making things difficult for them in a way you were not anticipating.

If someone has been doing CBT for social anxiety for a long time, what are one or two ways that they could step up to the next level based on your experience and knowledge of the research literature?

Many folks who have been doing CBT for social anxiety for a long time need to change up their game a bit. It is common to fall into a routine of doing the same types of in-session exposures over and over again for clients with similar presentations (if they keep up with doing exposures at all!). In most cases, these are small-talk conversations with people who occupy different roles in the client's life. These are important, but they can be done in so many different ways to increase the impact of the intervention. Depending on a functional analyses of the client's concerns, the therapist can focus the exposure on the specific aspect of a conversation that evokes anxiety. For example, if the client is afraid they will not know what to say, the exposure should involve saying whatever comes to mind without censuring topics beforehand. If the client is afraid of pauses, then the exposure should be filled with them. If the fear is about joining in an ongoing conversation, then that should be the focus, and several short exposures focusing only on the beginning of the conversation would be preferable.

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Only 6 months to go to the 10th International Congress of Cognitive Psychotherapy Virtual Congress - May 13th-15th, 2021

- ✓ 22 invited speakers
- ✓ 8 pre-congress workshops
- ✓ 8 free in-congress workshops
- ✓ 16 keynotes
- ✓ >60 parallel symposia

Dear colleagues,

since the beginning of the COVID-19 pandemic, we were hoping that the situation would improve quickly, thus giving us the exciting opportunity to welcome the 10th International Congress of Cognitive Psychotherapy (ICCP) in Rome (Italy) which led us to postpone it to May 2021.

However, taking into account that everybody's safety should be our top priority, we have decided, together with the IACP, to "move" the congress online. The ICCP 2021 will be the first virtual international congress of cognitive psychotherapy!

We are determined to use every advantage that technology can offer to us to work and get together in safety even if we are not able to meet in person.

On the congress' website (www.iccp2021.com) you can find the updated programme and you will be able to register within January in order to benefit from the early bird rate.

You can now submit symposia, open papers and posters. The final submission date is the 30th of December 2020 for symposia (January 30th, 2021 for open papers and February 28th, 2021 for posters) but with Christmas around this date don't leave it to the last minute. In order to be sure of getting the 'Early Bird' reduced registration rate submit as soon as you can. Guidelines on submitting can be found on the Congress website.

Important dates:

December 30, 2020 - Closing date Symposia Submissions

January 30, 2021 - Closing date Open Papers Submissions

February 28, 2021 - Closing date Poster Submissions

January 31, 2021 - End of Early Bird Registration

Join us to gain a new perspective on the science of CBT and its clinical practice!

Antonella Montano and Gabriele Melli

Congress Presidents
www.iccp2021.com -- Facebook: ICCP 2021

INTERNALIZED RACISM IN AFRICAN AMERICAN CLIENTS PART II: A CBT CASE EXAMPLE

JANEÉ M. STEELE, PHD, LPC

Janeé M. Steele is a licensed professional counselor and certified CBT therapist. Dr. Steele has been a professional counselor for 15 years, specializing in the treatment of depression and anxiety. In addition to her work as a counselor, Dr. Steele has also been a counselor educator for the past 10 years, and is currently a member of the core faculty at Walden University. Her most recent publication titled, "A CBT Approach to Internalized Racism Among African Americans," published in the International Journal for the Advancement of Counselling, describes cognitive conceptualization and treatment planning using CBT and a proposed cognitive model of internalized racism.

In the last *Advances in Cognitive Therapy* newsletter, I discussed the role of internalized racism in mental health challenges experienced by African Americans, and suggested that culturally adapted CBT provides a useful framework for conceptualizing and treating internalized racism and its psychological correlates in this population. Culturally adapted CBT is an approach to CBT that intentionally considers cultural influences on the creation and maintenance of an individual's cognitions and cognitive processes (Hays, 2006). One significant aspect of culturally adapted CBT is application of specific cultural knowledge in the cognitive formulation of a client's presenting concerns. In terms of cultural knowledge, several psychological phenomena prove relevant to African American mental health—some unique to this community, others applicable to the broader population of marginalized groups in our society as a whole. In this article, I explore various psychological phenomena and societal influences that affect the development of internalized racism and its associated psychological distress among African Americans, and describe how these topics might be broached during therapy. To illustrate the concepts discussed, I present a brief case example and session excerpt.

Case Study

Andre is a 40-year-old cisgender, African American man who is seeking counseling due to feelings of anxiety and depression after being fired from his place of employment. Andre, who was employed as a plant supervisor, explained that he was fired from his job 1 month ago due to low ratings on back-to-back performance evaluations. Since that time, Andre has experienced an overwhelming sense of sadness and worry, and has made little effort to find new employment. In the excerpt below, the therapist speaks with Andre, exploring central themes in his automatic thoughts, and how these themes may reflect underlying core beliefs.

Therapist: So, I understand that you've been sad and worried since you were fired from your job.

Andre: Yes. I haven't been able to do anything. I know I need to look for another job, but I just don't feel like it.

Therapist: It sounds like you're pretty overwhelmed by this situation. What thoughts go through your mind when you think about looking for a new job?

Andre: I guess I just don't see a point. I thought I would do well as a plant supervisor, but as soon as I got the position I started second guessing myself. Whenever my operations manager observed me on the floor, I had a hard time remembering things and had to ask for help. I don't know if I can handle being a supervisor, but my family can't survive on a lower paying job. It seems like things never work out for me.

Therapist: Andre, I hear that you're feeling defeated in your search for a new job.

Andre: Yes.

Therapist: It also sounds like you felt so nervous when being observed by your operations manager that you even had problems with your memory. Tell me, how did your feelings in this situation reflect your experience as an African American supervisor at the plant?

Andre: It's like I was held to a higher standard of performance. Other supervisors did the bare minimum and were never criticized, but I had to go above and beyond to prove my worth. And it still wasn't good enough. Maybe I should just stick to working on assembly lines.

Therapist: And if that were true, if your efforts aren't good enough and you should stick to assembly lines, what would that mean about you?

Andre: I guess it means I'm not good enough...

Discussion

In the excerpt above, several facets of culturally adapted CBT were illustrated with implications for addressing internalized racism in Andre's presenting concerns. Of vital importance is the therapist's attention to the therapeutic relationship. Positive therapeutic relationships are central to the effectiveness of CBT (Beck, 2011). A growing body of literature suggests a therapist's ability to broach topics surrounding race is a significant factor in therapeutic relationships with clients of color, as therapists who broach race are perceived as more credible and competent (Day-Vines et al., 2007). Broaching behavior is defined as, "a consistent and ongoing attitude of openness with a genuine commitment by the counselor

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TRAINERS' CORNER: HABIT REVERSAL

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R. Trent Codd, III, Ed.S. is Vice President of Clinical Operations – North Carolina for Refresh Mental Health. In addition to delivering clinical services he's active in training and supervision, including delivering training in the largest United States–based training initiative. He's a Diplomate, Fellow and Certified Trainer and Consultant of the Academy of Cognitive & Behavioral Therapies, and a former Academy of Cognitive Therapy Board Member at Large.

Habit Reversal, originally developed to treat nervous habits and tics (Azrin & Nunn, 1974), has been productively applied to a wide range of problematic repetitive behaviors. For example, habit reversal is efficacious in the treatment of tics, chronic hair pulling, temporomandibular disorder, nail biting, chronic skin picking, thumb sucking and stuttering, with large, reported effect sizes (d=0.80) relative to control conditions (Bate et al., 2011).

Procedure

Habit Reversal is a composite intervention comprised of five components: 1) Inconvenience Review, 2) Awareness Training, 3) Competing Response Training, 4) Social Support and 5) Generalization procedures.

Inconvenience Review

The purpose of this component is to enhance motivation to address maladaptive repetitive behavior. This process involves collaborating with a client to produce a thorough itemization of the various emotional, interpersonal, physical, and fiscal consequences they've experienced because of the behavior, and ideally preserving them in written form for easy reference. For example, a client struggling with chronic skin picking might note the financial costs incurred because multiple visits to dermatology were necessary, embarrassment stemming from frequent questions from others about observable tissue damage and the physical discomfort experienced from skin infections.

Awareness Training

Enhancing awareness of a repetitive behavior and its antecedents is necessary for occasioning the use of a competing response and is accomplished in several ways. First, a client is encouraged to provide a through description of the target behavior, from beginning to end. This may be facilitated by asking the client to emit the response multiple times in session, each time paying close attention to different parts of the sequence so that they may precisely describe the behavioral topography and any associated feelings. This can be further augmented by asking the client to "teach" the clinician how to do the repetitive behavior. This may entail periodically asking the client to go back and describe a part of the chain the clinician observed but was not included in the client's teaching description. This also allows the clinician, when mimicking the repetitive behavior, to notice component topographies and associated feelings in themselves, and to then ask the client whether they notice these things as well. The product is a thorough definition of the target repetitive behavior.

Second, the clinician works with the client to detect when the response occurs. Some habit behavior readily occurs in session. In these circumstances the clinician requests that the client provide some indication that the behavior is occurring as soon they observe it. When they can do so the clinician praises the client for noticing and then asks what they discriminated that suggested the response was taking place. They are also encouraged to search for a cue(s) earlier in the sequence than the one they just noticed to facilitate increasingly earlier detection. When a client fails to capture an occurrence of the repetitive behavior in session the clinician points this out and prompts them to identify what may be a discriminable cue on the next occasion.

Finally, a client is encouraged to identify when a repetitive behavior of concern is about to occur through the identification of immediate precursors such as urges, discomfort, tension, or various sensations.

Competing Response Training

The goal of competing response training is to instruct clients in the use of adaptive replacement behaviors once the repetitive behavior or, optimally, its antecedents are detected. Optimal replacement behaviors satisfy the following criteria: a) Physical incompatibility with the habit behavior, b) Maintainable for at least one minute without producing fatigue and c) Unnoticeable to others. For example, placing one's hands in one's pockets might be an effective competing response for nail biting because one cannot bite one's nails when they are in one's pockets, it will not produce fatigue when maintained for a long period of time and though observable by others it is socially discreet (i.e., it is common behavior with no apparent connection to nail biting). Clients are taught to use their competing response every single time their maladaptive repetitive behavior is occasioned and to maintain their response for at least one minute or until the private antecedents (e.g., the urge to engage in the behavior) run their course, whichever is longer.

Social Support

The social support component facilitates the optimization of out of session competing response practice. Social support persons, which may be parents, romantic partners, or friends, provide an important source of reinforcement when they deliver praise contingent on

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BIOGENETIC ETIOLOGIES OF MENTAL DISORDERS: AVOIDING SHORTCOMINGS AND DANGERS WITHIN PSYCHOEDUCATION.

WILLIAM SCHULTZ, MA, MHP

William Schultz is an OCD-survivor, researcher, and clinician in private practice at Maplewood Psychology, Maplewood, MN. William's research centers on the shortcomings and dangers of biogenetic etiologies of mental disorders. His work has been published in numerous peer-reviewed journals, including: Ethical Human Psychology and Psychiatry, Journal of Feminist Family Therapy, Journal of Obsessive and Related Disorders, Reason Papers, The Behavior Therapist, The Journal of Humanistic Psychology, and Theory & Psychology. His book, Mental Health: Biology, Agency, Meaning, was published in 2019.

Best practice during the assessment, diagnosis, and treatment of mental disorders includes the provision of psychoeducation. Psychoeducation is an effective route for knowledge transmission from clinician to client and improves mental health literacy, decreases stigma, increases help seeking attitudes, and can contribute to positive clinical outcomes.

Central to ethical and competent psychoeducation is disseminating accurate and comprehensive data regarding etiologies of mental disorders. The biopsychosocial (BPS) model is the dominant etiological framework for mental health researchers and clinicians and is meant to integrate biological, psychological, and social components into a comprehensive causal story of the genesis of mental disorders. The BPS model posits mental disorders emerge within an individual who possesses sub-personal components, such as molecules, cells, neurons etc., and supra-personal components, such as family, community, culture, etc.

Regrettably, data suggest there are often significant shortcomings associated with the biological component of BPS psychoeducation. It's widely believed by the public, and numerous mental health professionals, that mental disorders are caused by chemical imbalances in the brain or determined by an individual's genes (Lebowitz & Applebaum, 2019). Along similar lines, the National Institute of Mental Health's Research Domain Criteria research framework conceptualizes mental disorders as disordered brain circuits and hopes future research will identify clinically actionable biomarkers which will supplement and potentially supplant behavior and self-report in mental disorder diagnosis. Despite the prevalence of these biogenetic etiologies, there are currently no clinically actionable biomarkers or diagnostic tests that demonstrate neural circuit or neurotransmitter malfunction cause mental disorders. And, although an individual's genotype is involved in the development mental disorders, expert consensus is that genotype alone does not determine the development of mental disorders.

Unfortunately, these shortcomings are not benign. Although data indicate that biogenetic etiologies can decrease self-blame, data also show that these etiologies can contribute to at least two negative clinical impacts: biased treatment preferences and increased prognostic pessimism (Schultz, 2018). Increased belief in biogenetic etiologies cause individuals to expect psychotherapy to be less effective than biological interventions, such as SSRIs. This runs counter to years of data which suggest that CBT is generally at least as effective as SSRIs in the short-run and often has important advantageous over SSRIs in the long-run (Kirsch, 2019). Recent research has even called into question the rationale behind routinely suggesting combined treatment (psychotherapy + SSRI) due to numerous concerns associated with possible iatrogenic effects of medication (Hollon, 2020). Clients have the right to an accurate, comprehensive, and unbiased appraisal of their options when making treatment decisions and misleading components of biogenetic etiologies can interfere in this process.

Biogenetic etiologies also increase prognostic pessimism (Schultz, 2018). The more an individual endorses biogenetic etiologies of mental disorders, the more they believe their symptoms will be of greater magnitude and duration. The most prominent hypothesis explaining increased prognostic pessimism is that greater endorsement of biogenetic etiologies is connected to an increased belief in essentialism – the belief that an individual's identity, including development of mental disorders, is immutable. Increased prognostic pessimism is cause for concern due to established research showing that client expectation for improvement is a significant contributor to actual improvement. Clients who expect to do better, do better (Wampold & Imel, 2015).

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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, 2021. Submissions should be 350-900 words with no more than five references (using APA style and as an MS Word document). In addition, please include a brief (50-100 word) author bio and high quality photo/headshot with your submission.

Submissions and/or suggestions for how to improve the newsletter and/or topics that should be considered should be sent to: Scott Waltman, PsyD, Editor: walt2155@pacificu.edu.

UPDATES FROM THE INTERNATIONAL JOURNAL OF COGNITIVE THERAPY—THE OFFICIAL JOURNAL OF THE INTERNATIONAL ASSOCIATION OF COGNITIVE PSYCHOTHERAPY

VOLUME 13, ISSUE 4, DEC 2020

Kishon, R., Geronazzo-Alman, L., Westphal, M. *et al.* Psychological Mindedness and Alexithymia Predict Symptom Reduction in Cognitive Behavior Therapy for Major Depressive Disorder. *J Cogn Ther* **13,** 287–302 (2020). https://doi.org/10.1007/s41811-019-00062-6

Abstract

Cognitive behavior models present major depressive disorder (MDD) as a failure in emotional processing associated with disrupted metacognitive skills. Self-observation, a metacognitive ability, plays a vital role in emotion regulation. Studies have noted the role of mindfulness in cognitive behavioral therapy (CBT); however, few address psychological mindedness, the interest and ability to understand behaviors, thoughts, and feelings, or alexithymia, the inability to identify and describe emotions. Seventy-one depressed outpatients with mean age M = 42.5; (SD = 13.7) received 14 CBT sessions. Longitudinal regression showed that baseline psychological mindedness significantly predicted symptom reduction across the course of treatment (β = −8.43, 95% CI −14.33, −2.52, $p = 0.01$). Baseline alexithymia was unrelated to remission, yet positively correlated with symptom reduction through treatment. Treatment response may correlate more strongly with analytical than affective metacognitive ability, though affective skills increased during treatment. Further research can improve our understanding of processing affective information in depression and disruptions in emotion regulation and inform the selection of CBT strategies.

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Schwarz, S., Grasmann, D., Schreiber, F. *et al.* Mental Imagery and its Relevance for Psychopathology and Psychological Treatment in Children and Adolescents: a Systematic Review. *J Cogn Ther* **13,** 303–327 (2020). https://doi.org/10.1007/s41811-020-00092-5

Abstract

This review provides an overview of the current state of research concerning the role of mental imagery (MI) in mental disorders and evaluates treatment methods for changing MI in childhood. A systematic literature search using PubMed/Medline, Web of Science, and PsycINFO from 1872 to September 2020 was conducted. Fourteen studies were identified investigating MI, and fourteen studies were included referring to interventions for changing MI. Data from the included studies was entered into a data extraction sheet. The methodological quality was then evaluated. MI in childhood is vivid, frequent, and has a significant influence on cognitions and behavior in posttraumatic stress disorder (PTSD), social anxiety disorder (SAD), and depression. The imagery's perspective might mediate the effect of MI on the intensity of anxiety. Imagery rescripting, emotive imagery, imagery rehearsal therapy, and rational-emotive therapy with imagery were found to have significant effects on symptoms of anxiety disorders and nightmares. In childhood, MI seems to contribute to the maintenance of SAD, PTSD, and depression. If adapted to the developmental stages of children, interventions targeting MI are effective in the treatment of mental disorders.

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Shahsavani, S., Mashhadi, A. & Bigdeli, I. The Effect of Group Emotional Schema Therapy on Cognitive Emotion Strategies in Women with Migraine Headaches: a Pilot Study. *J Cogn Ther* **13,** 328–340 (2020). https://doi.org/10.1007/s41811-020-00073-8

Abstract

The aim of the current study was to examine the effect of emotional schema therapy (EST) on migraine severity and cognitive emotion regulation strategies. In this study, 16 women with migraine were randomly assigned to EST group (n = 8) and a waitlist control group (WLC; n = 8). Participants in the EST group received 12 sessions of group emotional schema therapy. Ahwaz Migraine Headache Questionnaire (AMQ) and Cognitive Emotion Regulation Questionnaire (CERQ) were measured pre-treatment, post-treatment, and at 1-month of follow-up. Results indicated that EST was more effective than WLC in reducing migraine severity at post-test and follow-up. In addition, participants in the treatment condition showed significant improvement in adaptive cognitive emotion regulation strategies at post-test and follow-up. Furthermore, as the results showed, time, group, and interaction did not reduce maladaptive cognitive emotion regulation strategies significantly. Our results suggest that emotional schema therapy may be useful in alleviating migraine pains.

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Khosravani, V., Samimi Ardestani, S.M., Mohammadzadeh, A. *et al.* The Emotional Schemas and Obsessive-Compulsive Symptom Dimensions in People with Obsessive-Compulsive Disorder. *J Cogn Ther* **13,** 341–357 (2020). https://doi.org/10.1007/s41811-020-00075-6

Abstract

Growing research shows an association between emotional schemas and psychopathology. Therefore, the study of emotional schemas in psychiatric disorders is an important issue regarding psychopathology. Also, emotional processes are important factors in relation to obsessive-compulsive disorder (OCD), but experimentally no study has examined the relations of emotional schemas to obsessive-compulsive (OC) symptom dimensions in people with OCD. The aims of this study were to compare emotional schemas between people with OCD and non-clinical control participants and

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Ассоциация когнитивно-поведенческой психотерапии

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The Russian Association for Cognitive and Behavioral Psychotherapy (RACBP) was founded in 1999 bringing together mental health professionals with the mission to promote cognitive and behavioral therapy in the Russian Federation as well as to provide highly professional help and support for our patients and clients. RACBP is one of the biggest psychotherapeutic and psychological non-profit organization in Russia with 2010 members (January 2021).

Russian Association for Cognitive and Behavioral Psychotherapy (RACBP) became and affiliate member of EABCT in 2017 and a full member in 2019. The President of the Russian Association for Cognitive and Behavioral Psychotherapy (RACBP) is Dmitrii Kovpak. The Association has 24 regional branches in Russia and is the only organization which has a State Educational License and legally provides CBT training for mental health professionals. Over 3000 clinicians have participated in our educational programs RACBP holds an annual CBT Forum as well as a number of local congresses, seminars in Russia, Belarus, Kazakhstan and educational programs including online courses in Russian with Arthur Freeman. RACBP has invited a number of internationally respected colleagues to its meeting including Donna Sudak (USA), Robert Leahy (USA), Arthur Freeman (USA), Keith Dobson (Canada) and Mehmet Sungur (Turkey). RACBP publishes the proceedings of its a conference and translates and publishes popular scientific books on CBT and has developed an online platform for education of CBT approach and for counselling for CBT-specialists.

In June2023 RACBP will be hosting the 11th International Congress of Cognitive Psychotherapy, which International Association for Cognitive Psychotherapy (IACP) in St-Petersburg. St Petersburg is looking forward to hosting the ICCP 2023 as we believe it will significantly contribute to the development of Cognitive behavioral Therapy in our region, as well as throughout the Russian Federation and in the post-Soviet area.

The ICCPis International Congress an outstanding event in the world of professionals in the field of mental health and socionomics, a great source for improving skills and gaining new modern knowledge for cognitive behavioral therapy and psychotherapy in general, a powerful impetus to professional growth and personal fulfillment.

St. Petersburg is included into the UNESCO World Heritage List uniting about 4,000 landmarks.
St. Petersburg is a home to summer white nights and drawbridges, famous museums, theaters, libraries, exhibition and concert halls. The Hermitage and Russian Museum art collections, the Mariinsky and Mikhailovsky theatres classic ballet and opera, Russia's National Library treasures, the Peter and Paul Fortress monarchy cradle make Saint Petersburg significantly inimitable.
St Petersburg is a rapidly developing destination with great intellectual, scientific and educational potential. Our Russian scientific cluster has much to show the world, but at the same time, challenges faced by Russian experts can only be overcome through establishing dialogue with international communities and multilateral collaboration.

We are happy to invite all of you to the upcoming congress and look forward to the upcoming meeting!

1000+ members

EABCT Representative
Dmitrii Kovpak
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A-CBT PRESIDENT'S MESSAGE CONTINUED FROM PG. 1

My goal is to broaden our global community so that together, we can move the Academy's mission forward. To do so requires outreach to those diverse experts in evidence-based practices and to those diverse soon-to-be experts in evidence-based practices. To advance requires the voices and input of all who value sound science in the practice of psychotherapy.

I invite you to actively join me in this pursuit. Get involved a little or a lot: weigh-in on the annual membership participation call, ask a question or add your perspective on the listserv, make a donation to our Student Award, distribute information about the Academy during a talk or conference, submit to Advances in Cognitive Therapy Newsletter, join one of our committees. It all counts.

Please reach out to me at eelliottmoskwa@gmail. com with your questions or suggestions.

IACP PRESIDENT'S MESSAGE CONTINUED FROM PG. 2

has rejoined the IACP as Board Member at Large. Joining Dr. McGinn, we are honored to have Jung Hye Kwon, Professor in the Department of Psychology at Korea University join the Board. Dr Kwon is also the Program Chair for the upcoming 2022 World Congress on Cognitive Behavioral Therapies in South Korea http://www.wccbt2022.org . Likewise, we are delighted to welcome Dmitrii Kovpak MD, President of the Association of Cognitive Behavioral Psychotherapy in Russia and also serving as Program Chair of the International Congress of Cognitive Psychotherapy in 2023. The IACP Board is now complete and we look forward to new initiatives, including a new website in the new year.

Finally, 2020 was such a strange year in so many ways but one thing I was really surprised about was how effective virtual conferences were. The International Congress of Cognitive Psychotherapy will be held virtually in May and promises to provide a top-notch conference experience with noted invited speakers (Robert Leahy, Steve Hayes, Paul Gilbert) recognizing the diverse umbrella of CBT, while maintaining the intimacy that the conference is known for. IACP members receive a significant discount on registration. Please visit iccp2021.com for more information.

Until next time,

Lynn McFarr, Ph.D.

REFLECTIONS ON TREATMENT FOR SOCIAL ANXIETY CONTINUED FROM PG. 3

If the fear is of spilling a drink at a party, then that should be arranged, and repeated, and repeated. If the fear is of being observed while writing and that one's hand will shake, then the client can be asked to exaggerate the tremor in their hand or they can be asked to sign their name to many documents on which the signature line gets smaller and smaller, while being observed of course. The basic idea here is to make sure that you catch the key fear in the situation and to make it "fun." It is possible to make in-session exposures into a sort of theater of the absurd in which what starts out as a feared situation ends up with therapist, client, and any role play assistants all joining together in a good laugh!

What is your advice to supervisors who are working with a supervisee who is using the Managing Social Anxiety (MSA) approach for the first time?

Keep in mind that administering the MSA protocol (or any other evidence-based therapy for anxiety) is the management of a bunch of moving parts. Although the protocol is designed to provide a lot of guidance to therapists-in-training, more than a little rehearsal is required to get it right. This requires, among other things, that the therapist-in-training

-- read the therapist guide and client workbook all the way through before starting to work with the client

-- study each chapter or unit closely before the appropriate session so that they can interact naturally with the client rather than being slavishly tied to session outlines or paying more attention to the workbook than the client

-- listen to or view recordings of previous therapists administering the various parts of the protocol whenever possible

-- role play specific parts of the protocol (e.g., anxious self/coping self dialogue, cognitive restructuring before and after in-session exposures, in-session exposure set-up and execution)

It is also important for the supervisor to keep in mind that the therapist-in-training's behavior is open to scrutiny by the supervisor and the trainee is open to the same kind of reactions to evaluation of their performance as is the case for their client with social anxiety disorder. It is important to model being nonjudgmental as a supervisor as well as be attuned to the trainee's negative automatic thoughts about their performance. The supervisor's approach to the trainee's negative thoughts can serve as a model of the work the trainee will do with their client.

Has your understanding of the role of culture and/or clients' lived experiences of marginalization as it plays out in the MSA treatment

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evolved over time? Does it matter if the client and therapist share similar identities?

To answer the first question, yes. To answer the second question, no, although there is a burden placed on the therapist when identities do not coincide. It is basically about coming to a place of understanding the world through the eyes of another, but it also involves acknowledgement of one's own privilege and the challenges that the client's marginalized identities bring upon them. It becomes very important to help the client understand the differences between negative evaluations they perceive from others that are a function of a socially anxious mindset and the negative evaluations they receive from others because of discrimination, marginalization, or exclusion based on other parts of their identities. The latter should not be addressed with cognitive restructuring but may inform when and how exposures are safely conducted. This is a much bigger question than "just" the treatment of social anxiety and speaks to the importance of cultural competence in the training of all clinicians.

There is a movement away from doing cognitive restructuring with exposure based treatment these days. What do you think about that notion? Why do you think clinicians working with socially anxious clients should still include cognitive restructuring?

There is certainly that movement, which is an outgrowth of mindfulness- and acceptance-based therapies, and it has considerable merit. There is no reason that cognitive restructuring should be considered an absolute requirement for treatment to be successful. In fact, if a client is able to be mindfully and nonjudgmentally aware of their negative thoughts and still move forward toward their valued goals, then there is reason to think that is enough. However, this is not always the case.

We see clients who are able to do this but many others who ultimately are unable to set their thoughts aside and move forward. The thoughts keep coming back and the client keeps getting entangled with them. In this case, it is necessary to engage the negative thoughts rather than set them aside. It is with this type of client that cognitive restructuring skills are important to engage. They need to be engaged in the context of exposures, which provide powerful disconfirmatory information, which may be the most potent form of cognitive restructuring of all!

Cognitive restructuring skills may be critical at the outset of a situation, if the client is sufficiently reactive to their anticipatory negative thoughts that they decide to avoid the situation entirely, use substances to get through the situation, or engage in other safety behaviors to which they will credit their success (or avoidance of failure). For other clients, cognitive restructuring activities may be most important after the exposure situation, so that the client does not engage in maladaptive post-event processing, in which they can turn an objectively successful social outcome into an abysmal social failure in their memory of the event, thus setting themselves up for greater anxiety in the next iteration of the situation.

Conclusion

Rick is a beloved mentor to his many students and trainees. Thousands of individuals with social anxiety around the world live fuller, more satisfying lives as a result of the treatment that he pioneered. Although his active research career may be ending, his influence will endure for many years through his students and the many clinicians who use the interventions he developed.

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INTERNALIZED RACISM IN AFRICAN AMERICAN CLIENTS

CONTINUED FROM PG. 5

to continually invite the client to explore issues of diversity" (Day-Vines et al., 2007, p. 402). Note how the therapist in the excerpt above broached race by asking Andre about his experience as an African American supervisor at the plant. By doing so, not only was the therapist able to gather data about one of Andre's core beliefs, but she was also provided with potential insight into relevant psychological phenomenon and societal factors to aid her conceptualization of Andre's concerns, particularly in terms of the development of his core and intermediate beliefs.

As previously stated, culturally adapted CBT recognizes the role of cultural stressors in client problems, and places a strong emphasis on the role of these stressors in the development of a client's automatic thoughts and beliefs (Hays, 2006). In the session excerpt, Andre describes being held to a higher standard than his peers. The idea of having to work twice as hard as others, particularly White counterparts, is a common psychological phenomenon within the African American community colloquially known as "Black tax." According to Palmer and Walker (2020), "Black tax is the psychological weight or stressor that Black people experience from consciously or unconsciously thinking about how White Americans perceive the social construct of Blackness" (para 2). In essence, Black people, aware of negative race-related

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stereotypes and the deficit lens through which Black people are viewed, believe they must outperform their Whites counterparts in order to be seen as equal. In the midst of this phenomenon, Black people often experience worry, anger, and frustration, and may even avoid situations in which they anticipate being forced to prove their intelligence or justify their right to occupy space in interracial environments. In the case of Andre, it appears that the notion of having to work harder than others may contribute to a schema of powerlessness (see Prilleltensky & Gonick, 1996), and may explain his doubt in his ability to be successful in future work as a supervisor. Knowing this, the therapist can validate his feelings and help him see his thoughts and behaviors within the context of the discrimination and racism experienced by African Americans rather than mere distorted thinking as she helps Andre identify adaptive ways to think about and address his problems.

Another issue worthy of note in Andre's case is the heightened sense of anxiety he experienced when observed by his operations manager. This anxiety may be partially due to stereotype threat, which is defined as fear of conforming to negative stereotypes about one's social group (Steele & Aronson, 1995). Research indicates that when activated, stereotype threat does in fact result in increased anxiety and worsened performance during assessments (David, 2009). Throughout U.S. history, African Americans have been stereotyped as lazy and unintelligent, and these stereotypes have served as legitimizing myths to justify disparities between African Americans and other social groups in nearly all facets of life (Green, n.d.). As Andre describes his problems with memory, a common symptom of anxiety, and his worsened performance while being evaluated, it may be beneficial for the therapist to explore the extent to which stereotype threat contributes to his experience. Gathering data of this nature would not only aid conceptualization of Andre's concerns, but would also provide a basis for culturally responsive treatment planning and intervention.

Conclusion

In this article, I discussed how therapists can explore factors relating to race and internalized racism during therapy with African Americans, as well as how therapists might include these factors in the cognitive conceptualization of these clients. While I provided examples of how therapists might broach race during sessions and how they might subsequently integrate obtained data into a client's cognitive formulation, it is important to note that therapists should first commit to developing their own multicultural orientation, which is to a way of being with clients characterized by humility, comfort in discussing matters related to culture, and commitment to take advantage of opportunities to discuss culture when they present themselves during sessions (Hook et al., 2013). In next issue's final article for this series, I hope to further elucidate these constructs as I conclude the case of Andre, describing culturally responsive treatment planning and intervention.

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TRAINERS' CORNER: HABIT REVERSAL

CONTINUED FROM PG. 6

the use of the competing response. They also increase client recognition of practice opportunities by verbally noting the occurrence of the target behavior or its observable precursors when they have escaped the client's detection. Ideally, the support person attends all clinical sessions in which habit reversal training is provided to the client so that they are fully informed about the procedure and have many opportunities to practice their role in the presence of a clinician.

Generalization Procedures

Programming for generalization is important in habit reversal training and is accomplished in two primary ways. The first means of generalization involves the use of a social support person, which

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has already been described. A second generalization strategy is to encourage the client to engage in extensive practice in multiple contexts. They should repeatedly enter every circumstance the behavior occurred in previously while simultaneously deploying their competing response. They should also use their competing response each time the behavior occurs.

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***Editor's note**: This column is part of a newer series of practice-oriented articles that are meant to teach and illustrate CBT in clinical practice. Submissions for this series are welcome. Email me with your ideas and suggestions. Scott Waltman, PsyD, ABPP, walt2155@pacificu.edu*

BIOGENETIC ETIOLOGIES OF MENTAL DISORDERS

CONTINUED FROM PG. 7

Fortunately, we now know that relatively simply modifications to psychoeducation can increase the benefits and reduce the disadvantages of biogenetic etiologies. Lebowitz and Applebaum (2019) reviewed research revealing that emphasizing malleability of the biological contributors to mental disorders contribute to increased mental health literacy and improved prognostic optimism. These modifications ought to include clinician elicitation of etiological beliefs from clients and subsequent clinician emphasis on brain-plasticity and the reality and importance of epigenetics and gene-environment interactions.

Clinical Implications:

- Clinicians should elicit information regarding client's etiological beliefs, maintaining vigilance for widespread biogenetic misconceptions surrounding causes of mental disorders.
- Ethical and competent psychoeducation includes addressing possible biases in client treatment preferences while simultaneously collaborating on individually tailored treatment plans
- Clients benefit when clinicians provide psychoeducation regarding the malleability of biological contributors to mental disorders, including emphasizing brain-plasticity and the reality and importance of epigenetics.
- Maintaining up-to-date knowledge of current research into biogenetic etiologies is increasingly important for clinicians.

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UPDATES FROM THE IJCT

CONTINUED FROM PG. 8

to investigate the relationships between emotional schemas and OC symptom dimensions in OCD. Eighty individuals with OCD completed the Leahy Emotional Schema Scale (LESS) and measures of clinical characteristics. Results showed that people with OCD had higher scores on the maladaptive emotional schemas of guilt and uncontrollability than non-clinical control group. Non-clinical control participants had higher scores on the adaptive emotional schema of higher values than people with OCD. Guilt significantly predicted the OC symptom dimensions of responsibility for harm and symmetry after controlling for clinical characteristics. Uncontrollability was a significant predictor of the OC dimensions of unacceptable thoughts. These findings indicate that specific dimensions of maladaptive emotional schemas such as guilt and uncontrollability may be associated with some specific OC symptom dimensions in people with OCD. This study provided more evidence for Leahy's emotional schema model in people with OCD.

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Ouellet-Courtois, C., Aardema, F. & O'Connor, K. Cognitive Confidence and Inferential Confusion in Obsessive-Compulsive Disorder: Differences Across Subtypes. *J Cogn Ther* **13,** 358–378 (2020). https://doi.org/10.1007/s41811-020-00087-2

Abstract

A lack of cognitive confidence (CC), defined as a distrust of one's attention, perception, and memory, has been implicated in obsessive-compulsive disorder (OCD) and could account for its core symptoms. The early research focus has been on CC in the context of checking OCD, yet research suggests that the construct may also apply to other OCD subtypes. A closely intertwined construct also implicated in OCD is inferential confusion (IC), whereby a distrust of the senses leads to an investment in imaginary possibilities. This study aimed to simultaneously examine these constructs across OCD subtypes.

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A total of 128 participants with OCD completed a measure of CC (MCQ-65; Metacognitions Questionnaire), IC (ICQ-EV; Inferential Confusion Questionnaire), and OCD symptoms (VOCI; Vancouver Obsessional Compulsive Inventory). TwoStep cluster analyses for CC revealed two clusters: (1) low CC/high checking/higher OCD symptoms and (2) high CC/low checking/lower OCD symptoms. The analyses for IC resulted in three clusters: (1) average IC/high "just right"/high contamination/low obsessionality, (2) high IC/ high "just right"/high obsessionality, and (3) low IC/low obsessionality/ low checking. Results are discussed in terms of the heterogeneity of OCD, which highlight the need to tailor research paradigms and treatment targets to different OCD presentations.

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Wong, D., McKay, A., Kazantzis, N. *et al.* Clinical Translation of Cognitive Behavioural Therapy for Anxiety and Depression: Adapted for Brain Injury (CBT-ABI): How Do We Train Competent Clinicians?. *J Cogn Ther* **13,** 379–395 (2020). https://doi.org/10.1007/s41811-020-00079-2

Abstract

Depression and anxiety are common following acquired brain injury (ABI) and can be effectively treated using cognitive behaviour therapy (CBT) that has been adapted to compensate for cognitive difficulties (CBT-ABI). Training clinicians to deliver CBT-ABI is a crucial step in effective translation into clinical practice. This study evaluated the outcome of didactic and skill-based training on competencies in delivering CBT-ABI. Participants were 39 registered psychologists who attended a day-long workshop on using CBT-ABI to treat anxiety and depression after ABI, which included knowledge and skill-based content. Fourteen participants completed three additional supervision sessions reviewing audio recordings of their use of CBT-ABI with clients. Training outcomes were measured using surveys rating the usefulness of the various workshop components, a checklist of competencies in CBT-ABI on which participants rated themselves pre-workshop and post-workshop and post-supervision, and the Cognitive Therapy Scale (CTS), used by supervisors and a blinded expert to evaluate supervisees' skills. Participant-rated competencies in CBT-ABI significantly improved following workshop training, with no further change after supervision. CTS ratings of the supervisor, but not the blinded expert, showed significant improvement after short-term supervision. At 16-month follow-up, self-rated competency gains were maintained, and therapist confidence and competence were no longer major barriers to using CBT-ABI in the workplace. These findings suggest targeted training is important for clinical translation of this evidence-based intervention.

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Barry, T.J., Hernandez-Viadel, J.V. & Ricarte, J.J. An Investigation of Mood and Executive Functioning Effects of Brief Auditory and Visual Mindfulness Meditations in Patients with Schizophrenia. *J Cogn Ther* **13,** 396–407 (2020). https://doi.org/10.1007/s41811-020-00071-w

Abstract

Brief meditations led by audio versus visual stimuli can lead to differential effects on mood and cognition in healthy people. We examine whether similar effects were evident amongst schizophrenia patients. Forty-three patients underwent either 30-min image- (e.g. a mountain stream; $n = 15$) or audio-led (e.g. running water; $n = 15$) meditations or waited 30 min without instructions ($n = 13$). Prior to and following the meditation/wait, participants completed a self-report measure of positive and negative affect and the Trail Making Test to measure attentional shifting abilities. Participants who underwent a visual-led meditation were significantly more positive than those who underwent an audio-led meditation or if they did not meditate. Irrespective of meditation modality, participants showed significant improvement in attentional shifting abilities. Brief meditative practice amongst patients with schizophrenia may have immediate effects on mood and cognition. Future research must explore these effects in larger mindfulness programmes and with longer follow-up assessments.