ADVANCES IN Cognitive Therapy newsletter

June, 2017

IACP Vol 17, Issue 2 / ACT Vol 18, Issue 2

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

EDITOR
Jamie Schumpf, Psy.D.

ACT PRESIDENT'S MESSAGE

I am delighted to report that the Board of the Academy of Cognitive Therapy just completed a successful strategic planning meeting on May 8th and 9th, 2017 in Philadelphia. I want to thank John Williams (Past-President), Lynn McFarr (President-Elect), Elaine Elliott-Moskwa (Secretary), Allen Miller (Treasurer), Steve Holland (Rep-at-Large), Brad Richards (Rep-at-Large), and Leslie Sokol (Rep-at-Large) for working with me to enhance the future of the Academy. Among other things, the Board modified the Academy's mission to reflect the multidisciplinary growth of our membership and our increased efforts in disseminating and implementing CBT. We also discussed the values that guide the Academy such as dissemination of research, excellence in dissemination and implementation of evidence-based treatments, outcomes monitoring, fostering a vibrant, intellectual community, pluralism, increasing access of care for diverse populations, and maintaining high standards in credentialing and ethics.

The Board reflected on a variety of goals for the Academy such as striving for increased excellence in credentialing, training, dissemination and implementation for professionals, increasing our efforts to conduct competency credentialing for clinicians, and to conduct calibration, competency coding for clinicians, training and research organizations, in both private and public health systems. We discussed ways to increase benefits for our credentialed clinicians and trainers, and to build and sustain our online practice directory. Advocating for the continued importance cognitive theory and therapy as a stand-alone intervention and as integrated with other CBT approaches continues to be a core value for the Academy.

The Board also met with Aaron T. Beck, Judith Beck, and Robert Leahy to discuss the benefits of a closer alliance with the International Association of Cognitive Psychotherapy. Both ACT and IACP have a shared vision, shared goals, and aligned interests to promote excellence in CBT, and are highly compatible in terms of culture and values. We look forward to working with IACP to ensure that the legacy of cognitive therapy is unified and maintained for generations to come.

Please visit our website (www.academyofct.org) to learn more about what the Academy can do for you and what you can do for the Academy and for our field. I want to thank the members for giving me the opportunity to serve the Academy. I look forward to serving you. Please contact me if you have suggestions or comments about the Academy, or to learn more about the Academy's Training Program.

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

CONTENTS

TOWARD INTEGRATIVE CBT: IMPLICATIONS FOR SCIENCE AND PRACTICE – THE 9TH CONGRESS OF THE INTERNATIONAL ASSOCIATION FOR COGNITIVE PSYCHOTHERAPY

DANIEL DAVID, PH.D.

Dr. David is President of the Congress and Professor Professor of clinical cognitive sciences at Babes-Bolyai University, Cluj-napoca, Transylvania, Romania and adjunct professor at Icahn School of Medicine at Mount Sinai School of Medicine, New York, USA.

Cognitive-behavioral therapy (CBT) is an umbrella for a large number of evidence-based psychological treatments. CBT is therefore becoming the golden standard in the field of psychotherapy. This Congress will aim to: (1) present the state of the art applications of CBT in a large variety of clinical and non-clinical contexts; (2) present the latest research in the field with powerful clinical implications; (3) increase the internal cohesion of CBT, by moving the field from various "schools" to an integrative and multimodal approach; (4) promote CBT as the best platform for integrating psychotherapy in the evidence-based framework; and (5) stimulate frontier research in CBT and infuse CBT with frontier research from related fields.

For 2017, the International Association of Cognitive Psychotherapy/IACP has decided that the 9th edition will take place in Cluj-Napoca, Transylvania, Romania. Probably the first congress of CBT was the meeting organized in New York in 1976, followed by other major CBT meetings (e.g., Philadelphia in 1983) as precursors of the future world/international congresses. Previous editions of the IACP's Congress were organized in important academic centers, such as Umea (Sweden, 1986), Oxford (UK, 1989), Toronto (Canada, 1992), Catania (Italy, 2000), Gotenborg (Sweden, 2005), Roma (Italy, 2008), Istanbul (Turkey, 2011), and Hong Kong (China, 2014). Between 1992 and 2005 some of the IACP's Congresses were merged with the World Congress of Behavioral and Cognitive Therapies/WCBCT (Copenhagen, Denmark 1995; Acapulco, Mexico, 1998; Vancouver, Canada, 2001; Kobe, Japan, 2004) and since 2005 it has been again organized as an independent world congress of the IACP, coordinated with the WCBCT (where IACP is also one of the organizers). The organizing consortium is comprised of: (1) International Association for Cognitive Psychotherapy (http://www.the-iacp.org/); (2) Romanian Association of Cognitive and Behavioral Psychotherapies (http://www.psihoterapiecbt.ro/); (3) Department of Clinical Psychology and Psychotherapy of Babes-Bolyai university (http://www.clinicalpsychology.ro and http://www.ubbcluj.ro); and (4) International Institute for te Advanced Studies of Psychotherapy and Applied Mental

(CONTINUED PG. 12)

MESSAGE FROM THE EDITOR: ADVANCES IN COGNITIVE THERAPY

NEWSLETTER EDITOR: JAMIE L. SCHUMPF, PSY.D.

Welcome to the Advances in Cognitive Therapy, a joint publication of the Academy of Cognitive Therapy (ACT) and the International Association of Cognitive Psychotherapy (IACP) and a benefit of membership for both organizations. Our newsletter is published three times a year (February, June, and October) and features a variety of articles on clinical issues, advances in research, conference and training information and often includes a few specialty columns. For example, in this month's issue we feature an article on how CBT is practiced in India. We are also lucky to have a notable clinician/researcher in the field write about his or her influences for our column titled, "Standing on the Shoulders of Giants." This issue features Dr. Steven Hayes, known for his work in Acceptance and Commitment Therapy. In our last issue we featured a book review and will be doing another book review in the Fall. If anyone is interested in being a book reviewer or having a new publication reviewed, please contact me.

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, 2017. 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.

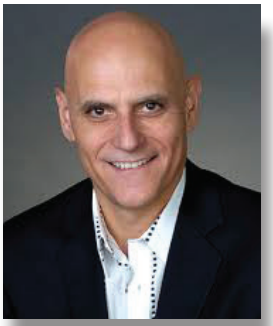
I look forward to hearing from you all!

Best,
Jamie

STANDING ON THE SHOULDERS OF GIANTS

WALKING THROUGH THE OPENED DOOR: MY CAREER LONG PURSUIT OF A USEFUL BEHAVIORAL APPROACH TO HUMAN COGNITION

STEVEN C. HAYES, PH.D.



Steven C. Hayes is a Foundation Professor of Psychology at the University of Nevada. An author of 45 books and nearly 600 scientific articles, he is especially known for his work on Acceptance and Commitment Therapy (ACT) and its underlying theory of language and cognition, Relational Frame Theory (RFT). Dr. Hayes has received several national awards, such as the Lifetime Achievement Award from the Association for Behavioral and Cognitive Therapy, and is ranked among the top most cited psychologists in the word.

As a lifelong behaviorist, is it surprising to be asked to provide an intellectual autobiography to the newsletter of the Academy and IACP? Perhaps, but I would prefer think it reflects a certain maturing in the interrelated journey of cognitive therapy and contextual behavioral science.

Classic behaviorism tried to close off psychology to the study of cognitive events, on both metaphysical and methodological grounds. The Skinnerian wing rejected that idea and opened wide the door to their analysis (Skinner, 1945). Unfortunately, few outside of the Skinnerian tradition would have any reason to know that fact, since behavior analysts were soon frozen in place by Skinner's brilliantly inadequate approach to the topic (1957). I've spent much of my academic life trying to undo that error -- finding a way to walk through that opened door in a behaviorally sensible way.

The answer I eventually reached (Relational Frame Theory or "RFT" -- Hayes, Barnes-Holmes, & Roche, 2001) is novel and broad in its implications: human cognition is not associative, it is relational and learned. Overtime it appears to have helped change a situation in which "behaviorism" could be taken in an unqualified way to mean "without a serious approach to cognition." Acceptance and Commitment Therapy (ACT: Hayes, Strosahl, & Wilson, 1999) is an important applied extension. There are now a few hundred studies testing RFT ideas in additional empirical programs ranging from language learning to improving IQ, from establishing perspective taking in disabled children to the assessment of implicit bias (O'Connor, Farrell, Munnelly, & McHugh, 2017). Therapists can use RFT without involving themselves in ACT per se (Villatte, Villatte, & Hayes, 2016) and major cognitive scientists agree that it can be used to address mainstream topics there (e.g., De Houwer, 2012). The term "contextual behavioral science" (CBS) has come to refer to those behaviorists who take this functional approach to cognition seriously (Zettle, Hayes, Barnes-Holmes, & Biglan, 2016). It's core international organization is about 8,200 people strong with 27 chapters around the world (www.contextualscience.org).

I have built my life as a psychologist around efforts like this: call it the squaring of circles. I decided to be a psychologist in high school because it touched my interests in art and literature on the one hand, and experimental science on the other. In college, I read and loved Maslow, Perls, Suzuki, and Watts but was also totally captivated by Skinner's Walden Two; I edited the college literary magazine, and yet established a rat colony in the attic of the science building, conducting and successfully publishing animal operant research. I got my doctoral clinical degree at West Virginia University under behavioral assessment pioneer John Cone, while working with basic and applied behavior analysts (Rob Hawkins, Andy Lattal, and John Krapfl), but I also worked with basic cognitivists and cognitive behavior therapists (Hayne Reese and Norm Cavior).

I was in David Barlow's first internship class at Brown in '75-76 (himself a circle squarer as a former editor of the Journal of Applied Behavior Analysis and a well-known CBT researcher). I consider John Cone and David Barlow to be my primary mentors. Through John I can trace my academic lineage to the University of Chicago and the functional school; through David to the very first behavior analysts impacted by B. F. Skinner, and eventually to William James.

During my years as a faculty member at the University of North Carolina at Greensboro (1977-1986) I worked with another behavioral assessment pioneer, Rosemery Nelson-Gray, but also ran my lab with the most brilliant basic behavior analyst I ever met, the late Aaron Brownstein. I continued to explore eastern and human potential ideas, including the est training after seeing it profoundly impact various well-known behavior analysts and behavior therapists in the late 1970's including John Cone. When I developed a panic disorder, it was eastern and human potential ideas that I found most helpful, not just my behavioral and cognitive behavioral training (see www.bit.ly/StevesFirstTED). Fascinated, I threw effort into the development of ACT on the one hand, and a search for a more adequate approach to human cognition on the other.

By 1982 I was doing ACT workshops and studies but most of these stayed in the file drawer until after the turn of the century while we explored a more basic understanding. In the 1980's my lab ran and published eight studies finding that cognitive methods did indeed work, but not in ways the traditional model predicted. We conducted several basic studies finding verbal rules produced a startling insensitivity to experience. Working with Brownstein, the core idea inside RFT (derived relating is learned as an operant, but alters how operant and classical conditioning works) was developed

(CONTINUED PG. 9)

COGNITIVE-BEHAVIORAL COUPLE THERAPY

NORMAN B. EPSTEIN, PH.D.

Dr. Epstein is a pioneer in the development of cognitive-behavioral therapy with couples and families. His research, writing, teaching, and training of clinicians have focused on cognitive processes in relationship adjustment and dysfunction, assessment and treatment of intimate relationships, couple and family coping with stress, cross-cultural studies of couple and family relationships, and treatment of psychological and physical aggression in couple relationships. He focuses on cultural sensitivity in the practice of couple and family therapy, including the adaptation of Western-derived therapy models for appropriate use in other cultures.

Although cognitive therapy was developed to treat problems in individuals' personal functioning such as depression and anxiety disorders, many of the distressing life events that individuals present involve relationships with significant others. However, individual cognitive therapy for relationship problems has been limited in impact because members of a couple commonly are stuck in patterns of negative behavioral interaction that the therapist cannot access. Initially, Epstein (1982), Beck (1988), Ellis et al. (1989), and Dattilio and Padesky (1990) addressed relationship problems by applying cognitive therapy principles jointly with members of distressed couples. At the same time that cognitive therapy models were emerging, behavioral marital therapy based on social learning principles (e.g., Jacobson & Margolin, 1979) was gaining momentum. The concept of functional analysis played a role in development of micro-level assessment of couple interactions. Dyadic patterns such as one partner pursuing and the other withdrawing were found to be destructive. Conjoint therapy was focused on reducing exchanges of negative behavior and increasing pleasing actions.

The focus of cognitive therapy on individuals' subjective experiences of their relationships and the focus of behavioral marital therapy on overt interactions provided complementary components for an integrative cognitive-behavioral couple therapy (CBCT). Baucom and Epstein (1990) and Rathus and Sanderson (1999) emphasized the interplay among cognitions, affect and behavior. Family systems concepts such as circular causality were applied to understand negative dyadic patterns, although systemic thinking holds each individual responsible for his or her own harmful acts.

Subsequently, Epstein and Baucom (2002) developed an enhanced CBCT with a broader contextual perspective in which a couple's functioning is influenced by multiple system levels, ranging from each partner's traits to environmental stresses such as economic problems. The model also includes a stress and coping component in which a couple's success depends on their ability to cope with life demands. Furthermore, it pays significant attention to partners' emotional responses; those with deficits in awareness or expression of emotions can be coached in mindfulness techniques and communication skills, whereas those who have difficulty regulating emotions can be guided in self-soothing approaches and stress reduction self-talk (Epstein & Baucom, 2002).

Initially the "bottom line" goal of CBCT was to improve overall relationship satisfaction. However, empirically supported applications of CBCT have expanded dramatically in two major domains: (a) couple interventions for problems in individual functioning (e.g., depression) and (b) interventions for specific relational problems (e.g., partner aggression) (Epstein, Dattilio, & Baucom, 2016).

Expanding Clinical Applications of CBCT

CBCT for Individual Mental and Physical Health Problems

Depression. Based on evidence of a bi-directional link between relationship distress and depression, couple interventions were designed to decrease negative behavioral interactions and enhance mutual emotional support. Studies indicated that when individuals experienced both problems, couple therapy reduced both but individual cognitive therapy did not reduce relationship distress (Whisman, 2013).

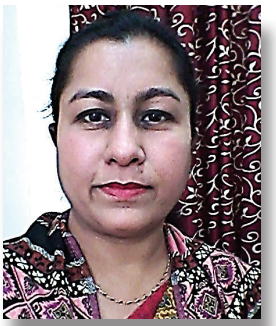
Substance abuse. O'Farrell and his colleagues (Birchler, Fals-Stewart, & O'Farrell, 2008) developed and found empirical support for a combination of behavioral couple therapy and individual substance abuse interventions (e.g., self-help meetings, medication to inhibit drinking). The couple therapy has foci including increasing pleasing and caring behavior, increasing shared rewarding activities, improving communication and problem-solving, avoiding physical aggression, and generally attending to the present rather than past problems.

Anxiety disorders. CBCT has been applied as an adjunctive intervention with standard CBT anxiety treatments. Chambless (2012) uses couple therapy that includes: psychoeducation about characteristics of anxiety and couple interactions; communication and problem-solving training; preparation for coping together with symptoms; and strategies to reduce couple accommodation to the symptoms (e.g., a partner taking over an agoraphobic individual's activities that require leaving the house). Abramowitz et al. (2013) developed couple-based exposure and response prevention interventions for obsessive-compulsive disorder, including psychoeducation about exposure and response prevention, and guiding the couple in engaging in exposure together, with the partner coaching the symptomatic person. Finally, Monson and Fredman's (2012) cognitive-behavioral conjoint therapy for PTSD includes psychoeducation about mutual influences between

(CONTINUED PG. 11)

CBT IN INDIA

NIMISHA KUMAR, M.A., M.PHIL, PH.D., MSC IN CBP



Dr. Kumar is a Clinical Psychologist and is the Founding President of the Indian Association for Cognitive Behaviour Therapy (IACBT). She is an Assistant Professor in Psychology at the Centre for Early Childhood Development and Research (CECDR) in New Delhi.

CBT is 'the' evidence-based psychological intervention, which is most widely practiced, researched and disseminated throughout the world. It is extensively used in India as well but there has been a lack of systematised structures for CBT practice, training and research. A large majority of the Indian mental health practitioners use CB techniques in their 'eclectic' practice, however there has been an absence of a portal which can help in connecting, sharing and developing this common interest area.

India is one of the most ancient civilizations, a land of myriad contrasts with Unity and Diversity as its hallmark. Counselling/ Psychotherapy has had a long tradition here symbolised in the days of the Epic Mahabharta, the great historical war between the cousins - Kaurawas and Pandavas, mediated by Lord Krishna, the legendary 'counsellor'. Psychotherapy as a professional field has often been criticised for being a 'westernised' approach in a land where listening, guiding and helping has been part and parcel of our basic societal fabric.

India is also amongst the fastest growing economies in the world. It is in a state of transition between massively transformed and 'modern' lifestyles on one hand and the influence of traditional values, customs and mind-set on the other. In view of the current realities of urbanization-modernization, cross-national migration, increased violent conflict, un-rest and displacement, as well as rapid societal transformation, the biggest challenges that have been posed to mental health treatment approaches concerns with cross-cultural relevance, adaptability and applicability to multi-ethnic and increasingly complex communities. Over the last few decades, the demand and 'space' for 'evidence-based' non-pharmacological approaches to mental health treatment has been created even amongst the collectivistic societies of the world, which have traditionally been dependent on strong family ties and social support networks for addressing their emotional needs and interpersonal conflicts.

However, the lack of systematised institutional mechanisms to regulate practice, training and supervision and the virtual absence of large-scale scientific research, has resulted in the scenario where Indian mental health services, particularly Counselling and Psychotherapy, are still largely unorganised and grossly inadequate to meet the requirements of the times. There continues to be a major dependence on traditional, alternative and faith-based treatments in the non-urban areas, and a preference for psychiatric (medication-based) treatments in urban areas. Training and Supervision in CBT are limited to the few hospital-attached mental health Institutes in India such as NIMHANS, CIP and IHBAS as well as some privately funded Universities.

Evidence-based and culturally suited interventions are being developed and researched in Western countries but India still lags significantly behind. In India, there has been a blind copying of western models of psychotherapy which has been criticized as well as at the same time a neglect of the traditional and indigenous extremely rich texts and resources on mental health which are either perceived to be too challenging to decipher or 'old fashioned' to use.

In such a challenging context, the Indian Association for Cognitive Behaviour Therapy (IACBT) has been set up in 2016 with the goal of promotion of evidence based mental health intervention in the country and to get together mental health and related professionals on the same platform for professional training, practice and research in the field. IACBT envisions to put India on the global mental health map through intensive networking, evidence-based practice and meaningful research. We are fortunate to have the support and guidance of Dr. Lata K. McGinn, our Honorary President and Former President of the International Association for Cognitive Psychotherapy (IACP), New York. We have organized two successful International Conferences on CBT in 2015 and 2017 with wide participation from within India and special invitees from UK, US and Australia. We have recently become a member of the Asian CBT Association and hope to contribute meaningfully in the region for the development of evidence-based therapies within our unique cultural context and specific requirement of our populace. In addition, being a developing country and lacking financial resources, we hope to get guidance and support from colleagues in the West in developing structures for CBT Practice and Training in India.

ADVANCES IN THE TREATMENT OF SUBSTANCE USE DISORDER AND ADDICTIVE BEHAVIORS WITH CBT

BRUCE S. LIESE, PHD

BECAUSE IF YOU ARE A PRACTICING COGNITIVE THERAPIST, YOU ARE TREATING PEOPLE WITH ADDICTIONS.

Dr. Liese is a Professor of Family Medicine and Psychiatry at the University of Kansas Medical Center and Courtesy Professor of Clinical Psychology at the University of Kansas. He completed post-doctoral training at the Center for Cognitive Therapy under the supervision of Dr. Aaron T. Beck and has co-authored two texts on addictions with Dr. Beck. He serves as President-elect of APA Division 50 (Addiction Psychology). Dr. Liese is a researcher, teacher, clinical supervisor, and clinician. His work focuses primarily on the diagnosis and treatment of addictive behaviors and, over time, he has supervised hundreds of cognitive-behavioral therapists.

> *"Tom" is a 32 year-old man receiving cognitive-behavioral therapy (CBT) for social anxiety. After developing trust in his therapist, Tom admits that he has been self-medicating with daily marijuana use. He understands that his marijuana use is likely a problem but says, "I can't even think about quitting until my anxiety is under control."*

Identifying and conceptualizing SUDs and addictive behaviors with CBT

CBT for substance use disorders (SUDs) and addictive behaviors is remarkably similar to CBT for other psychological and behavioral problems. It begins with identification of patients' problems and formulation of comprehensive case conceptualizations, followed by psychoeducation and structured techniques aimed at modifying self-defeating thoughts, beliefs, and behaviors (Beck, Wright, Newman, & Liese, 1993; Liese, 2014; Liese & Tripp, in press; Wenzel, Liese, Beck, & Friedman-Wheeler, 2012). The basic model of CBT for SUDs and addictive behaviors is presented in the figure 1 (see below).

As with other psychological and behavioral problems, SUDs and addictive behaviors tend to manifest as cyclic processes that begin with triggers (i.e., high-risk stimuli). These triggers activate learned addiction-related thoughts and beliefs, which lead to urges to engage in immediately gratifying but ultimately self-defeating behaviors. And despite countless opportunities to abstain from addictive behaviors, individuals with SUDs and addictive behaviors give themselves permission to lapse and ultimately relapse.

Needless to say, identifying a SUD or addictive behavior might not be as straightforward as identifying depression or anxiety. Addictive behaviors begin as rewarding activities and they continue to be associated with reward long after they have become self-defeating. Hence, individuals with addictions may be reluctant to admit to addiction problems for fear they might be pressured to abstain before they are ready to do so. Another factor that interferes with admitting to SUDs and addictive behaviors is stigma, which may be external (social stigma) or internal (self stigma). Patients who stigmatize themselves may be ashamed to admit that they have addictions. And therapists, who themselves are fallible human beings, might risk stigmatizing patients as a result of their own implicit biases about people with addictions. For example, they may hold beliefs like, "People with addictions never change" or "People with addictions are impossible to treat." A manifestation of this implicit bias is labeling. Over the years it has become apparent that labels like "addict" and "alcoholic" are not useful. Even terms like "denial" may not be useful, especially given the fact that individuals who struggle with addictions typically spring back and forth between the various stages of change (i.e., precontemplation, contemplation, preparation, action, maintenance, and relapse).

It is also important to note that the diagnosis of a SUD or addictive behavior is not dichotomous (i.e., black and white; all or none). Instead, addictive behaviors range from mild to severe and, especially when they are mild, they are easily eclipsed by other mental health disorders (e.g., social anxiety). In one of his CBT sessions Tom freely talked about his marijuana use. He readily admitted to three DSM-5 marijuana use disorder symptoms: smoking more than he intended (i.e., daily), unsuccessful efforts to cut down, and craving when trying to reduce consumption. According to DSM-5, the presence of two or three symptoms indicates that Tom has a mild marijuana use disorder. He maintains that he has not failed to fulfill major role obligations, he hasn't given up any important activities to smoke marijuana, nor has he used in ways that are necessarily hazardous.

Treating SUDs and addictive behaviors with CBT

CBT for SUDs and addictive behaviors is most effective when delivered in the context of collaborative therapeutic relationships. Therapists who are caring, patient, empathic, and willing to fully conceptualize their patients with addictions are likely to achieve collaboration. Collaborative goal setting is an essential component of CBT, and goals for each patient are inevitably different. Some patients wish to fully abstain from addictive behaviors while others wish to merely reduce harm associated with their addictions. To be effective, therapists must understand that imposing their own goals on patients is likely to damage the collaborative therapeutic relationship.

CBT sessions are well structured and they incorporate substantial amounts of psychoeducation and structured techniques. Psychoeducation can vary from teaching patients the symptoms

(CONTINUED ON NEXT PAGE)

of addictive behaviors to helping them understand the role of thoughts and beliefs in maintaining addictive behaviors. Perhaps the most important single technique used in CBT for addictive behaviors is functional analysis. Functional analyses are guided discussions wherein therapists help patients to better understand the intricate steps and choices that ultimately lead to lapses and relapses. The model presented in the figure above can be useful in this regard. Tom found it helpful to review his marijuana use by means of this figure, and he confirmed that most of his use was triggered by anxiety (and especially fear of becoming anxious in social situations), followed by the thought "Smoking weed always makes me feel better." Over the course of CBT with his therapist, Tom learned to use cognitive and behavioral strategies for reducing his anxiety, and ultimately he was able to curb his use by "surfing" through urges and focusing on his own good thoughts and feelings about being independent from marijuana.

Lessons learned and recommendations for treating individuals with SUDs and addictive behaviors

Most of the advances in CBT for SUDs and addictive behaviors have been learned from treating thousands of individuals with addictions over the past quarter century. Here are seven of these lessons, along with specific recommendations:

(1) Screening for addictions is essential in any CBT practice. If you are a practicing cognitive therapist you are treating people with SUDs and addictive behaviors. So screen all patients for SUDs and addictive behaviors – or you will fail to treat these problems that may underlie or exacerbate other mental health problem you are trying to treat.

(2) A well-formulated case conceptualization is essential, and it is especially important to integrate readiness to change and the function of addictive behaviors into the case conceptualization.

(3) Motivational interviewing (MI) is necessary when individuals do not readily recognize the damage incurred by their addictive behaviors. In fact, the processes of acceptance and empathy, so central to MI, should also be integral to CBT for all mental health problems.

(4) CBT for SUDs and addictive behaviors is remarkably similar to CBT for other disorders. It involves functional analyses (i.e., identification of thoughts, feelings and behaviors that all trigger or influence each other). It also involves teaching skills for modifying these processes.

(5) Be careful not to judge individuals with addictions, even implicitly, and avoid language that stigmatizes them. For example, do not call them alcoholics or addicts, and do not view them as being in denial when they are actually in the precontemplation stage of change, and likely to move in and out of contemplation over time.

(6) Do not fall prey to the all-or-none belief that the only good outcome is abstinence. Positive lifestyle changes, improved relationships, harm reduction, and improved coping skills, are all reasonable outcomes when working with people with SUDs and addictive behaviors.

(7) Do not allow yourself to get discouraged. Treating people with SUDs and addictive behaviors is not necessarily more difficult than treating people with other mental health concerns (e.g., anxiety and depression) and it is certainly not futile – as some therapists believe it to be. It's actually very rewarding!

References:

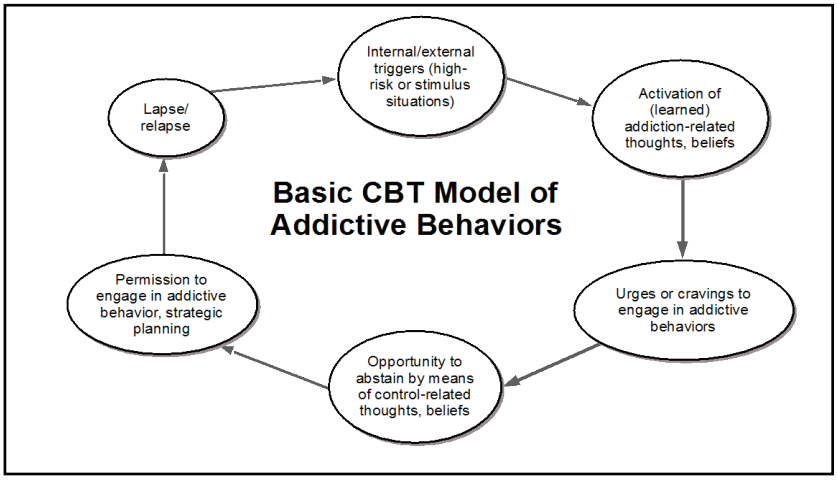
Beck, A. T., Wright, F. D., Newman, C. F., Liese, B. S. (1993). *Cognitive therapy of substance abuse.* New York: Guilford Press.

Liese, B. S. (2014). Cognitive-Behavioral Therapy for Addictions. In S.L.A. Straussner (Ed.), *Clinical work with substance abusing clients* (3rd ed.; pp. 225-250). New York: Guilford Press.

Liese, B. S., Tripp, J. C. (In press). Cognitive-behavioral therapy for addictive behaviors. In R. L. Leahy (Ed.), *Science and Practice in Cognitive Therapy: Foundations, Mechanisms, and Applications.* New York: Guilford Press.

Wenzel, A., Liese, B. S., Beck, A. T., Friedman-Wheeler D. G. (2012). *Group cognitive therapy of addictions.* New York: Guilford Press.

FIGURE 1



MENTAL IMAGERY IN MENTAL DISORDERS: FROM EMOTIONS AND DEPRESSION TO USING IMAGERY TO CHANGE PEOPLE'S BEHAVIOUR

FRITZ RENNER, PH.D. & EMILY HOLMES, PH.D., DCLINPSYCH

Dr. Renner is a Marie Curie Fellow working in the Emotional Disorders and Mental Imagery Group at the MRC Cognition and Brain Sciences Unit in Cambridge (Holmes Group). He is an experimental psychologist and his research is on the impact of mental imagery on behaviour with a focus on developing experimental interventions that target behavioural aspects of depression. His research is supported by a Marie Skłodowska-Curie Individual Fellowship from the European Union.

Before joining the MRC Cognition and Brain Sciences Unit he was based at Maastricht University, the Netherlands, Department of Clinical Psychological Science where he completed his PhD in 2014 'Chronic Depression: An integrative approach to the study of underlying vulnerability factors and psychological treatment'. He completed part of his research training at the University of Pennsylvania. His current research investigates the relationship between mental imagery and behaviour. Understanding how mental imagery can impact behaviour can help inform the development of new interventions, for example for depression by targeting behavioural aspects of depression.

Dr. Holmes is a Professor at the Karolinska Institutet's Department of Clinical Neuroscience, Sweden since 2016. Her field is mental health and experimental psychopathology, with a focus on psychological treatment innovation. Her interdisciplinary research places cognitive science alongside clinical psychology, psychiatry and neuroscience to investigate psychological processes. Her work in post-traumatic stress disorder (PTSD), Depression and Bipolar Disorder is linked by an interest in mental imagery and emotion.

Dr. Holmes received her degree in Experimental Psychology at the University of Oxford. She completed her clinical psychology training doctorate at Royal Holloway University of London, and a PhD in Cognitive Neuroscience in Cambridge. She is a Visiting Professor of Clinical Psychology at the University of Oxford and holds an Honorary Scientific Appointment at the MRC Cognition and Brain Sciences Unit in Cambridge. Her work has been recognized by the British Psychological Society's Spearman Medal (2010), Humboldt Foundation Friedrich Wilhelm Bessel Research Award (2013), and the American Psychological Association (2014). She is Associate Editor of "Clinical Psychological Science".

Mental imagery is often described as seeing with the mind's eye, hearing with the mind's ear and so on (Kosslyn, Ganis, & Thompson, 2001). It allows us to re-experience the past and pre-experience the future. Images recalled from memory give rise to as-real experiences in the absence of sensory input. People use mental imagery in day-to-day life, spontaneously or deliberately, for example when thinking about the past or planning the future.

Why is mental imagery important for psychopathology and its treatment? The importance of mental imagery for psychopathology has long been recognized. As noted early on by Beck (1970), "Sometimes, the cognition may take a pictorial form instead of, or in addition to, the verbal form", describing a case where "the anxiety was preceded by a pictorial image" (Beck, 1970, p. 348). These early ideas about mental imagery and its relationship to emotion (e.g. negative imagery leading to anxiety) have now been put to rigorous empirical testing: Experimental studies have shown that mental imagery, compared to verbal processing of the same information, indeed works as an 'emotional amplifier' for positive and negative information (e.g. Holmes, Lang, & Shah, 2009; Holmes & Mathews, 2005).

What is so special about mental imagery? Neuroimaging studies have shown that mental imagery processing involves the same underlying brain structures that are involved in actual perception (Kosslyn et al., 2001; Pearson, Naselaris, Holmes, & Kosslyn, 2015). The same is true for other modalities: when imagining specific motor movements, the same brain areas that are involved in the actual movements are activated (Kosslyn et al., 2001). These findings from neuroscience demonstrate that mental imagery can indeed mimic real-life perceptual events which helps to explain why imagery can have a strong impact on our emotions and behaviour. Given the special relationship between mental imagery and emotions it is intriguing to study mental imagery in emotional disorders.

Mental imagery in emotional disorders: implications for treatment
Mental imagery plays an important role across different emotional disorders (for a review: Holmes & Mathews, 2010). In depression, for example, mental imagery can take the form of intrusive negative imagery, for example scenes of past childhood aversive events popping into mind involuntarily. Individuals with depression might also struggle to imagine anything positive happening to themselves in the future, i.e. they might experience a lack of positive future imagery (for a recent review of mental imagery in depression see: Holmes, Blackwell, Burnett Heyes, Renner, & Raes, 2016). Mental imagery dysfunction in depression and other emotional disorders can be targeted in traditional forms of psychotherapy as well as possibly by novel computerized, therapist-free, treatment approaches though these require further development (Holmes et al., 2016).

We need to ask about imagery in assessments: Although mental imagery

(CONTINUED ON NEXT PAGE)

techniques have been recognized in various psychological therapies, such as Cognitive Therapy, in practise Cognitive Therapy has tended to focus on assessment and treatment of verbal cognitions (Hackmann, Bennett-Levy, & Holmes, 2011). Clinicians can report that they are wary of using imagery due to its powerful effects (Bell, Mackie, & Bennett-Levy, 2014). However, given the importance of imagery dysfunction across many emotional disorders enquiring about distressing / maladaptive imagery based cognitions in addition to verbal negative automatic thoughts should be a standard part of assessment (for more details of how to do imagery assessment see: Hales et al., 2015).

Imagery can be addressed in many ways in treatment: Distressing imagery in emotional disorders can be addressed in Cognitive Therapy with many of the same established techniques that would be used for dysfunctional verbal cognitions (Hackmann et al., 2011). Other recent experimental work under development in the area of depression includes novel computerized cognitive training programs, directly targeting underlying processes, such as cognitive biases in imagery (Blackwell et al., 2015) or behavioural aspects of depression (Renner, Ji, Pictet, Holmes, & Blackwell, 2017). Innovative imagery based approaches have the potential to further unravel the mechanisms underlying emotional disorders, and to improve current treatments by contributing to innovative methods for mental health treatment innovation (Holmes, Craske, & Graybiel, 2014). Mental imagery research can help to understand mechanisms on different levels of functioning (See Figure 3 in Holmes et al., 2016 for an interactive illustration). One area of functioning where this approach might be particularly fruitful is behaviour.

One example: How might imagery help to boost behavioural activation in depression? Individuals with depression often experience a lack of positive future imagery. Positive future imagery of engaging in behavioural activities can influence actual behaviour. Using data from a randomized controlled trial (Blackwell et al., 2015), we have shown that a positive future imagery intervention can increase reports of behavioural activities in individuals with depression when compared to an active non-imagery control condition (Renner et al., 2017). This has potential implications for treatments where behaviour is the main target, such as Behavioural Activation (Martell, Dimidjian, & Herman-Dunn, 2010), or for behavioural techniques such as homework assignments in Cognitive Therapy. This area of research needs to be further developed and tested.

What is the take home message? Mental imagery is an important aspect across the emotional disorders and should be assessed in treatment. The lack of positive future imagery in depression suggest that positive imagery interventions could be brought into different treatments as an important transdiagnostic technique. Potential applications include using positive imagery interventions targeting behaviour change to help boost the effectiveness of current treatments focusing on behaviour change (e.g. Behavioural Activation; Martell et al., 2010) or Cognitive Therapy (e.g. to use imagery to help people completing their homework assignments). This is an important future research area where researchers and clinicians should work together for mental health science informed treatment innovation (Holmes et al., 2014).

References:

Beck, A. T. (1970). Cognitive therapy: nature and relation to behavior therapy. *Behavior Therapy*, 1(2), 184-200. doi:http://dx.doi.org/10.1016/S0005-7894(70)80030-2

Bell, T., Mackie, L., & Bennett-Levy, J. (2014). 'Venturing towards the dark side': the use of imagery interventions by recently qualified cognitive–behavioural therapists. *Clinical Psychology and Psychotherapy*, 22(6), 591-603. doi:10.1002/cpp.1920

Blackwell, S. E., Browning, M., Mathews, A., Pictet, A., Welch, J., Davies, J., . . . Holmes, E. A. (2015). Positive imagery-based cognitive bias modification as a web-based treatment tool for depressed adults: a randomized controlled trial. *Clinical Psychological Science*, 3(1), 91-111. doi:10.1177/2167702614560746

Hackmann, A., Bennett-Levy, J., & Holmes, E. A. (2011). *Oxford guide to imagery in cognitive therapy.* Oxford: Oxford University Press.

Hales, S. A., Blackwell, S. E., Di Simplicio, M., Iyadurai, L., Young, K., & Holmes, E. A. (2015). Imagery-based cognitive-behavioral assessment. In G. P. Brown & D. A. Clark (Eds.), *Assessment in Cognitive Therapy.* New York: Guilford Press.

Holmes, E. A., Blackwell, S. E., Burnett Heyes, S., Renner, F., & Raes, F. (2016). Mental imagery in depression: phenomenology, potential mechanisms, and treatment implications. *Annual Review of Clinical Psychology*, 12, 249-280. doi:10.1146/annurev-clinpsy-021815-092925

Holmes, E. A., Craske, M. G., & Graybiel, A. M. (2014). Psychological Treatments: a call for mental-health science. Clinicians and neuroscientists must work together to understand and improve psychological treatments. Nature, 511(7509), 287-289. doi:10.1038/511287a

Holmes, E. A., Lang, T. J., & Shah, D. M. (2009). Developing interpretation bias modification as a 'cognitive vaccine' for depressed mood - Imagining positive events makes you feel better than thinking about them verbally. *Journal of Abnormal Psychology* 118(1), 76-88. doi:10.1037/a0012590

Holmes, E. A., & Mathews, A. (2005). Mental imagery and emotion: A special relationship? *Emotion*, 5(4), 489-497. doi:10.1037/1528-3542.5.4.489

Holmes, E. A., & Mathews, A. (2010). Mental imagery in emotion and emotional disorders. *Clinical Psychology Review*, 30(3), 349-362. doi:10.1016/j.cpr.2010.01.001

Kosslyn, S. M., Ganis, G., & Thompson, W. L. (2001). Neural

(CONTINUED ON NEXT PAGE)

foundations of imagery. *Nature Reviews Neuroscience*, 2(9), 635-642. doi:10.1038/35090055

Martell, C. R., Dimidjian, S., & Herman-Dunn, R. (2010). *Behavioral Activation for Depression: A Clinician's Guide.* New York, NY: The Guilford Press.

Pearson, J., Naselaris, T., Holmes, E. A., & Kosslyn, S. M. (2015). Mental imagery: functional mechanisms and clinical applications. *Trends in Cognitive Sciences*, 19(10), 590-602. doi:10.1016/j.tics.2015.08.003

Renner, F., Ji, J. L., Pictet, A., Holmes, E. A., & Blackwell, S. E. (2017). Effects of Engaging in Repeated Mental Imagery of Future Positive Events on Behavioural Activation in Individuals with Major Depressive Disorder. *Cognitive Therapy and Research*, 41(3), 369-380. doi:10.1007/s10608-016-9776-y

STANDING ON THE SHOULDERS OF GIANTS

CONTINUED FROM PG. 3

and was soon used to explain how rules had this effect and what to do about it. We simultaneously began to develop clinical measures and methods to target cognitive, emotional, and behavioral inflexibility. Finally, in 1999 and 2001, the first ACT and RFT books were published and we began doing randomized trials again. The second ACT RCT from my lab was published in 2002, 16 years after the last one. Today there are nearly 200 RCTs published on ACT.

Here the details of my intellectual history become a bit more visible to modern cognitive therapists. My presidential year at ABCT in 1997-1998 had two major highlights: giving the lifetime achievement award to Tim Beck, and describing ACT in my presidential address. In 2004 I declared the arrival of the third wave of CBT and two years later my popular book Get Out of Your Mind and Into Your Life was written up in a five-page story in Time. The reporter presented ACT as if it was in some kind of war with cognitive therapy. There never was such a war, though there were and are notable scientific and clinical differences between traditional CBT and CBS regarding how cognition is understood, targeted, and changed.

The years since have proven that the field has room for these kinds differences, and indeed that positive growth can happen in periods of robust intellectual discussion. ACT is now widely viewed as a credible form of evidence-based practice that is a positive player within in the CBT family writ large. I am especially uplifted by the fact that important alliances have grown between CBS and CBT, to the benefit of both. For example I am working with Stefan Hofmann, an early ACT critic, to bring process-based CBT more to the fore (our textbook on the topic will be out in January: Hayes & Hofmann, in press). We are also working together to help move the field away from a syndromal approach toward a more process-based alternative (our book on that topic is in preparation).

I am honored to have been asked to discuss my intellectual history with this group. I hope that the useful dialectic between CBS and cognitive therapy will continue many years into the future, to the mutual benefit of both traditions. That would be a circle worth squaring.

References:

De Houwer, J. (2012). Foreword to Advances in Relational Frame Theory. S. Dymond & B. Roche (Eds.), *Advances in Relational Frame Theory.* (p. 8-9). Oakland, CA: Context Press / New Harbinger.

Hayes, S. C., Barnes-Holmes, D., & Roche, B. (2001). *Relational Frame Theory: A Post-Skinnerian account of human language and cognition.* New York: Plenum Press.

Hayes, S. C. & Hofmann, S. (Eds.) (in press). *Process-based CBT: Core clinical competencies in evidence-based treatment.* Oakland, CA: New Harbinger Publications.

Hayes, S. C., Strosahl, K., & Wilson, K. G. (1999). *Acceptance and Commitment Therapy: An experiential approach to behavior change.* New York: Guilford Press.

O'Connor, M., Farrell, L., Munnelly, A., & McHugh, L. (2017). Citation analysis of relational frame theory: 2009–2016. *Journal of Contextual Behavioral Science*, 6, 152-158.

Skinner, B. F. (1945). The operational analysis of psychological terms. *Psychological Review*, 52(5), 270-277.

Skinner, B. F. (1957). *Verbal behavior.* Acton, MA: Copley Publishing Group

Villatte, M., Villatte, J., & Hayes, S. C. (2015). *Mastering the clinical conversation: Language as intervention.* New York: Guilford.

Zettle, R. D., Hayes, S. C., Barnes-Holmes, D. & Biglan, T. (2016). (Eds.) *The Wiley handbook of Contextual Behavioral Science.* Chichester, UK: Wiley/Blackwell.

COGNITIVE-BEHAVIORAL COUPLE THERAPY

CONTINUED FROM PG. 4

symptoms and couple behavioral patterns (including avoidance), as well as strategies for increasing positive couple interactions, improving emotion regulation, building communication skills to reduce emotional numbing and avoidance, and improving problem-solving skills.

Eating disorders. Bulik, Baucom, Kirby and Pisetsky (2011) applied CBCT with anorexia nervosa. Their program combines interventions specific to the eating disorder (e.g., psychoeducation about the disorder and recovery; couple collaboration to support the patient's goals for recovery; strategies to avoid arguments about food) with CBCT problem-solving and communication training to reduce couple conflict.

Physical health problems. CBCT also has been applied to help couples deal with physical illness, such as Baucom et al.'s (2009) program for women being treated for breast cancer. Couples are taught communication skills and apply them to topics regarding cancer (e.g., fear of mortality), as well as problem-solving skills for making treatment decisions. They also receive psychoeducation about psychological and physical effects of treatments on sexual functioning.

CBCT for Severe Relationship Problems

Specialized CBCT approaches have been developed for major relationship problems, including partner aggression, infidelity, and sexual dysfunction.

Partner aggression. Clinicians commonly avoid therapy with couples in which physical violence has occurred, to prevent further violence. Perpetrators are referred to anger management groups and victims to shelters and clinicians who empower them to leave abusive relationships (Epstein, Werlinich, & LaTaillade, 2015). However, there is substantial evidence that many couples engage in mutual psychological and mild to moderate physical aggression and do not intend to end their relationships. Consequently, couple therapy protocols have been developed and evaluated that address risk factors for partner aggression, such as "over-learned" aggressive behaviors, deficits in communication and problem solving skills, negative cognitions that fuel anger, and poor regulation of anger. These programs have been predominantly CBCT-based (Epstein et al., 2015), with components of psychoeducation about risk factors, anger management training, training in communication and problem-solving, and techniques for challenging anger-eliciting thoughts. Couples are screened and monitored regularly, and the programs have been found to be safe for reducing partner aggression.

Infidelity. Baucom, Snyder and Gordon (2009) developed a predominantly CBCT-based program that helps both partners cope with the impact of infidelity, gain insight into factors that contributed to the affair (e.g., the perpetrator's low self-esteem, erosion in the couple's emotional connection), make decisions about the future of their relationship, and develop strategies for reducing risk factors if they choose to stay together. Preliminary outcome evidence has been positive.

Sexual dysfunction. Extensive marketing of medications for erectile dysfunction has contributed to a common belief that sexual problems are mostly physiological. However, psychological and relationship factors have major influences on desire, arousal and orgasm. Cognitions such as perfectionistic standards for performance and tendencies to engage in "spectatoring" (focusing on how one's body is responding) have been implicated in sexual dysfunctions, as has relationship conflict (Metz & McCarthy, 2011), so conjoint sex therapy tends to be heavily cognitive-behavioral. It involves psychoeducation regarding factors influencing sexual response, challenging of negative thoughts related to sex, communication and problem-solving skills, as well as exercises for enhancing sensual and erotic experiences, increasing relaxation, and decreasing performance anxiety (Metz & McCarthy, 2011). Unfortunately, there have been no controlled trials of CBCT for sexual dysfunctions.

Conclusions

Cognitive-behavioral couple therapies are the most extensively researched approaches, with considerable evidence of effectiveness (Gurman, 2013). Studies have produced support for CBCT for individual disorders and relationship problems such as partner aggression and infidelity. Its multi-faceted nature gives it great potential as an intervention model.

References:

Abramowitz, J. S., Baucom, D. H., Wheaton, M. G., Boeding, S., Fabricant, L. E., Paprocki, C., & Fischer, M. S. (2013). Enhancing exposure and response prevention for OCD: A couple-based approach. Behavior Modification, 37, 189-210.

Baucom, D. H., & Epstein N. (1990). Cognitive- behavioral marital therapy. New York, NY: Brunner/Mazel.

Baucom, D.H., Porter, L.S., Kirby, J.S., Gremore, T.M., Wiesenthal, N., Aldridge, W., Fredman, S.J., Stanton, S.E., Scott, J.L., Halford, K.W., and Keefe, F.J. (2009). A couple-based intervention for female breast cancer. Psycho-Oncology, 8, 276-283.

Baucom, D. H., Snyder, D. K., & Gordon, K. (2009). Helping couples get past the affair: A clinician's guide. New York, NY: Guilford.

Beck, A. T. (1988). Love is never enough. New York, NY: Harper & Row.

(CONTINUED ON NEXT PAGE)

Birchler, G.R., Fals-Stewart, W. and O'Farrell, T.J. (2008). Couple therapy for alcoholism and drug abuse. In A.S. Gurman (Ed.), Clinical handbook of couple therapy (4th ed., pp. 523-544). New York, NY: Guilford.

Bulik, C.M., Baucom, D.H., Kirby, J.S., and Pisetsky, E. (2011). Uniting couples (in the treatment of) anorexia nervosa (UCAN). International Journal of Eating Disorders, 44, 19-28.

Chambless, D.L. (2012). Adjunctive couple and family intervention for patients with anxiety disorders. Journal of Clinical Psychology: In Session, 68, 548-560.

Dattilio, F. M., & Padesky, C. A. (1990). Cognitive therapy with couples. Sarasota, FL: Professional Resource Exchange.

Ellis, R., Sichel, J.L., Yeager, R.J., DiMattia, D.J., & DiGiuseppe, R. (1989). Rational-emotive couples therapy. New York, NY: Pergamon.

Epstein N. (1982). Cognitive therapy with couples. American Journal of Family Therapy, 10, 5-16.

Epstein, N.B., & Baucom, D.H. (2002). Enhanced cognitive-behavioral therapy for couples: A contextual approach. Washington, DC: American Psychological Association.

Epstein, N.B., Dattilio, F.M., & Baucom, D.H. (2016). Cognitive-behavior couple therapy. In T.L. Sexton & J. Lebow (Eds.), Handbook of family therapy (4th ed., pp. 361-386). New York, NY: Routledge.

Epstein, N.B., Werlinich, C.A., & LaTaillade, J.J., (2015). Couple therapy for partner aggression. In A.S. Gurman, J.L. Lebow, & D.K. Snyder (Eds.), Clinical handbook of couple therapy (5th ed., pp. 389-411). New York, NY: Guilford Press.

Gurman, A.S. (2013). Behavioral couple therapy: Building a secure base for therapeutic integration. Family Process, 52, 115-138.

Jacobson, N. S., & Margolin, G. (1979). Marital therapy: Strategies based on social learning and behavior exchange principles. New York, NY: Brunner/Mazel.

Metz, M.E., & McCarthy, B.W. (2011). Enduring desire. New York, NY: Routledge.

Monson, C.M., & Fredman, S.J. (2012). Cognitive-behavioral conjoint therapy for PTSD. New York, NY: Guilford Press.

Rathus, J. H., & Sanderson, W. C. (1999). Marital distress: Cognitive behavioral interventions for couples. Northvale, NJ: Jason Aronson.

Whisman, M.A. (2013). Relationship discord and the prevalence, incidence, and treatment of psychopathology. Journal of Social and Personal Relationships, 30, 163-170.

TOWARD INTEGRATIVE CBT

CONTINUED FROM PG. 2

Health (http://www.psychotherapy.ro).

A combination of (1) outstanding keynote speakers (Gerhard Andersson, Judith Beck, David M. Clark, Pim Cuijpers, Raymond DiGiuseppe, Daniel Freeman, Martin Hautzinger, Steven Hayes, Stefan Hofmann, Steven Hollon, Robert Leahy, Lata McGinn, John Riskind, Philip Spinhoven, Mehmet Sungur, Ed Watkins); (2) workshop presenters (Gerhard Andersson, Judith Beck, Raymond DiGiuseppe, Keith Dobson, Kristene Doyle, Thomas Dowd, Arthur Freeman, Daniel Freeman, Steven Hayes, Robert Leahy, Lata McGinn, Agnieszka Popiel, John Riskind, Tullio Scrimali, Mehmet Sungur, Ed Watkins) and (3) symposia presenters will try to elucidate the challenges of integration that CBT faces today. Also, we planned two stimulating round tables (1) Integrative and multimodal CBT: Implications for practice (Daniel David, Raymond DiGiuseppe, Steven Hayes, Stefan Hofmann, and Robert Leahy) and (2) Integrative and multimodal CBT: Implications for research (Gerhard Andersson, Pim Cuijpers, Daniel David, Daniel Freeman, and Steven Hollon), to further debate and understand the future of CBT.

The venue of the congress will be provided by the Babes-Bolyai University, Cluj-Napoca. All scientific activities (workshops, keynotes, symposia, open paper an poster presentations) will take place inside the main building of the University, situated on No. 1 Kogalniceanu Street, and other nearby facilities, all at walking distances from one another. The venue is situated right in the city center of Cluj-Napoca. The scientific activities will be held in large and beautiful halls, such as the University's "Aula Magna" and the "Auditorium Maximum" concert hall. The academic tradition of Babes-Bolyai University started in 1581. Babe-Bolyai University is known as one of the best academic education institutions in Central and Eastern Europe. Its name commemorates two important Transylvanian figures, the Romanian physician Victor Babes and the Hungarian mathematician Janos Bolyai. Located in an area with a strong interethnic and interconfessional character, Babes-Bolyai University has chosen multiculturalism as its main direction of development, its students and teachers being Romanian, Hungarian, German and even representatives of the Romani people. Babes-Bolyai Unversity is an academic educational institution aiming to promote and sustain the development of specific cultural components within the local, regional, national and international community. To fully benefit from your trip to Romania, we highly recommend you to visit some of the fantastic places in this country (e.g., the Danube Delta, the Dracula-related trips, the famous Romania monasteries, the Transylvania medieval cities, the traditional areas like Maramures, etc.).

We are looking forward having you in Cluj-Napoca, Transylvania, Romania! *Note:* More info. about the Congress can be found on the website at http://www.iccp2017.org