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ACT PRESIDENT'S COLUMN

As I look back the last two years of my term as president, I am proud at what we have all accomplished together. I am especially proud that the Academy of Cognitive Therapy continues to fulfill its mission to ensure quality control in training and certifying clinicians to conduct principle based evidence-based practice. The Academy has trained or credentialed people in 44 countries to date, including Argentina, Australia, Bahrain, Brazil, Canada, China, Colombia, Denmark, Egypt, France, Germany, Greece, Guatemala, Hong Kong, India, Indonesia, Iran, Ireland, Israel, Italy, Jamaica, Japan, South Korea, Kuwait, Lebanon, Mexico, Netherlands, New Zealand, Norway, Panama, Peru, Philippines, Puerto Rico, Romania, Russia, Saudi Arabia, Scotland, Singapore, South Africa, Spain, Sweden, Turkey, the United Kingdom, and the United States. The Academy has extremely stringent standards for training and credentialing and is comprised of an extremely large, vibrant academic community of researchers, educators, and clinicians from all over the world who help ensure that our credentialing and training continues to stay abreast of the research in the field and is inclusive of all the modern, cutting edge developments in the field of cognitive and behavioral therapies.

In other accomplishments over the last two years, I am delighted to let you know that after many years of discussions, we have been successful in creating a formal alliance with the International Association of Cognitive Therapy. Dr. Aaron T. Beck's longstanding wish to integrate the science and practice arms of cognitive therapy was finally realized in time for his 97th birthday this year. In the month of July, 2018, the Academy of Cognitive Therapy and the International Association of Cognitive Psychotherapy signed an affiliation agreement to cement our commitment to work together to integrate and advance the science and practice of cognitive therapy. I look forward to celebrating this historic agreement with all of you at the Academy's annual social, meeting and Aaron T. Beck award ceremony on November 15th at 7 pm at the Association of Behavioral and Cognitive Therapies.

At our meeting in November, you will also have the opportunity to meet each other, get to know the boards of both organizations, and celebrate Dr. Sabine Wilhelm as she receives an award. Dr. Sabine Wilhelm is the recipient of the 2018 Aaron T. Beck Lifetime Achievement award. She is Chief of Psychology and Director of the OCD and Related Disorders Program at Massachusetts General Hospital (MGH), Professor of Psychology at Harvard Medical School (HMS), and President of the

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IACP'S PRESIDENT'S COLUMN
MEHMET SUNGUR, MD.

I would like to start by thanking all of the distinguished board members of IACP and ACT for their historic decision taken to affiliate and work together to disseminate the science and good practice of CBT. The idea of working together and collaborating to promote CBT with preservation of the unique character of each individual association (IACP and ACT) is very exciting for me and for all of our board members. Coming together is only a beginning but working together is success. I hope that this collaboration will be welcomed and appreciated by all members of both associations. This affiliation will be celebrated at the upcoming ABCT meeting in Washington DC. I would like to invite all of our members to join us during the memorialization of this major agreement event on the 15th of November at 7 pm. I believe that it is time to unite rather than divide as the term CBT is losing its specificity. CBT is now recognized as an umbrella term that aim to cover many different empirically supported approaches including those defined as new (third) wave (generation) therapies focusing on different processes and thus certainly widening our scope and perspective in understanding our clients and reducing the pain they are going through.

Science and good practice goes hand in hand and our mutual aim is to increase the number of scientist practitioners to improve the quality of service given to our patients in the process of reducing human suffering and pain. IACP has always been flexible and open to collaborate and liaise with other International associations or Institutions that share similar goals. That is to disseminate the science and good practice of CBT. Our peer reviewed journal (International Journal of Cognitive Therapy) and our board members continuous lectures and workshops conducted in different parts of the world aim to materialize this goal. I believe that our aim should not be towards building up empires or power elites or to compete with each other, but simply to unite to help reduce human suffering. That is why many of us have devoted their lives in training professionals working in the area of mental health. Just recently many past and present board members of IACP made immense contributions to the scientific quality of the recent EABCT congress held in Sofia in September of 2018. On top of conducting workshops and giving keynotes in different congresses organized in different parts of the world, the IACP organizes truly international congresses every three years. The upcoming 10th ICCP (International Congress of Cognitive Psychotherapy) will be held in Rome in the year 2020 and I hope many of the IACP and ACT members will be actively involved in turning this traditional congress into another memorable one just like the prior ones. Dr. Antonella Montano, the president of the upcoming ICCP will soon announce and promote the congress.

As the last but not the least I am delighted to encourage you to become members or to renew your existing membership to IACP which will certainly bring many benefits. Please find out more information about the benefits of becoming new members or sustaining your membership at www.the-iacp.com.

You are always welcome to contact admin@the-iacp.org for further information. I hope that we will all work harder to unite in order to collaborate and cooperate to reduce human pain and suffering.

ACT PRESIDENT'S MESSAGE

Association for Behavioral and Cognitive Therapies. Among other accomplishments, Dr. Wilhelm has been a principal investigator on many NIH-funded trials, a mentor to more than 40 junior investigators in the field, serves on eight editorial boards. She has 239 publications and has written 7 books on OCD, BDD, and related disorders, and has given more than 220 invited lectures on these subjects nationally and internationally.

It is the ultimately the work of Executive Director, Troy Thompson and our new administrator Kenneth Cobbs, that allows the Academy to achieve its mission and I am deeply indebted to them for their work in executing the vision of the Academy. A special note of appreciation and thanks to Troy for his immense talent and contributions. I also want to thank Brad Richards, Trent Codd, and Leslie Sokol for their contributions to the board, thank Jeanne Czajka for her invaluable role in advising the Academy to get its administrative and compliance issues in order, thank Jamie Schumpf for her incredible work on our joint newsletter, and thank members of the IACP board (President Mehmet Szungur, Past-President Stefan Hofmann, Secretary-Treasurer Nikolaus Kazantzis, Rep-at-Large David A. Clark, Rep-at-Large Lynn McFarr, and Journal Editor, John Riskind) and the ACT board (John Williams, Lynn McFarr, Elaine Elliott-Moskwa, Denise Davis, Robert Leahy, and William C. Sanderson) boards for their skill, hard work, and unwavering support over the last few years. I am grateful to Dr. Aaron T. Beck for his vision in uniting our two organizations and to both Dr. Aaron T. Beck and Dr. Judith Beck for their advice and support in facilitating our alliance.

As we move ahead, the Academy is eager to partner with you to broaden our umbrella to represent all forms of cognitive and behavior therapies in the future and to use cutting edge research to ensure that our certification and training represents all the evidence-based advances in the field. Our field needs unity and not divide, and we are ultimately committed to the same goal, which is to reduce human suffering and better people's lives. The Academy continues to be open and excited about collaborating with the Beck Institute and other like-minded organizations and individuals in

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STANDING ON THE SHOULDERS OF GIANTS
STEVEN HOLLAND, PSY.D.

Stephen Holland, Psy.D. is Founder and Director of the Capital Institute for Cognitive Therapy in Washington, DC. Washingtonian Magazine named Dr. Holland one of the top therapists in the DC area. He is co-author, with Robert Leahy and Lata McGinn, of Treatment Plans and Interventions for Depression and Anxiety Disorders, a widely used text on empirically supported treatments. He is a Founding Fellow of the Academy of Cognitive Therapy, as well as a Certified Trainer/Consultant and a member of the Board of Directors. I did not set out to become a cognitive-behavioral therapist.

I started graduate school in my late 20s, influenced in part by my own experience in therapy. My goal was to get into a psychoanalytic Ph.D. program.

Then I met Bob Leahy.

In the summer of 1989, my masters level Psychopathology class was taught by Bob, who had recently returned to New York from training with Aaron Beck. Being Bob, he was provocative and brilliant and, to my annoyance, challenged many of my assumptions. Ultimately, I could not resist the logic of his arguments for empirically supported practice.

At the end of the semester, I gathered all my courage and asked Bob to lunch. With characteristic warmth and generosity, he agreed. A year later, when I needed an externship, I called him.

I worked with Bob for four years. Supervision was a remarkable experience. Over and over we role played interactions with my clients. To my frustration, Bob was much better at the techniques (of course) than I was and my patients were better at their entrenched distorted viewpoints than I could role play. But I learned. To illustrate key principals, Bob would tell stories from his training with Drs. Aaron T. Beck and David Burns. It was thrilling to feel myself getting direct transmission from the masters.

Also influential was Bob's personal approach to therapy. I had only been exposed to the psychoanalytic blank screen stance, so the first time I heard Bob greet a patient in the waiting room as warmly as if he or she were an old friend, it was revelatory. From Bob I learned that it was OK to be warm and real and laugh with patients--not only OK but essential.

While I worked with Bob, I pursued my doctoral degree at the Rutgers University's Graduate School of Applied and Professional Psychology, where I did research on short term dynamic therapy with Stan Messer. I also did three years of group supervision with Nancy McWilliams, who would become a prominent figure on the psychoanalytic world.

Simultaneously learning CBT and psychoanalytic psychotherapy from two master clinicians was a heady, and at times, confusing experience. I became interested in taking concepts I found useful from analytic therapy and trying to understand them in cognitive-behavioral terms. Ideas like the importance of empathy and attunement, attending to my own emotional reactions as information, and using the inevitable misunderstandings and conflicts that occur during sessions in the service of schema change were not antithetical to core CBT principals but were emphasized more in my analytic training. The one analytic concept I could not find a good existing CBT model for was defense; the idea that people engage in distorted thinking and maladaptive behavior to avoid threatening internal experiences.

Meanwhile, Bob asked me to join him as co-author on a book. It was the mid-1990's and there was panic in the field over the growing impact of managed care. Bob and I set out to take the best research-proven protocols and create a accessible guide for clinicians working in typical outpatient settings. Treatment Plans for Depression and Anxiety Disorders became a widely used text.

Eventually I moved to Washington, DC, where I established my own practice, the Capital Institute for Cognitive Therapy. And then the third wave happened. While I disagreed with some of the critiques of cognitive therapy that I did not think were supported by a full reading of the research literature, it was finally in the work of third wave giants like Steve Hayes and Marsha Linehan that I was able to find what felt missing from CBT theory. The concept of experiential avoidance dovetailed with psychoanalytic concepts of defense and my own clinical experience. And there was another benefit. I had been studying Buddhism and practicing meditation since I was first introduced to Zen in college in the 1970's. The growing body of empirically support for mindfulness-based approaches finally allowed me to share with to my patients something I had personally found profoundly helpful.

When the time came to do a second edition of Treatment Plans, Lata McGinn (current President of the Academy) added her expertise to the project. We updated the text with the latest conceptualizations and treatment innovations, including third wave and meta-cognitive approaches.

Throughout these years, Bob and I stayed in regular contact. One of the greatest pleasures of those conversations was getting to talk with Bob as he developed the ideas that would become his Emotional Schema model. It's rare privilege to witness that kind of creative process up close. His model grounds current CBT understanding of emotion in cognitive theory.

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DIGITAL BEHAVIORAL HEALTH: USES IN ENHANCING THE PRACTICE OF CBT

NICHOLAS R. FORAND, PH.D., ABPP

Nicholas R. Forand, Ph.D., ABPP, is a licensed clinical psychologist, Director of Evidence-Based Psychotherapy at Northwell Health, and Assistant Professor of Psychiatry at the Donald and Barbara Zucker School of Medicine at Hofstra/Northwell. He is board certified in Behavioral and Cognitive Psychology. Dr. Forand's role at Northwell is to increase patient access to evidence-based psychological treatments, including cognitive behavioral therapy. In this role, Dr. Forand trains providers, supports training in evidence-based approaches and develops clinical services. Dr. Forand has a specific interest in integrating digital behavioral health solutions into practice, including digital outcome assessments and internet-based cognitive behavioral therapy (iCBT). Dr. Forand's research interests include personalized medicine approaches for depression, depression vulnerability, cognitive behavioral therapy, and digital behavioral health, and he has published over 25 papers in peer-reviewed journals. He completed a post-doctoral fellowship at the University of Pennsylvania focusing on the causes and treatments of major depression and maintains active collaborations with researchers at The Ohio State University and the University of Pennsylvania. Dr. Forand provides CBT for adults with depression, anxiety, and related conditions at Northwell Health.

About 95% of the population owns a mobile phone, and 77% of the population owns a smartphone ("Demographics of Mobile Device Ownership," 2017). Apps, websites, wearables and other tech are increasingly being leveraged to deliver services to mental health consumers.

This area, broadly known as "digital behavioral health" (DBH), can be confusing and intimidating for providers, but it can also be an opportunity. As noted by Kazdin and Blase (2011), there are far too few trained providers to meet the needs of the population, so developing novel service delivery methods is essential. As CBT providers, we are also well positioned to take advantage of digital approaches because the capabilities of mobile tech support the therapeutic activities we encourage, including in vivo monitoring and practice. This piece serves as a brief introduction to the digital behavioral health world, specifically as it relates to the delivery of CBT.

Population Health. Faced with a shortage of trained CBT providers, employers, health plans, and health systems are working with DBH companies to provide their populations with digital services, including internet CBT (iCBT). These companies are anticipating that increased access to evidence-based care will improve population outcomes and reduce costs of care. Despite the promise of this approach, it is unclear whether DBH services improve population outcomes, although some research is suggestive (Abhulimen & Hirsch, 2018). Our team at Northwell Health is actively exploring clinical care pathways involving the use of iCBT.

Subscription Services. Other digital options are the consumer-facing subscription services. These services range from video and chat therapy with licensed therapists to fully developed and automated courses of iCBT, sometimes supported by a coach. Anyone can access these services by paying a monthly fee. Some of them have been developed by CBT experts and tested in randomized controlled trials, for example SHUTi, a program that delivers CBT for insomnia (Ritterband et al., 2017). These services can be a powerful adjunctive to regular clinical practice, particularly for patients who need services that are outside of specific provider expertise or for whom attending regular sessions is difficult. Of the existing DBH services, these are the most likely to be considered "alternatives" to face to face therapy, and evidence suggests that they can be as effective as these traditional service models (Calbring, 2018).

Apps and Websites. There are thousands of mental health smartphone apps, many of which are quite good, and many others that are not. Patients often do not wait for provider recommendations before downloading apps, so providers should have knowledge of this space. Apps can be used to provide psychoeducation, teach CBT skills, monitor thoughts, emotions, or behaviors, prompt users at specific times, or to support "in the moment" skills practice or homework exercises. One app I particularly like is iPromptU, a CBT homework tool developed by the Cognitive Behavioral Institute of Albuquerque. This app will alert users during the day to respond to a series of customizable questions. Other apps, such as *CPT Coach*, developed by the Department of Veteran's Affairs, are explicitly intended to be adjuncts to clinicians delivering manualized interventions. For applying skills "in the moment," Northwestern University's Center for Behavioral Intervention Technologies has developed a suite of apps called *IntelliCare*. These apps allow users to learn a specific skill, such as cogntive restructuring, behavioral activation, relaxation, or skills from positive psychology. With so many mental health apps available, the key for therapists is being able to identify and evaluate the apps most likely to be effective for the intended purpose.

How should you evaluate digital products? There is little guidance for users to determine which products and services are legitimate or effective, never mind if they have empirical support. The following is some basic advice for evaluating a DBH product: 1) Use the product before recommending it. A major determinant of effectiveness is user experience. Ensure it is attractive, intuitive, easy to navigate and use, persuasive, and has feature set you want. 2) Look at the developer page and determine whether the app creators have the credibility to create a mental health product.

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TRIAL-BASED COGNITIVE THERAPY AND SOCIAL ANXIETY DISORDER: A CASE REPORT

KÁTIA CAETANO, PH.D. & IRISMAR REIS DE OLIVEIRA, M.D., PH.D.

Kátia Cætano, Ph.D., is a postdoctoral student at the East Bay Behavior Therapy Center, California, seeing adults, teens and children suffering with anxiety disorders and depression. She is also a Brazilian licensed psychologist and a former Professor at colleges of Psychology in Brazil. Cætano has been in private practice since 2012, and she has done research in the field of fear, anxiety and CBT since 2010. Cætano's research focuses on the treatment of anxiety disorders through evidence-based interventions.

Irismar Reis de Oliveira, M.D., Ph.D., is Professor of Psychiatry at the Federal University of Bahia, in Salvador, Brazil, and Adjunct Professor at the Department of Psychiatry and Behavioral Sciences, McGovern Medical School, University of Texas Health Science Center at Houston (UTHealth). He is the developer of Trial-Based Cognitive Therapy (TBCT) and has trained therapists in Brazil and other countries. Currently, Dr. de Oliveira teaches this model in different cities of the East and West Coasts of the USA and other countries. He published numerous articles and is the editor of Standard and Innovative Strategies in Cognitive Behavior Therapy, co-editor of Integrating Psychotherapy and Psychopharmacology: A Handbook for Clinicians, and the author of Trial-Based Cognitive Therapy: A Manual for Clinicians and Trial-Based Cognitive Therapy: Distinctive Features.

Social Anxiety Disorder (SAD) is marked by intense fear of negative evaluation in social interactions and avoidance of social situations. SAD is the most prevalent condition among anxiety disorders, and one of the most common psychiatric disorders (Kessler et al., 2005). Cognitive Behavioral Therapy (CBT) is the first-line treatment for SAD. However, a considerable number of patients either do not improve or present relapse after completing a CBT intervention. Thus, it is important to optimize CBT tools and develop new ones to more effectively treat SAD.

Trial-Based Cognitive Therapy (TBCT) is a new evidence-based branch of CBT. It was inspired by Kafka's novel The Trial, and aims to help patients to identify and modify dysfunctional core beliefs through the systematic use of imagination and experiential exercises (de Oliveira, 2011). Research has shown the efficacy of TBCT for SAD and other disorders (de Oliveira, 2016; Caetano et al., 2018).

Trial I, one of the main TBCT techniques, is a seven-column thought record in which the therapist guides the patient through the simulation of a court trial by means of the empty-chair technique. It is a law metaphor where patients' core beliefs are conceptualized as self-accusations. During Trial I, patients become aware of their distorted core beliefs and are encouraged to gather elements to implement their own defense, and activate more functional beliefs about themselves (de Oliveira, 2015).

However, how does TBCT work in a real setting? How are patients engaged in a court trial aiming to challenge their dysfunctional core beliefs? The aim of this paper is to describe a TBCT intervention with a patient whose primary diagnosis is SAD.

"Lina" is a 29-year-old female living in the Southeast of Brazil with her fiancé. Lina sought therapy because of social anxiety symptoms. During the initial assessment, generalized SAD and comorbid Depression were confirmed through the SAD module of the Structured Clinical Interview for DSM-IV – Research Version (First, et al., 2002) and the clinician version of the SCID (First, et al., 1996). Additionally, the following self-report measures were used at intake, every four sessions, and two weeks after treatment: 1) Social Phobia Inventory (SPIN); 2) The Beck Depression Inventory (BDI-II), and the Beck Anxiety Inventory (BAI).

Lina used to avoid several social situations such as: talking to strangers; making eye contact with co-workers, consumers and strangers; eating in public; coordinating meetings at work; sharing opinions with colleagues; and public speaking. One of her main avoidance behaviors was writing in public. Lina had avoided getting married and taking her driver's license examination for example. She presented as dysfunctional beliefs: "I am awkward. I am inadequate. I am incapable. I am crazy."

Lina received 16 individual 90-minute sessions of TBCT. Session 1 covered psychoeducation about anxiety, SAD, TBCT, and therapy goals. Additionally, the patient rated a 60-item list using the color-coded symptoms hierarchy (CCSH), a TBCT Likert scale designed to organize and facilitate exposure to feared actions (Figure 1). In the same way as the Subjective Units of Distress Scale, CCSH provides a hierarchy of symptoms to which they are supposed to be exposed in order to promote habituation of anxiety symptoms. The CCSH scores were obtained every session in order to choose the exposure item to be implemented as homework during the week. Green symptoms are those to be implemented daily. Throughout sessions, yellow and red symptoms, those scoring 4 or 5, gradually become green, most likely due to habituation of anxiety symptoms and cognitive restructuring.

In sessions 2 and 3, the cognitive model, automatic thoughts and cognitive distortions were introduced through the TBCT conceptualization diagram. The main goals of sessions 4 and 5 were restructuring dysfunctional automatic thoughts with the

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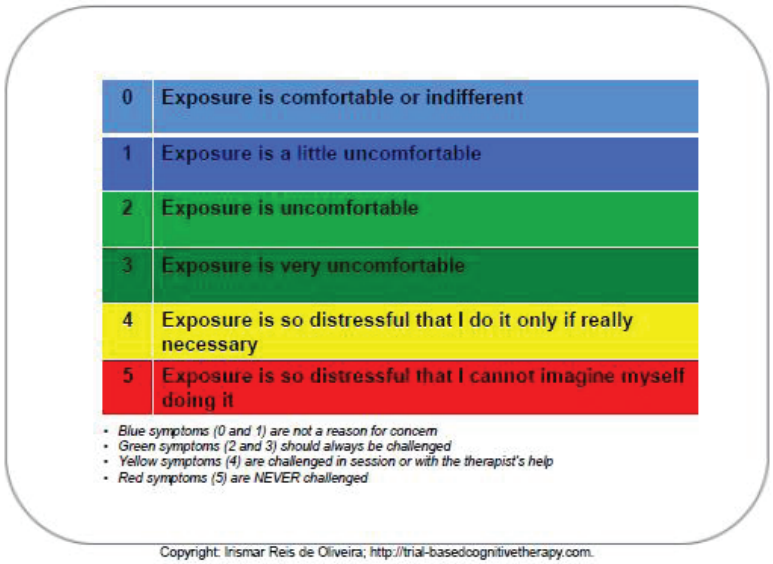
Figure 1: Color-coded Symptoms Hierarchy (CCHS).



Intrapersonal Thought Record, a TBCT thought record. Sessions 6 to 8 were used to restructure underlying assumptions and challenge safety behaviors, such as avoidance. The Consensual Role-Play technique was used during these sessions to target both conditional beliefs and avoidance behavior. Sessions 9 to 13 were used to change dysfunctional core beliefs by means of the Trial I technique, where Lina was actively engaged in a simulation of a court trial. In sessions 14 and 15, metacognitive processes were made clear to the patient with Trial II. As in Trial I, in Trial II Lina was engaged in the simulation of a court trial to foster awareness of the self-accusatory nature of dysfunctional core beliefs by a bully prosecutor. Finally, in session 16, relapse prevention and the main aspects of therapy were discussed.

Throughout therapy, the patient had a decrease of social anxiety, depression and anxiety symptoms. Following the use of Trial I, Lina started to activate new functional core beliefs, such as "I am capable" and "I am normal"; and thoughts such as "Anxiety is part of everyday life and I can feel it." By the end of therapy, the patient got married and got her driver's license. Additionally, she reported that she was no longer avoiding eye contact, she was involved in small meetings with sales associates at work, and she was expressing her opinions at church and to her friends. Figure 2 shows the evolvement of different symptoms over the treatment.

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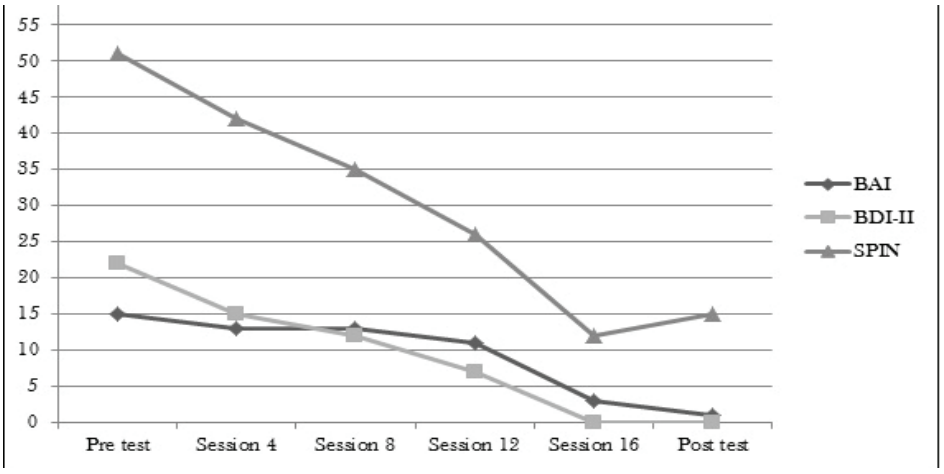
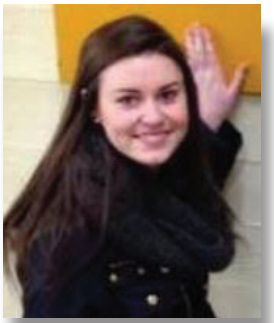
Figure 2: BAI = Beck Anxiety Inventory; BDI-II = Beck Depression Inventory. SPIN = Social Phobia Inventory; SRQ = Self-Rated Questionnaire.



COGNITIVE BEHAVIORAL THERAPY WITH DEPRESSED ADOLESCENTS

MARK A. REINECKE, PH.D. & KELSEY R. HOWARD

Mark A. Reinecke, Ph.D. is Professor of Psychiatry and Behavioral Sciences and Chief of the Division of Psychology at Northwestern University's Feinberg School of Medicine. He is a Distinguished Fellow and former president of the Academy of Cognitive Therapy, and a Diplomat of the American Board of Professional Psychology (ABPP) in Clinical Psychology and Clinical Child and Adolescent Psychology. Dr. Reinecke also is a Fellow of the American Psychological Association, the Association for Psychological Science, and the Association for Behavioral and Cognitive Therapies. His research and clinical interests center on understanding and treating depression, suicide, and anxiety among children and adolescents. Dr. Reinecke was a principal investigator on the Treatment of Adolescents with Depression Study (TADS). He has lectured internationally and has served as a visiting professor at institutions in Europe and Asia. Dr. Reinecke is widely published, and has authored or edited ten books, including Cognitive Therapy across the Lifespan, Comparative Treatments of Depression, Cognitive Therapy with Children and Adolescents, Personality disorders in Children and Adolescents and Cognitive-Behavioral Therapy with Adults. His first book for a general audience, Little Ways to Keep Calm and Carry on was published by New Harbinger.



Kelsey Howard is a doctoral candidate within the Clinical Psychology Doctoral Program at Northwestern University Feinberg School of Medicine. She is under the supervision of Dr. Mark Reinecke in the Child and Adolescent Mood Program. Her research focuses on the family context of youth depression, including the role of family in the treatment of depression and the effects of child mood on family well-being. Her clinical interests are in the areas of clinical child, family, and pediatric psychology.

Significant gains have been made over the past 20 years in our understanding of Major Depressive Disorder (MDD) in adolescents and its treatment. A number of effective psychotherapeutic and psychopharmacological treatments have been established. Cognitive Behavioral Therapy (CBT) has received a substantial amount of attention during this time and is considered by many to be a treatment of choice for depressed youth (effectivechildtherapy.org). CBT has been found effective in several randomized controlled trials, including the Treatment for Adolescents with Depression Study (TADS; March et al., 2006), the Treatment of Resistant Depression in Adolescents (TORDIA; Brent et al., 2008) study, and the Improving Mood with Psychoanalytic and Cognitive Therapies (IMPACT; Goodyer et al., 2011) study. Results of these trials indicate that CBT therapy, alone or in combination with medication, can effectively treat depressive symptoms and improve quality of life for youth.

Recent findings suggest, however, that the incidence of depression and suicide among U.S. adolescents is on the rise. One study found that the 12-month prevalence of major depressive episodes for U.S. adolescents rose from 8.7% in 2005 to 11.5% in 2014 (Mojtabai et al., 2016). Recent data from the Centers for Disease Control and Prevention indicate that the incidence of youth suicide rose by 56% between 2007 and 2016 (Curtin, Heron, Minino, & Warner, 2018). Suicide is now the second leading cause of death for children and adolescents between 10-19 years of age (Heron, 2018). Treating adolescent depression, then, remains a significant public health concern.

CBT with depressed youth is similar in structure and form to CBT with depressed adults. Treatment includes a focus on psychoeducation, identifying and challenging maladaptive beliefs, developing problem-solving skills, and engaging in rewarding activities. CBT strategies employed with youth typically include rational responding, articulation of goals, development of affect regulation skills, and development of adaptive coping strategies. In addition, CBT with adolescents involves the development of several competencies not typically addressed in work with adults. These include a focus on parenting practices, parental mood, attachment security, and parent-child interactions. CBT with youth, as with adults, is strategic, focused, time-limited, formulation-based, and can be tailored to meet the individual needs of the teen and their family. As with adults, attention is paid to the development of therapeutic rapport. In as much as studies indicate that feeling misunderstood or unsupported by one's therapist is predictive of premature termination and poor treatment compliance in child therapy, CBT clinicians place an emphasis on insuring that children and parents feel understood at the end of every session. Close attention is paid, then, to developing and maintaining a supportive and collaborative therapeutic relationship.

Systematic reviews and meta-analyses indicate that effect sizes for CBT with depressed youth range from modest to large, with stronger effect sizes for studies published earlier compared to more recent work (Compton et al., 2004; Klein et al., 2007). CBT appears to be most rapidly effective in treating depression when used in conjunction with antidepressant medication. However, findings from TADS indicate that CBT monotherapy can be as effective as medication alone or combined CBT and medication when treatment is extended to 24 weeks (Kennard et al., 2009). As many but not all children will show improvement in the first 12 weeks of treatment, a consistent and patient stance is recommended. Teenagers and their parents should be encouraged

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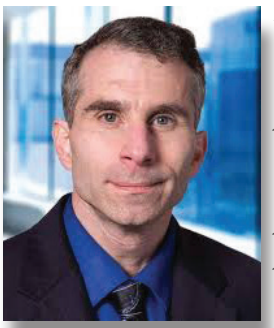
IMPORTANT CONSIDERATIONS IN CONCEPTUALIZING AND TREATING OBSESSIVE-COMPULSIVE DISORDER

LAWRENCE NEEDLEMAN, PH.D., ABPP



Lawrence Needleman, Ph.D., ABPP specializes in treating OCD and anxiety disorders. He developed the CBT training program for the psychiatry residents at the Ohio State University Department of Psychiatry, where he is an associate professor. He mentors doctoral clinical psychology students and psychiatry residents. He authored the book--Cognitive Case Conceptualization: A Guidebook for Practicitioners, completed a postdoc with the Becks at Penn, and is an Academy of CT Founding Fellow. Dr. Needleman greatly enjoys being surprised by clients and working to understand/conceptualize why clients think or act different that his conceputalization would have predicited. He also loves to see students get excited when learning to conceptualize and treat clients and to be stimulated by them to learn new perspectives and methods.

In this article, I will share perspectives/lessons/strategies that I've learned over the past 20 years from CBT literature and clinical experience that I wish I knew when I began treating Obsessive Compulsive Disorder (OCD).

I first treated clients suffering from OCD during my pre-doctoral internship. That year, an interesting client who had contamination fears panicked whenever he drove near a street that had a name that rhymed with 'shit.' Since then I have treated approximately a thousand clients with OCD. Even after all these years, I find OCD fascinating and rewarding to treat.

Even the most 'mundane' OCD is interesting. For example, compulsive lock checking involves lack of trust in one's vision, hearing or memory; this mistrust often is limited to the door-locking context, [and terminating checking has nothing to do with the lock but is determined by feelings or rules.] At the other end of the continuum are bizarre obsessions. A recent client had the over-valued idea, "If I am outside with an uncovered drink, a bat will fly over salivating, and I will die from rabies."

Beliefs and cognitive processes are essential drivers and maintainers of OCD.

Beliefs. OCD sufferers typically "fuse" with intrusive thoughts and catastrophic beliefs as if they are reality, important, personally relevant, and require action or mental control ("thinking about doing this heinous act makes it more likely or is the moral equivalent," "thinking about an event will make it happen," "objects take on bad luck or feelings"). Other beliefs and metabeliefs that are important include the expectation that compulsions prevent catastrophe, excessive responsibility, rules for stopping compulsions, malicious perfectionism, intolerance of uncertainty, and excessive threat expectations (McNicol & Wells, 2012).

Cognitive processes. These include attempts to suppress thoughts, which often paradoxically tend to increase their frequency or salience and mental compulsions. Mental compulsions include fear-driven excessive prayer, thought substitution, analysis, counting, mental reassurance, and memory hoarding. Unlike obsessions that are intrusive and distressing, mental compulsions (like external compulsions), are intentional to decrease distress or prevent catastrophe. This crucial distinction is confusing because both are cognitive phenomena. If mental compulsions are not detected and stopped, even if clients are doing exposure without doing external compulsions, they are likely to have limited benefit because mental compulsions prevent them from learning that if they didn't engage in mental compulsions, catastrophes usually don't happen.

Another important issue for OCD clinicians is to be aware of two common but often subtle compulsions--reassurance seeking and confessing. These compulsions, like others, contribute to the maintenance of OCD. Also, many OCD clients are masters of subtly and furtively looking for reassurance. Even if loved ones refuse to give reassurance, clients can derive comfort by observing their behavior. E.g., when an OCD sufferer asks a passenger, "Was that bump I felt a person?" and the passenger refuses to answer and looks unconcerned, the client might still feel reassured. Therefore, clients, significant others, and therapists should collaboratively and carefully plan how to decrease clients' reassurance seeking and significant others' reassuring behaviors.

Targeted Cognitive behavioral interventions for OCD.

- Thought suppression experiments, which address beliefs about the importance of and need to control thoughts;Pie chart of responsibility, which addresses excessive responsibility;
- Exposure-with-Response-Prevention (ERP)/Behavioral experiments--in which clients intentionally confront OCD triggering situations without doing compulsions and observing what (doesn't) happen(s). Importantly, OCD thinking often involves discounting experiments' outcomes (e.g., "I really would have stabbed you if I were panicking"). Therefore, to maximally change beliefs, after each behavioral experiment, it is necessary to do follow up experiments that target discounting thoughts (e.g., interoceptive exposure when holding a knife). To address discounting beliefs, it is often necessary for the experiments to be done repeatedly, for prolonged periods of time, and with much variation. This helps clients learn that castrastrophe doesn't happen, that they can cope, and that their distress eventually diminishes. Formal ERP is in essence systematic and prolonged

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BOOK REVIEW, HOLLIE GRANATO, PH.D. *THE JEALOUSY CURE: LEARN TO TRUST, OVERCOME POSSESSIVENESS, AND SAVE YOUR RELATIONSHIP* BY ROBERT LEAHY, PH.D.

Dr. Hollie Granato, Ph.D. is an assistant professor in the psychiatry department at the University of California - Los Angeles (UCLA) David Geffen School of Medicine and a joint staff psychologist at the Harbor - UCLA Medical Center. She serves as the clinical lead for DBT/CBT through the Los Angeles County Department of Mental Health. She completed her Ph.D. in clinical psychology at the University of Washington, where her research and clinical work focused on the intersection between substance use, trauma, and emotion regulation. During her graduate studies, Dr. Granato trained extensively with Dr. Marsha Linehan in Dialectical Behavior Therapy (DBT) for both adults and adolescents, and has been invited to speak internationally on DBT as well as published on the treatment of co-occuring Post-Traumatic Stress Disorder (PTSD) and Borderline Personality Disorder (BPD). Additionally, she has served as a consultant and trainer for both DBT as well as Motivational Interviewing interventions for youth and adolescents. Dr. Granato's current research interests focus on DBT, emotion dysregulation, and the dissemination of evidence-based practices - specifically DBT and CBT - within community mental health and private practice settings.

Whenever I ask my clients what emotions they would choose to get rid of if they could, there are two emotions in particular that stand out as the target of much animosity – anxiety and jealousy. Over a decade ago, Dr. Robert Leahy provided the world with a widely acclaimed, highly accessible, and evidence-based book to address the impact of worry called *The Worry Cure: Seven Stops to stop Worry from Stopping You* (2005). This book detailed clear steps, based in the principles of Cognitive Behavioral Therapy, which readers could use to to begin to take ahold of their anxiety and decrease their worry. This year, Dr. Robert Leahy has returned to again offer the world with a succinctly and clearly outlined a path for those seeking to help with another painful emotion many people struggle with - jealousy.

I was delighted when asked to read and review this book because much like my clients, I too have often shared the fantasy of a life where jealousy does not exist. However, as my clients and I have repeatedly discovered and as Leahy compellingly explains in his book, the emotion of jealousy is in fact crucial to our lives. As Leahy early on highlights, "[...] jealousy can tell us about what our relationship needs more of, whether its commitment, honesty, transparency, or choice." However, he also quickly underscores the painfully damaging and sometimes devastating effects that acting on jealousy can have for relationships. Grounded in principles of Cognitive Behavioral Therapy (CBT), *The Jealousy Cure: Learn to Trust, Overcome Possessiveness, and Save your Relationship*, is a concise yet thorough evaluation of jealousy that provides a very accessible explanation on a challenging and complex topic. In general, this book seeks to explain the function of jealousy to readers while also elucidating the transactional relationship between beliefs we hold about ourselves and others, emotions, and the behaviors we engage in in order to manage jealousy. By increasing awareness of these transactions, *The Jealousy Cure* ultimately coalesces into a pathway for healing from jealousy based on cognitive-behavioral strategies and interventions. Ranging from cognitive restructuring to mindfulness, this book provides interventions and suggestions that not only can one try out on their own, but also suggests strategies for communication and resolving jealousy as a partnership. As jealousy is often an emotion that does not exist in isolation, I found this to be a particularly helpful aspect of the strategies provided.

Another particular strength of this book is that it offers a non-judgmental insight into the emotion jealousy that balances validation for those who have felt the painful impact of jealousy on their relationships while also holding the reader accountable for changing how they respond to jealousy. In doing this, it helps readers to confront and sit with deeply held beliefs and potentially shame-inducing ineffective past behaviors that have kept them stuck in a jealousy loop. For readers who may not have struggled with jealousy personally but have loved someone who has, it also provides a compassionate conceptualization of this emotion. In doing so, this books highlights again the transactional nature of jealousy in relationships and offers tools for partners of those who struggle with jealousy as well as those struggling with jealousy. As Leahy notes, "[...] jealousy is not inherently bad and is part of human nature, it is not blameworthy or something to be ashamed about [...]", and this approach offers hope for all impacted by jealousy.

You will find in *The Jealousy Cure* a helpful evidence-based resource for CBT clients and students alike who have encountered the difficulties associated with jealousy. Although largely employing heteronormative examples, this book skillfully avoids gender stereotypes associated with jealousy. It also effectively highlights the pervasive nature of jealousy across many different types of relationships including for example friendships and family relationships in addition to romantic partnerships. As a therapist who primarily engages in Dialectical Behavior Therapy, the non-judgmental approach and transactional nature of jealousy described in this book also appealed to me. I will and have already recommended this book to several clients, students, as well as friends – because as Leahy emphasizes, jealousy is an emotion that is necessary, impacts us all whether we are the person struggling with jealousy or the target of jealous feelings, and that no one gets out of feeling from time to time.

ACT PRESIDENT'S MESSAGE

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order to advance the field of CBT. It is our collective strength that is the Academy's biggest asset and we are eager to have your talents in service of the academy, so please get involved.

Thank you for permitting me to serve the Academy.

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

MY CBT TRAINING AND EVOLUTION

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I should comment that I have hardly been alone in benefitting from Bob's generous mentorship. A number of people who have assumed leadership positions in the field trained with Bob. This includes the Presidents-elect of both the Academy of Cognitive Therapy, Lynn McFarr, and the Association for Contextual Behavioral Science, Dennis Tirch.

While my approach to therapy has evolved over the years, two core principles remain that I first learned from Bob. I am still committed to empirically supported treatment. And I continue to find in Beck's cognitive model the theoretical framework that allows me to integrate all of the diverse influences on my work.

DIGITAL BEHAVIORAL HEALTH

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3) Carefully review the content to ensure that the app delivers information and interventions that are consistent with CBT theory and evidence. For example, make sure an OCD app is not focused on teaching relaxation skills. For a good discussion on how CBT apps can be consistent with CBT principles see Bakker, Kazantzis, Rickwood, and Rickard (2016). 4) Finally, review the privacy policy in detail to determine what the app developer does with user data. Another option is to use DBH rating service. One service that has taken an empirical approach is Mindtools.io, a website that tasks expert raters with evaluating digital products (Baumel, Faber, Mathur, Kane, & Muench, 2017). The expert reviews on this site are intended to help the public make educated decisions about digital tools. This website is a good first stop if you are looking for a specific type of product.

Summary. This article only scratches the surface of the digital space, but I hope it helps broaden your understanding of the potential for these tools to enhance the practice of CBT. If you would like to learn more, feel free to contact me at nforand@northwell.edu.

Disclosure: I have no financial or personal interest in any of the products or services discussed in this article.

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CBT WITH DEPRESSED ADOLESCENTS

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to stay the course if gains are not immediately apparent.

Taken together, research indicates that CBT, alone or in combination with medication, can be effective for treating depressed youth. Questions, however, remain. In order to effectively target treatments, more research on predictors and moderators of response is needed (Nilsen, Eisemann, & Kvernmo, 2013). Additionally, little is known about the mechanisms of change in CBT with depressed youth. Few studies have been completed examining the role of therapeutic alliance, treatment fidelity, and change in cognition as mediators of improvement with CBT treatment (Webb, Auerbach, & DeRubeis, 2012). More research also is needed on other potential mediators of treatment response, such as affect regulation, ruminative style, processing of

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rewards and losses, and perceptual disengagement from aversive stimuli. Moreover, many youth do not fully remit following treatment with CBT or medications. Treatment resistance, then, is both an important clinical and conceptual challenge. Additional research is needed to improve outcomes for treatment nonresponders.

Although a majority of research on the treatment of adolescent depression has evaluated CBT, other approaches also show promise. Interpersonal Psychotherapy (IPT), for example, also has been recommended as a treatment for depressed youth (effectivechildtherapy.org). More recently, Mindfulness-Based Stress Reduction (MBSR) has been found to have a moderate effect size with depressed youth (Chi et al., 2018). Comparative outcome studies, however, have not been completed. A useful question for future research is perhaps not whether CBT is superior to other evidence-based treatment modalities, but rather which treatment modality is effective for each presenting patient. Additional research on predictors, moderators, and mediators of treatment response may lead to more effective, individually-tailored treatment options for depressed youth. Research in affective neuroscience may also illuminate mechanisms of change in CBT with depressed youth.

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IMPORTANT CONSIDERATIONS IN CONCEPTUALIZING AND TREATING OCD

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behavioral experiments in which clients confront successively more distressing OCD triggering situations. Although traditionally the goal of ERP has been habituation vs. belief change, recent studies have found that belief change is a more effective target than habituation (see Craske et al., 2014; Jacoby & Abramowitz, 2016).

Intentionally facing OCD triggering situations without compulsions is often highly distressing; therefore working to maintain motivation throughout treatment is essential. Ways to do this:

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- Collaboratively develop a compelling case conceptualization that emphasizes OCD maintaining factors, especially counterproductive effects of avoidance, thought suppression, and compulsions, which are negative reinforcing and prevent disproving catastrophic expectations, etc.
- Use motivational metaphors, detailed metaphors about coming out from hiding to face the bully, turning 180 degrees toward it, etc.
- Use motivational scripts (Grayson, 2014).
- Used valued life directions as leverage (ACT, MI).
- Use session limits (Yadin, Foa, & Lichner, 2017) e.g., set the ambitious expectation of reaching the top of the exposure hierarchy midway through a 13-session protocol. Clients start ERP in the 50s/100 range of the hierarchy; in each subsequent week, the target range increases by 10 until they reach the top. Clients know that if they avoid or procrastinate, they will run out of time and are unlikely to reach their treatment goals. After reaching the top of the hierarchy mid-way through, the rest of treatment can focus on generalization and relapse prevention.

Working with OCD is both interesting and rewarding. For those who are interested the International OCD Foundation has excellent 3-day trainings with 6 month follow up case consultation.

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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 January 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@einstein.yu.edu.

I look forward to hearing from you all!