ADVANCES IN Cognitive Therapy newsletter

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EDITOR
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IACP PRESİDENT'S COLUMN MEHMET SUNGUR, PH.D.

It is a great honor and pleasure to write the President's column once again after a break due to an unfortunate road traffic accident on my side.

One mission of IACP has always been disseminating the science and good practice of CBT by organizing truly International congresses regularly held with three year intervals in different parts of the world. I am very happy to inform you all that the next (10th) ICCP Congress will be held in Rome between 18th-21st June, 2020. Keynote speakers and pre-congress full day workshops have already been appointed. As the president of IACP and as a member of the International Scientific Committee of this Congress. I would like to invite you all to this excellent venue and enjoy the highly scientific meeting organized by Antonella Montana and Gabriele Melli. Futher information can be found from www.iccp2020.com. Please come and join us to make this Congress a memorable event as the success of a Congress depends on the contributions of its delegates.

IACP is also represented as an International umbrella association in the World Confederation of Cognitive and Behavioural Therapies (WCCBT) which is recently established to represent all of the continents. Representators of WCCBT is at the stage of discussing procedures for admitting new members, collecting data about training standards, improving research areas and promotion and advocacy for mental health and dissemination of the good practice of evidence based therapies. I am hoping to give further information about this confederation in future issues of this newsletter.

I would also like to inform the members of IACP and ACT that the 9th World Congress of Behavioural and Cognitive Therapies (WCBCT) will soon be held in Berlin between 17th-20th July 2019. You can find the programme at www.wcbct2019.org. As part of the Scientific Committee I am very happy to inform you that more than 4000 professionals representing 80 countries are expected to attend this Congress.

I believe the time has come to talk not only about disseminating CBT but emphasizing the significance of disseminating good and ethical practice of CBT. Although CBT has become popular and have been disseminated widely, it might be more appropriate to view it as a maturing discipline as it is not anymore a single approach but a broad set of evidence based psychotherapies that continually evolve and change. I would like to thank all the scientific practitioners for their immense contributions into the field of evidence based therapies. Two weeks ago I was in St Petersburgh with Dr. Robert Leahy where we both presented keynotes and workshops. I was very impressed to see the number of professionals attending and actively participating in the Congress. It is such a wonderful experience to see so

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ACT PRESIDENT'S COLUMN
LYNN MCFARR, PHD

The Academy of Cognitive Therapy has had a banner year so far, and it's only half over.

At the end of June we wrapped up the first five years of our large scale implementation of CBT for Los Angeles County Department of Mental Health. LA County Roll Out of CBT (LACROCBT) has been a labor of love for me. I had been training small groups of county clinicians for 15 years with the help of my postdoctoral fellows and front line clinicians. However, the geography in Los Angeles does not lend itself well to people traveling from all over for a weekly class. The demand for a larger scale implementation was evident. Enter the Academy of Cognitive Therapy. The Academy was able to do what I could not do alone. Modeled on Improving Access to Psychological Therapies (IAPT), and with an amazing group of certified consultant trainers we were able to comprehensively train 1500 clinicians on a very tight budget in case-conceptualization based CBT. The trainings could not have happened without the leadership of Leslie Sokol, Ph.D., Urmi Patel, Psy.D., and our tireless Executive Director, Troy Thompson. Certified Consultant Trainers who have leant their expertise to this project include: Leslie Sokol, Michele Robins, Catherine Panzarella, Trent Codd, Mark Lau, Scott Waltman, Lauren Jackson, John Ludgate, Daniel Beck, Noah Clyman, Kevin Kuehlwein, Mudita Bahadur, Marci Fox, and Shelley Milestone, who each led novice clinicians into basic competency. I also want to take a moment to thank Stefan Hofmann, Lata McGinn and John Riskind for serving as Principal Investigators on the evaluation of the outcomes of the project. The data is being cleaned and entered as I write this and we hope to contribute to the growing body of dissemination and implementation literature.

In related news, the Academy Board has approved the development of a Research Committee. Dr. Scott Waltman, who helped pilot LACROCBT will be at the helm along with Dr. Hollie Granato And Dr. Lizbeth Gaona, who have served as consultants on the project as well. They will be tasked with guiding the analysis of the roll out data as well as critically evaluating CBT research from all sources.

I also want to take a moment to welcome Lauren Jackson, Psy.D., Lynn Martin, Ph.D., and Jude Hale who will bring their expertise from the VA system and local CBT organizations and Social Work to our group. Welcome!

Finally, I want to introduce our new Board Members, Dr. Jamie Schumpf and Dr. Lizbeth Gaona to the Board. Dr. Schumpf is well know to the Academy, serving as the newsletter editor. Dr. Gaona is the first social worker to join the board and has published on cultural competency in CBT and DBT. It is with this spirit of representation and inclusion that I want to welcome them to the Board, not only in terms of discipline, but also in terms of representation of culture and a broad embrace of modern CBTs. I am so excited about the future of the Academy.

Lynn McFarr, Ph.D.

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 September 15th, 2019. Submissions should be 350-900 words with no more than five references (using APA style and as an MS Word document). In addition, please include a brief (50-100 word) author bio and high quality photo/headshot with your submission.

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

STANDING ON THE SHOULDERS OF GIANTS
ROBERT DERUBEIS, PH.D.

Rob DeRubeis, Ph.D. *has been on the faculty at the University of Pennsylvania since receiving his doctorate in clinical psychology from the University of Minnesota in 1983. He is the director of Penn's doctoral training program clinical psychology and he has served as department chair as well as associate dean in Penn's School of Arts and Sciences. He has authored or co-authored over 100 articles and book chapters on topics that center on the treatment of depression. Among the awards he has received for his research and mentoring are APS's James McKean Cattell Award for lifetime contribution to applied psychology, the Senior Distinguished Career Award from the Society for Psychotherapy Research, and the Provost's Award for Ph.D. Teaching and Mentoring. His empirical research comparing the benefits of cognitive therapy and medications for severe depression, published in the American Journal of Psychiatry and the Archives of General Psychiatry, has been the subject of media reports in The Economist, the Wall Street Journal, and USA Today. He has spoken about his work in a variety of forums, including to the Congressional Biomedical Research Caucus here in Washington, DC.*

Dr. DeRubeis' research has focused on the processes that cause and maintain disorders of mood, as well as the treatment processes that reduce and prevent the return of mood symptoms. The contexts for this work are randomized clinical trials, the data from which he uses to further an understanding of the mechanisms through which treatments exert their effects. His team is currently working to apply techniques from artificial intelligence to problems in mental health decision-making, with a focus on methods to improve the precision of person-specific treatment recommendations.

As a college student at the University of Wisconsin in the early 1970s, philosophy was my passion. The opportunity to confront The Big Questions motivated me and, I like to think, prepared me to work on the more tractable problems with which we contend in clinical science. While running through several second majors, all in the social sciences, I continued with Philosophy. Only as I reached my senior year did I begin to think seriously about alternatives to law school or to graduate work in Philosophy. I served as a research assistant to Prof. Loren Chapman, who modeled rigor around questions that were of interest to me and seemed very important: the nature of psychosis and the genetics of avoidance behavior, the latter line of work requiring a rodent lab, supported by funds he earned as Editor of the Journal of Abnormal Psychology. It impressed me that he was willing to forego personal compensation for this purpose, a virtue I would see in spades in one of my later heroes, Steve Hollon.

Professor Richard McFall, then at Wisconsin, intrigued me and the other students in a seminar that focused on treatment of abnormal behavior. (I had not taken Abnormal Psychology, so this was my first in-depth exposure to topics in what would become my professional area.) Prof. McFall opened my mind to the possibility that rigorous empirical research could provide answers not only to questions about the nature of human suffering, but also about the most effective ways to ameliorate it. Unlike questions in philosophy, which to me were exceeded in their importance by their seeming intractability, I was learning that in psychology one could ask a critical question, design a study, and collect and analyze data that could at least constrain the answers to that question. So my goal shifted away from philosophy and law and toward "graduate school in Psychology" which, I was surprised to learn, needed to be narrowed down to an area of Psychology! I liked perception (tied with McFall's as my favorite course) and animal learning (pretty good, too), but I made my decision to apply to Clinical Psychology programs for one reason: it seemed to leave me with the option of either academic or applied work.

I was accepted at a few places, including Penn State (Craighead, Kazdin, and Mahoney were there) and Minnesota, known for its excellence in Clinical and related areas (Meehl, Tellegen, Lykken, Garmezy, Gottesman, et al.). I forget who advised me to take Minnesota's offer, but thank you! Although my ultimate PhD advisor was not on the faculty when I applied, the abiding excellence of the program shone through when, during my time there, the department added a true giant, Steve Hollon, to its faculty. (Meanwhile, the three stars at Penn State were leaving, one by one, for other universities.) From the same search that identified Steve, Phil Kendall was also hired; not bad! But whereas Phil's CV listed numerous publications, Steve's listed ... one! Minnesota took a gamble, and they were so right. Since Steve's arrival at Minnesota in 1978, he has had a profound effect on how I think and what I do as a clinical scientist, as he has had on countless clinical scientists around the world. But I also learned scientific values, and how to think critically, from Profs. Auke Tellegen, Paul Meehl, and David Lykken, and Irving Gottesman, who remain among the smartest people I have ever met.

Following in Steve's footsteps, I applied for academic positions with, shall we say, a thin CV. Steve encouraged me to apply for the open position at the University of Pennsylvania, the Psych department he most revered. I bombed my first job visit, at a Canadian university, had an exhilarating experience in my second one (Penn, where I had figured my chances were less than one in a hundred), and was bored during my third, at a southwest U.S. university. Evidently Penn was a good match in both directions, as I was offered and eagerly accepted a position on the tenure track in Psychology. (I received no other offers, and indeed each of the two other places I visited chose not to extend an offer to anyone.)

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STATUS OF COGNITIVE BEHAVIOR THERAPY IN PERU
NATALIA FERRERO, LIC. PSY.

Natalia Ferrero, Lic. Psy. *is a Psychologist, Universidad de Lima. REBT & CBT Psychotherapist and Supervisor. Trained at the Beck Institute for CBT. Founder & director of Psicotrec in Lima Peru affiliated to The Albert Ellis Institute. Faculty of the Spanish Training in REBT & CBT at The Albert Ellis Institute. Member of the Editorial Board of the Journal for Rational Emotive & Cognitive Behavioral Therapy. Author of the first Spanish RcdsYesEBT video demonstration session.*

Peru, with a population of more than 32 million people is a multicultural and extremely diverse country that built a long historical empire that reach a major cultural development in Latin-America. Bordered in the north by Ecuador and Colombia, in the south by Chile, in the east by Brazil and Bolivia, and in the west by the Pacific Ocean, it is divided in 3 regions: the coast, the mountains and the jungle. Its largest city, Lima, the capital, has also the biggest population, representing approximately 41.2% of urban population. (Estadística Poblacional, 2018).

Peru is a country with significant poverty which favors lack of access to medical and health services. In 2017, poverty affected 21.7% of the country's population, meaning 6,906,000 people received incomes below the poverty line. (Díaz Munguía, Romero Calle, Salas & Carnero, 2018). Unfortunately, these indicators of poverty lead to malnutrition, a lower educational level and lack of accessibility and availability to medical services. According to the official data of the Ministry of Health, one out of every four Peruvians need care for some type of mental disorder, but only three out of ten receive it. The government invests only about 3% of their health care expenses towards mental health, approximately US$ 3.35 and basically towards psychiatric institutions located in Lima. (Salud Mental del Subsector Ministerio de Salud del Perú 2008, 2009).

Given this reality, we can say that unfortunately psychotherapy is not a priority to the government agenda and so it is not properly widespread.

The practice of psychotherapy in Peru was initially considered a medical discipline within the psychiatric practice. In the 60's, psychologists slowly begun to have a more visible participation in the mental health field with the creation of the first Psychology Department in one of the most prestigious university in Lima of that time. The theoretical orientation that prevailed at this stage was psychoanalytic, but soon after, around the beginning of the 70's the behavioral orientation was also developed with great recognition. Universities started to incorporate at that time courses on behavioral modification and experimental analysis within the curricular grid of the Psychology Departments. Bearing in mind the importance of the development of increasing evidence-based techniques, and the growing interest and research in the cognitive field, the dissemination of Cognitive Behavior Therapy tradition in the country soon started at the end of the 70's and this interest was reaffirmed with professionals oriented in the clinical area. They gradually started to incorporate not only behavioral but also cognitive techniques in their professional practices at the mental health services of general hospitals as well as in the hospitals specialized in Mental Health.

Psychotherapy trainings and specialization programs in CBT in Peru prevailed currently and are offered since the 80's by Psychology Institutes or private institutions mostly in Lima. These are mainly conducted by professionals trained in CBT internationally. With the growing interest in CBT, psychotherapy is starting to be more popular and more mental health professionals around the country are seeking training in CBT, however, there are limitations regarding the training of professionals outside our capital. Informal training programs and courses in CBT are offered since the end of the 80's and beginning of the 90s, but it is still needed to be offered in different cities of our country and get CBT to be more acknowledge and recognize in order to cover the mental health needs of the big Peruvian population. Additionally, being Peru a culturally diverse country with high levels of poverty, it will be important to work towards incorporation of CBT to better serve the less favoured communities considering their cultural identity.

CBT research in Peru is still in a beginning stage. Lack of government support and funding is one of the major causes that limits its expansion. Peru still has insufficient studies examining the efficacy or effectiveness of CBT intervention. Most of them are documented by different Universities and are framed in the student's thesis to obtain their degree in clinical psychology. It is estimated that, given CBT increasingly stronger presence in Peru and current university regulations requiring students to conduct research to achieve their professional psychologist degree, these studies will increase significantly in successive years.

Today there is access in our country to formal institutions that offer training in the cognitive behavioral tradition, specially Ellis's Rational Emotive Behavior Therapy and Beck's Cognitive Therapy. Some institutions start offering workshops and trainings in dialectical behavioral therapy, acceptance and commitment therapy and mindfulness-based interventions with relative success. This is a desirable since it helps trainees in being less dogmatic and more able to recognize the strong and weak points of different psychotherapy orientations, particularly those of the cognitive-behavioral tradition. However, as already stated, one of the limitations is that these trainings are basically offered in Lima. There is a need for trainings to be delivered outside the capital and be responsive to the needs of very

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COGNITIVE BEHAVIOR THERAPY AND NEUROLOGY
SUMA CHAND, PHD

***Suma Chand, PhD**, is a Professor and Director of the Cognitive Behavior Therapy (CBT) Program in the Department of Psychiatry and Behavioral Neuroscience, St. Louis University School of Medicine. She is a licensed Clinical Psychologist who has received training in Cognitive Behavior Therapy from the Beck Institute for Cognitive Therapy and Research. She is a certified cognitive behavior therapist who has received certification from the Academy of Cognitive Therapy. She is a Fellow of the Academy of Cognitive Therapy. She is involved in the training of Psychiatry residents and fellows in CBT and as a SLUCare Provider where she runs clinics for adults and older adults offering individual and group CBT. She is on the Public Education Committee of the Anxiety and Depression Association of America and serves on the Board of Directors for the National Social Anxiety Center. Her research interests are in the areas of CBT for adults and older adults with anxiety, depression, sleep problems and maladaptive perfectionism. She also writes mental health related blog posts.*

Psychiatric co-morbidity in patients with neurological disorders is a frequent occurrence (Carson et al., 2003) and adds to the suffering of neurological patients in different ways. Depression and neurological disorders like stroke, dementia, Parkinson's disease, and epilepsy have been found to have a bidirectional relationship which can have a progressively negative impact on the individual (Barry et al., 2008). Psychiatric disorders in neurological patients are a major cause of disability (Carson et al., 2000) and also increases the costs of the disorder by 50% [Katon, 2003].

Pharmacological treatments for psychiatric symptoms in neurological patients can have a beneficial impact but the associated risk of adverse events and side effects makes their use in treatment difficult (Menza et al., 2009; Koch et al., 2011). Cognitive behavior therapy (CBT) has been well established as an effective intervention for mood and anxiety disorders (Chambless et al., 2001). This paper explores the inroads CBT has made into establishing its role as a useful treatment modality for co-morbid psychiatric symptoms in patients with neurological disorders.

Parkinson's Disease (PD) and CBT

Mixed depression and anxiety is the most common psychiatric co-morbidity, affecting about 50% of PD patients (Landau et al., 2016). The efficacy of medication in treating depression and anxiety in PD patients has been reported to be of moderate effect size but statistically non-significant in pooled analyses (Troeung, Egan & Gasson, 2013). The negative impact of polypharmacy is an issue of concern (Menza et al., 2009) as also the complicating factor of co-morbidity with anxiety predicting lower response rate to antidepressants in Parkinson's patients (Moonen et al., 2014).

The problems associated with the use of medications has led to the use of non-pharmacological means for treating the co-morbid depression and anxiety seen in PD patients. There have been a small number of randomized controlled trials (RCT) that have studied the efficacy of CBT in treating co-morbid psychiatric symptoms in PD patients. In their review article Koychev and Okai (2017) found that CBT had significant benefits for depressive and anxiety symptoms. This was noted at the end of the trial and at the follow up stage which extended from 1 to 6 months. Some studies tailored the protocol to the difficulties associated with PD, such as activity scheduling based on on-off PD symptom effects, motor symptoms acting as triggers for anxiety, fear of falling and preparation for disease progression (Dressig, 1999; Troeung, Egan & Gasson, 2014). A recent RCT utilized CBT that was personalized to the PD patients and also incorporated caregiver education. The study reported significant improvements in the cognitive and behavioral symptoms of depression (Dobkin et al., 2019). Some studies have adopted further modifications to accommodate the executive and somatic features of PD, such as less use of written work and unlimited breaks during session to allow patients to attend to their needs (Troeung, 2014). Several uncontrolled pilot trials and case series (Dobkin et al., 2011; Dobkin Allen & Menza, 2007; Farabaugh et al., 2010) have reported beneficial outcomes with CBT, using individual, group and the telehealth format as well.

Multiple Sclerosis (MS) and CBT

Up to 50% of patients with MS will have a major depressive episode during the course of their illness (Feinstein et al., 2014). Suicidal ideation associated with depression has been reported as being prominent in MS patients with depression (Feinstein, 2002). Although findings from a Cochrane review showed some benefit of anti-depressant medications in MS patients with depression, a higher risk for adverse side-effects from such treatment is seen in this population (Koch et al., 2011).

A Cochrane review of psychological interventions carried out in 2006 examined 19 databases until December 2004 and concluded that there was reasonable evidence that cognitive behavioral approaches are beneficial for treating depression in MS patients and helped them adjust and cope with the debilitating illness (Thomas et al., 2006). Later studies have reported CBT as having a moderate treatment impact on depression compared with standard care and other psychotherapeutic interventions (Hind et al., 2014; Lynch et al., 2010). Mohr and colleagues have reported significant benefits of CBT in treating depression by using a protocol that was adapted to address the specific problem associated with MS such as fatigue, pain, social and interpersonal difficulties resulting from the disease

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CO-COMPULSING WITH OCD PATIENTS
SALLY WINSTON, PSY.D. & MARTIN N. SEIF, PH.D.

***Sally M. Winston, PsyD**, founded and co-directs the Anxiety and Stress Disorders Institute of Maryland in Towson, MD. She served as the first chair of the Clinical Advisory Board of the Anxiety and Depression Association of America (ADAA), and received their prestigious Jerilyn Ross Clinician Advocate Award. She is a master clinician who has given sought-after workshops for therapists for decades. She is coauthor of What Every Therapist Needs to Know About Anxiety Disorders (Routledge), Overcoming Unwanted Intrusive Thoughts (New Harbinger), and Needing to Know for Sure (New Harbinger, In Press)*

***Martin N. Seif, PhD**, cofounded the Anxiety and Depression Association of America, and was a member of its board of directors from 1977 through 1991. Seif is associate director of The Anxiety and Phobia Treatment Center at White Plains Hospital, a faculty member of New York-Presbyterian Hospital, and is board certified in cognitive behavioral psychology from the American Board of Professional Psychology. He maintains a private practice in New York, NY, and Greenwich, CT, and is coauthor of What Every Therapist Needs to Know About Anxiety Disorders (Routledge), Overcoming Unwanted Intrusive Thoughts (New Harbinger) and Needing to Know for Sure (New Harbinger, In Press).*

We are Dr. Sally Winston and Dr. Marty Seif, two psychologists who have been specializing in anxiety disorders and Obsessive Compulsive Disorder (OCD) since the time of DSM-II. For decades, misunderstandings about the nature of OCD have interfered with successful treatment and allowed unnecessary suffering. OCD used to be considered rare and treatment resistant but it turns out that it is, in fact, both quite common and highly treatable if the right approach is taken.

One giant leap in understanding OCD came when the traditional conceptualization of obsessions as cognitive phenomena and compulsions as behavioral was revised. Instead of the old definition of obsessions as "irresistible" thoughts and compulsions as "irresistible" actions, OCD specialists adopted a functional definition: obsessions raise anxiety (or guilt or some other dysphoric emotion), and compulsions temporarily lower it. Many compulsions are entirely cognitive. For a short time, the idea of "Pure O" (obsessions without compulsions) was introduced, but that missed the relationship between obsessional worry and the subtle cognitive compulsions which serve the same function as behavioral rituals.

This provides a host of new insights. It turns out that most compulsions are purely mental phenomena. People argue with themselves in attempts to comfort, reassure, distract, or just plain avoid the distress triggered by obsessive intrusions. They provide rational refutations, they try to relax away anxious thoughts, they tell themselves to stop thinking those anxious thoughts. These "coping techniques" temporarily lower distress, so they fit the functional definition of compulsions. A behavioral component, such as washing or checking or arranging may not be present.

All compulsions, whether cognitive or behavioral, provide negative reinforcement. They are the engines driving future obsessions: the more you compulse, the more you obsess. Treatment must interfere with the self-perpetuating OCD cycle of obsessional worry followed by temporary relief, followed by more obsessional worry.

A functional definition also shows the intimate relationship between the toxic worry of GAD (generalized anxiety disorder) and OCD itself. We can conceptualize GAD as ego-syntonic all cognitive OCD, and OCD as ego-dystonic GAD. Both disorders have a "what if?" thought that raises anxiety, followed by another thought to try to "solve" the issue. The difference is in the reasonableness of the thought's contents. Obsessions can morph from one "issue" to another, ranging from bizarre to mundane content. We have come to name toxic worry as "OCD-Lite." What we have learned is that the critical issue for treatment of both GAD and OCD is not the content of the worries but the functional relationship between distress-inducing thoughts and distress-reducing attempts which inadvertently reinforce the obsessional worries.

Understanding the constant presence of cognitive compulsions in most patients with OCD has profound implications for treatment. It informs traditional ERP (exposure and response prevention) enormously. For example, the therapist might put their hands on a (dirty!) carpet, rub them over their face, and ask the patient to do the same. Then there can be no washing of any sort for the next 45 minutes. The theory is that not washing constitutes legitimate response prevention and should interrupt the OCD cycle by providing emotional processing (Foa & Kozak, 1986) or inhibitory learning (Craske et al., 2008). However, this might not be the case at all. Patients report that they get enormous anxiety relief by imagining how good they are going to feel when they get home and take a long shower. These cognitive compulsions defeat an apparently standard ERP session.

An even greater implication is that most OCD is invisible. It exists as looping mental gymnastics—back and forth between two internal

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POSTTRAUMATIC STRESS DISORDER
BRET A. MOORE, PSY.D., ABPP

Bret A. Moore, Psy.D., ABPP is a clinical and prescribing psychologist in San Antonio, Texas and the Vice Chair of the Boulder Crest Institute for Posttraumatic Growth in Bluemont, Virginia. Dr. Moore has authored or edited 18 books and his most recent release is "Treating PTSD in Military Personnel: A Clinical Handbook–Second Edition".

The term posttraumatic stress disorder (PTSD) may be a relatively recent psychiatric label, but it is far from being a modern day condition. The 5th century Greek philosopher Herodutus wrote of a warrior who was rendered blind, not by the tip of a spear or the blade of a sword, but by witnessing a fellow warrior perish next to him during battle. The 18th century gave birth to the term "Swiss disease" due to the manifestation of physical and psychological symptoms in seemingly healthy Swiss villagers who were forced to serve in militia-type armies. "Irritable heart" became the popular term during the Civil War to describe panic-type symptoms in soldiers who were exposed to combat, but suffered no physical injuries. Irritable heart was eventually replaced by a string of other terms to include "shell shock", "war neurosis", and "battle fatigue". In 1980 we arrived at the current label of posttraumatic stress disorder. Although the name has not changed over the past four decades, our understanding of the disorder has done so considerably.

Depending on your perspective, treatment advancements for military-related PTSD may have kept pace with our understanding of the disorder or lagged behind it. I tend to believe it's a little bit of both. The field has seen a surge of research on evidence-based psychotherapies, particularly prolonged exposure and cognitive processing therapy. Reductions in scores on objective measures for PTSD are the norm in these studies. And treatment groups outperform waitlists or "treatment as usual". However, a substantial number of veterans dropout of trauma-focused psychotherapies prematurely and a sizeable proportion retain the diagnosis upon "successful" completion of treatment. Then there is the issue of innovation. The reality is that the evidence-based psychotherapies of today are based on cognitive and behavioral principles from decades ago. In essence, they've been repackaged, manualized, and put through more rigorous scientific inquiry.

I am grateful for the time, personnel, and financial resources we have put into studying the global and nuanced effects of trauma-focused, evidence-based psychotherapies for PTSD. Our veterans are getting better because of them. However, I often wonder if a touch of myopia has crept into the field with regard to the treatment of military-related PTSD. Why are we no longer studying treatments like stress inoculation training or short-term psychodynamic psychotherapy? Why are non-trauma psychotherapies relegated to the back of the clinical research funding bus? Is there not room at the PTSD treatment table for interpersonal psychotherapy or mindfulness-based behavioral and cognitive therapies? Why does it seem like there is less focus on psychosocial rehabilitation than ever before? Do we no longer believe that teaching veterans how to communicate better with their loved ones or how to more effectively manage their finances can bring about ecologically relevant gains for them? And what about complementary and alternative therapies? When I talk to some of my colleagues about the potential benefits of meditation, yoga, and adventure therapy they struggle to keep a straight face. It's as if the notion of using anything other than interventions with multiple randomized controlled trials equates to heresy.

We have made important gains in the treatment of PTSD. We have a better understanding of which veterans are more likely to experience the disorder and why. But I hope we can move beyond our focus on just a few "mainstream" interventions and reductions in symptoms. To what degree does having fewer symptoms on a checklist even correlate with living a better and more fulfilling life? I'm not sure we know the answer.

BOOK REVIEW
BARUCH FISHMAN, PHD
HOW TO THINK LIKE A ROMAN EMPEROR: THE STOIC PHILOSOPHY OF MARCUS AURELIUS BY DONALD ROBERTSON

Baruch Fishman, PhD, is the Executive Director of the Cognitive Therapy Center of Manhattan, where he has a clinical practice. He received his Ph.D. from the University of Pennsylvania in 1984, where he also trained for three years at the Center for Cognitive Therapy under the direction of Dr. Aaron T. Beck. In 1994, Dr. Fishman founded the Cornell Cognitive Therapy Clinic at the Weill Cornell Medical College in Manhattan and served as the Executive Director for 19 years, until his retirement. Dr. Fishman is a certified cognitive therapist and a founding fellow of the Academy of Cognitive Therapy.

The history of modern Cognitive Therapy can be traced back to several philosophical traditions, but none is as important as the Stoic philosophy of the late Greek and Roman periods. While there have been many references to this tradition in the Cognitive Therapy literature, there had been relatively little scholarly elucidation of its fundamental and rich intellectual influence. Albert Ellis was an

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early and important exception when he based his REBT theory and techniques explicitly on Stoic philosophy. Donald Robertson has been the more recent exponent of the philosophical foundation of CBT, with several books such as The Philosophy of Cognitive-Behavioural Therapy and Stoicism and the Art of Happiness. In his most recent book, How to thinks like an Emperor, he weaves the substance and practice of Stoic philosophy with the biography of Marcus Aurelius, the Platonic "Philosopher King", into a highly engaging book for clinicians and clients alike.

The Stoic philosophers, in contrast to other Hellenistic traditions, conceived their philosophy explicitly as a form of psychotherapy. They were not interested in metaphysical and naturalistic investigations but solely in the question of how to live the Good Life. For them, the answer was to live in harmony with nature. They accepted that humans are natural, biological beings who share instincts and passions with the animals, but they emphasized that humans are "first and foremost thinking creatures, capable of exercising reason". Therefore, humans can evaluate decisions and regulate action in accordance with their values and enlightened interests, rather than passively react to external forces and internal urges impulsively. To achieve this, we humans need a good enough understanding of "the nature of things", a clear set of values or "virtues" to guide our conduct, and the actual skills to practice the "Herculean effort to keep to the right path". Following Socrates, the Stoics defined the cardinal virtues as: Wisdom, Justice, Courage, and Moderation. Wisdom is the key virtue that guides action in the social sphere (justice), and in the management of fears (courage) and desires (moderation). Wisdom refers to the discipline of clearly understanding matters such as of what we can control and what we cannot; What is real and what is imagined; What is passion fueled by instinct and what is consequential in the the objective world. But understanding alone is insufficient because both internal and external forces dominate human behavior. To learn to "bare and forbear" in the face of these pressures requires a daily, lifelong practice of self-training. This is not a vision a vision of a suppressed 'stiff upper lip" life, devoid of joy, affection and emotional experience, as the modern meaning of the term stoic implies. Robertson debunks this misconception by describing Stoicism as a philosophy of meaning, purpose, excellence, social connection and the authentic joy of the actualization of human potential.

Robertson uses the original language of the stoics, and particularly Marcus' book Meditations, to explain ideas and practices that he then connects directly to modern terminology and empirically based procedures. Among these are detailed prescriptions for how to define personal values, how to conquer desire, how to tolerate pain, how to relinquish fear and how conquer anger. Modern Cognitive Behavior therapists will find both ideas and techniques familiar when described in Robertson's contemporary language. One may nod and observe that "there is nothing new under the sun", but the book can also be seen as a map for coherent integration of the rich variety of behavioral and cognitive methods: from first wave behaviorism through Cognitive Therapy, and on to third wave approaches like acceptance, value-based commitment and mindfulness. For practicing clinicians there are plenty of specific ideas, observations and techniques that can inspire and enrich the practice of even the most experienced among us.

Finally, on a personal note, in recent years I have fused the "Philosophical Attitude" as a guiding framework with many patients. Robertson's previous books were an inspirational and practical guide for me as a clinician, but when patients asked for additional readings, I often came short. I am therefore delighted that I will be able to recommend this book as an accessible, engaging and practical guide for patients, as well as for anybody interested in living a fulfilling, free and self-determined life.

STANDING ON THE SHOULDERS OF GIANTS CONTINUED FROM PG. 3

I arrived at Penn with data I could mine from my early collaborations with Steve, and not much else. I was greeted with an incredible level of support from colleagues in clinical and in areas far from clinical. I was awed by how clearly and powerfully they thought through questions in their own research, and not a little overwhelmed by their expectation that I would do likewise. Social Psychologist John Sabini, a deep and creative thinker and very much a giant to me, became my "big brother/uncle." In our daily conversations he pushed me to articulate the essence of whatever research question I was working on. I can feel his influence this day, more than a decade since his untimely death. Martin Seligman, too, played a role in my development, but Penn Psychology did not and does not have areas, per se', so I learned from the likes of Robert Rescorla and Jacob Nachmias, both members of the National Academy of Sciences, but neither in areas remotely clinical. Dianne Chambless' arrival in our department, about half-way into my time at Penn, was a boon to our program and to me personally and professionally.

But talk about giants! Beginning in 1983, when Aaron T. (Tim) Beck was a young man of 61, I have had the honor and pleasure of frequent meetings with him to discuss whatever he is working on, as well as my latest ideas and plans. Through the years I have cherished my time with Tim, including many dozens of hours on the tennis court, and an equal number sitting on the side of the court in conversation. When Tim was no longer able to see the ball well enough to continue playing, in his late 80s, we shifted to weekly lunches, which continue to this day. What an inspiring and humble man! In his 70s he let me know that he wanted to develop a net game, and in his 90s he instigated a revolution in the way we think about, and help, individuals with chronic psychotic conditions. Now 97, he inquires each week about what I have been working on, and then asks for feedback from me on his latest theory or project!

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I have also been inspired throughout my career by incredible students who come to Penn to prepare themselves to make significant contributions to our field. Our program has fostered this goal, with its focus on research training, its insistence on engagement in research beginning day one, and our department's belief that narrowly focused training limits students' potential for "seeing the big picture" in whatever path they pursue. I am not one who enjoys the solitude of writing, though I do it. I prefer the back-and-forth that, with good colleagues or students, pushes ideas beyond what I could produce on my own. Early in my career Steve Hollon was a frequent interlocutor and co-author, often with one of my students as a third partner, and this continues today. Over the last two decades, many of my favorite papers and projects have relied on the passion, dedication, collaborative spirit, and talents of my students: working with Jacques Barber on the measurement of skills acquired in therapy; with Mike Feeley and Lois Gelfand on methods to disentangle cause and effect in the associations between therapist behaviors, the therapeutic relationship, and outcomes; with Tony Tang on "sudden gains;" with Dan Strunk on how cognitive therapy achieves its prevention effects; with Shannon Wiltsey-Stirman on the relevance of "ivory tower" clinical science for clinical practice; with Jay Fournier on patient characteristics that predict specific response to medications or to cognitive therapy; with Christian Webb and Lorenzo Lorenzo-Luaces on the nuances of the therapeutic alliance; and of late with Zach Cohen, Lorenzo again, Nick Forand, Jack Keefe, Colin Xu, and Tom Kim, on the pursuit of precision mental health. This latest work has brought me into contact with numerous European collaborators, including Marcus Huibers and Pim Cuijpers (The Netherlands), Steve Pilling, Jaime Delgadillo, and Barney Dunn (England), and Wolfgang Lutz (Germany), each of whom has enriched our work, as have the many students they have sent to my lab for extended visits, to learn from and collaborate with us.

I often think back to graduate school, when Paul Meehl let us know that anyone who could spend their life working in the academy would be crazy not to do so. Clinical research is not for everyone, but I count myself fortunate that I have been able to pursue of questions that seem to matter, and to have learned from so many giants and budding giants along the way.

IACP PRESIDENT'S COLUMN

CONTINUED FROM PG. 1

many Professionals involved in learning in order to reduce human suffering and pain by touching other people's lives.

As the last but not the least I would like to cogratulate Lynn McFarr, who has been elected as IACP President Elect, and Leslie Sokol, who has been elected as IACP Representative at Large and express IACP's distinguished board members' wish to invite you to become new members or renew your membership for IACP. We as board members are looking forward to serving you in any way we can.

Please do not hesitate to guide us to serve you better.

Warm regards,
Mehmet Sungur, MD
President of IACP

CBT IN PERU

CONTINUED FROM PG. 4

culturally diverse population in our country. It is central that CBT professionals delivering training programs in CBT have supervisor credentials and provide continuously CBT supervision to trainees, if we want to guarantee good quality and standards of CBT trainings as well.

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CBT AND NEUROLOGY

CONTINUED FROM PG. 5

(2000; 2001; 2005). CBT delivered via telephone has also been found to be effective (Mohr et al., 2001) and is an option for MS patients who struggle with motor symptoms that impact their ability to travel and for those patients who live in areas that do not have CBT providers. Computer based CBT for depression has been found to bring about some improvement in mild to moderate depression compared to wait listed patients (Fischer et al., 2015) but therapist -guided internet based interventions have reported better results (Johansson & Andersson, 2012). The studies examining CBT efficacy for treating depression in PD patients are few and also have

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limitations but they all suggest that CBT is beneficial, especially when it is tailored to the specific difficulties associated with MS.

Prevalence rates of anxiety disorders in MS patients have been reported to be as high as 21.9% (Marrie et al., 2015). However, research regarding CBT for anxiety in MS patients is a neglected area (Fiest et al., 2016). A significant part of treatment for MS is through self-injection and anxiety regarding self-injection has been found to impact treatment adherence negatively (Mohr et al, 2001). There have been some small studies that have examined the efficacy of CBT in treating self- injection anxiety and found it to beneficial. In one pilot study, all 8 participants showed significant improvement in their injection anxiety and were all injecting themselves by the end of 8 sessions and 7 out of the 8 subjects continued to do so at the 3 month follow up (Mohr et al., 2002). CBT by telephone was found to also bring about similar improvements (Mohr, Cox & Merluzzi, 2005).

Stroke and CBT

The most common psychiatric disturbances seen after stroke include depression and anxiety disorders (Cummings et al., 2006). Depression has been found to occur in about 40% of patients after an acute stroke (Robinson and Spalletta, 2010). Overall the literature indicates that post stroke depression is significantly associated with a poor prognosis (Robinson, 2006). Antidepressants have been found to be beneficial in the treatment of post stroke depression (Hackett et al., 2008; Mead et al., 2012). However high risk adverse effects such as intracerebral and intracranial hemorrhage have been reported to be associated with the use of antidepressant medications, such as selective serotonin reuptake inhibitors (SSRI) (Hackam and Mrkobrada, 2012).

Studies that have examined the efficacy of CBT in treating post stroke depression are limited with more studies being published in China than in the Western population (Wang et al., 2018). The RCTs carried out in China have reported a significant beneficial impact in treating post stroke depression (Yuan & Li, 2015; Zhou & Wang, 2015). The few RCTs conducted outside of China have used small to moderate sample sizes (Kootker et al., 2017; Lincoln & Flannaghan, 2003). The first meta-analytic study that examined the efficacy of CBT in treating post stroke depression was published in 2018 (Wang et al., 2018). Per their analysis Wang et al., reported that both CBT alone and CBT combined with antidepressants significantly improved depressive symptoms, response and remission rates in post stroke depression. They however advised that the results be interpreted with caution because of the potential bias and significant heterogeneity of the studies. Researchers have pointed out that post stroke depression is a heterogenous disorder (Kneebone & Dunmore, 2000) and also impacted by sociocultural factors (Chen et al., 2015; Jeon et al., 2014) and CBT should therefore be adapted and customized accordingly.

Epilepsy and CBT

Major depression has been reported as the most common psychiatric condition in patients with epilepsy and prevalence rates range from 3.9% in patients with controlled epilepsy to 20-55% in patients with recurrent seizures (Lyketsos, Kozauer & Rabins 2007). Patients with depression and epilepsy have been found to have a high rate of suicide (de Oliverira et al., 2011). The depression has also been reported to have a negative impact on seizure control (Cramer et al., 2003). Despite the high prevalence and negative consequences of co-morbid depression, it often remains untreated in patients with epilepsy (Kanner, 2009). The major barriers for the treatment of co-morbid depression by physicians has been identified as being the fear of antidepressant medications lowering seizure threshold and adverse drug interactions between antidepressants and antiepileptic drugs (Noe, Locke & Sirven, 2011).

Well-designed clinical trials of CBT for treating co-morbid depression in epilepsy patients have been limited. Many of the studies have also focused on seizure frequency, rather than depression for the main outcome. A Cochrane review on psychological interventions including CBT concluded there could be a possible beneficial impact on seizure frequency (Ramaratnam et al., 2008). There have been some better designed studies that focused on mood as outcome and reported that CBT reduces depression, and epilepsy related distress (Ciechanowski et al., 2010; Goldstein et al., 2003). Preliminary research has reported that CBT with a mindfulness component may be effectively delivered via internet or telephone and also in group format which would increase accessibility and cost effectiveness (Thompson et al., 2010; Macrodimitris et al., 2011). Even though good quality studies are limited the international consensus clinical practice statement for the treatment of neuropsychiatric conditions associated with epilepsy recommended CBT as the psychological treatment of choice for depression in individuals with epilepsy (Kerr et al., 2011). A later systematic review concluded that although the studies are limited and have methodological shortcomings the CBT interventions that were tailored towards improving depression were efficacious while those that focused on seizure control were not (Gandy, Sharpe & Nicholson, 2013).

Myasthenia Gravis (MG) and CBT

Depression and anxiety disorders are frequently reported among MG patients (Ybarra et al., 2011) and a higher prevalence of anxiety is found among patients with MG compared to patients with other chronic neurological illnesses (Lundeen et al., 2004). A high prevalence of insomnia is also reported (Qiu et al., 2010). Caution is advised in the pharmacological treatment of mood and anxiety disorders in MG patients because of the potential adverse reactions they can trigger, causing direct impairment of neuromuscular transmission or respiratory depression (Kulaksizoglu, 2007).

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Research investigating the use of psychological interventions to treat mood, anxiety and sleep disorders in patients with MG is almost non-existent. A recently published case study utilizing only CBT and no medications to treat anxiety, depression and insomnia in a MG patient indicated very beneficial outcomes that were durable (Chand & Kaminski, 2017). The outcome clearly underlined the utility of using CBT in treating MG patients in whom pharmacological treatment can place them at risk.

Discussion:

Research in the application of CBT for the treatment of co-morbid psychiatric symptoms that occur in patients with neurological disorders is limited but very promising.

Importantly, non-pharmacological approaches have been reported as being highly preferred by individuals with neurological disorders and co-morbid psychiatric symptoms (Oehlberg et al., 2008). The lack of adverse risk factors and side effects makes CBT a highly useful and beneficial treatment option for neurological patients with psychiatric co-morbidity. More awareness among neurologists about the utility of CBT would be crucial to ensuring that neurological patients gain the benefit of an effective non-pharmacological form of treatment for psychiatric co-morbidity.

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CO-COMPULSING WITH OCD PATIENTS

CONTINUED FROM PG. 6

voices of the mind that we have called Worried Voice and False Comfort (Winston & Seif, 2017)–in an ongoing and ultimately fruitless struggle to banish anxiety. Anything that lowers anxiety after an obsession has the potential to reinforce that obsession, so rational self-talk, calculating probabilities, distracting oneself, and many other traditional anxiety management and second wave CBT techniques often result in increased symptomatology.

Here is where we need to change our traditional ways of doing therapy. Much of what many therapists do for OCD sufferers actually worsens the problem. Empathic reassurance, rational disputation, and coping skills to manage anxiety only serve to refuel the obsession by providing temporary relief. When we enter into and become entangled in the content of the worries, we give the client the message that their obsession is important and intolerable, that there might be some meaning behind the symptom, and that mental intrusions must be fixed. We reinforce the idea that a worry might be a wish, a signal, a warning or "a message from below," instead of just a false alarm. Our own interventions can serve as compulsions that reinforce and power the next round of obsessive intrusions. We call this circular process *co-compulsing*.

We define *co-compulsing* as inadvertently providing unhelpful reassurance or comfort that masquerades as empathy, analysis, rational discussion, suggested coping skills, or factual reminders.

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Your patient might talk about an obsessional issue or problem and you provide her with a reframe or some reassurance—which gives comfort. The patient feels much better during that session, but the issue soon comes up again....perhaps in a slightly different version.... but the issue seems unresolved, and perhaps unresolvable. Treatment continues as if the content of the doubts are worth exploring and that abolishing doubts or finding a solution or an insight will fix the distress. There is no long term resolution, and this circular process only reinforces your patient's need to figure it out. If you have a patient whose treatment feels like "Groundhog Day", you might have inadvertently become involved with co-compulsing.

Empathy and reassurance come naturally to therapists. It's tempting to tell a client who is obsessed about a mistake he's made that others would forgive him, or to remind him compassionately that we're all human. When a client worries constantly that his husband's upcoming surgery might kill him, it would seem supportive to say, "That doctor is highly skilled and has an excellent success rate." We can easily miss that we're caught up in *co-compulsing*. As we dignify unanswerable questions and attempt to provide certainty or empty reassurance, we teach the patient ever more elaborate cognitive compulsions.

As an example, a patient might say, "I know this sounds crazy, but I've become terrified that my friend will be hurt if I don't put the soap back the right way while taking a shower. Sometimes I get stuck there for hours." We might want to say, "Doesn't that seem incredibly unlikely? When was the last time you hurt someone with your thoughts?" But the act of trying to explore or argue rationally with the anxiety-provoking thought gives it too much importance. Rather than looking at the thought as a harmless and absurd pop-up that sets off a false alarm, we have increased obsessive entanglement with content and have inadvertently supplied a new cognitive compulsion. The patient will soon find that repeating to herself "what is the likelihood that I will harm my friend? " will not reduce her shower time. This is true whether the obsession seems ego-syntonic and consistent with their values, such as "Will my children be happy?" or ego-dystonic and abhorrent, such as "What if I killed someone while driving and didn't notice?"

Are there times when discussion of an issue is helpful? Of course! If a discussion leads to a decision, a resolution, or an action plan and is put to rest, the worry was not an obsession. It's always worth it to try traditional anxiety management techniques once or twice. If they work, then there is no need to look further. But when discussions of a client's worries go round and round, session after session, the content of the worry is likely irrelevant, and the most therapeutic approach is to explain what is happening to the patient ("The good news is I have figured out why this is not working! This is a highly treatable form of OCD"), stop *co-compulsing*, move to the meta-level, and teach the patient a new relationship with their thoughts.

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