Master Clinician Seminars

Throughout the Convention attend these useful sessions where the most skilled clinicians explain their methods and show recordings of clients' sessions.

Friday 8:00 – 10:00 a.m.

Master Clinical Seminar 1

Acceptance and Commitment Therapy and the Therapeutic Relationship: Core Skills and Acts of Compassion

Robyn D. Walser, National Center for PTSD

Moderate level of familiariaty with the material

This seminar will broadly explore the core components of ACT, with a specific focus on present-moment processes and the therapeutic relationship. In addition, this session will focus on the therapy processes that trigger each of the six components and how therapists can flexibly adopt the six ACT processes, including work that is linked to personal psychological experience in session. The focus will include a description of how the most basic part of the ACT therapeutic stance naturally flows from a therapist’s application of the ACT model of language and human functioning to their own professional and personal life as well as that of their clients. Participants will engage in a number of ACT-based activities and experiential exercises. Additionally, role-plays with feedback and from therapist and client will be presented.

You will learn:

• The six core components of ACT and the processes that trigger these components

• The processes that trigger use of the six core components in session

• How present-moment processes promote connection and compassion in the therapeutic relationship

Recommended Reading: Pierson, H., & Hayes, S. C. (2007). Using Acceptance and Commitment Therapy to empower the therapeutic relationship. In P. Gilbert & R. Leahy (Eds.), *The therapeutic relationship in cognitive behavior therapy* (pp. 205-228). London: Routledge.

Friday 10:15 a.m. – 12:15 p.m.

Master Clinical Seminar 2

Avoiding Common Stumbling Blocks in Parent-Child Interaction Therapy: A Workshop for Experienced PCIT Clinicians

Cheryl B. McNeil, West Virginia University

Moderate to Advanced level of familiarity with the material

This seminar will examine issues that have arisen repeatedly during consultation with PCIT therapists at various levels of experience. These common pitfalls will be presented with a focus on providing practical solutions that can help therapists raise their PCIT skills to the next level. To illustrate points, Dr. McNeil will show videos of her own CDI (child-directed interaction) and PDI (parent-directed interaction) coaching, pausing the action to discuss problem-solving processes. The goal of this talk is to discuss a variety of stumbling blocks that have tripped up many fine PCIT therapists over the years. Problems to be addressed in this talk encompass both CDI concerns (e.g., homework noncompliance, getting stuck in a rut with coaching) and PDI issues (e.g., cannot get a time-out in session, lack of generalization of improvements from clinic to home). Additionally, changes in coaching techniques over the course of therapy will be presented by comparing initial and later sessions. This intermediate-to-advanced seminar is geared towards therapists with experience in PCIT.

You will learn:

• Advanced coaching techniques
• Strategies for enhancing generalization of improvements from clinic to home
• Techniques for improving homework compliance

Recommended Readings: Eyberg, S.M. (2005). Tailoring and adapting parent-child interaction therapy for new populations. *Education and Treatment of Children, 28,* 197-201. Hood, K.K., & Eyberg, S.M. (2003). Outcomes of parent-child interaction therapy: Mothers' reports on maintenance three to six years after treatment. *Journal of Clinical Child and Adolescent Psychology, 32,* 419-429. McNeil, C.B., & Hembree-Kigin, T. (2010). *Parent-Child Interaction*

Therapy: Second Edition. New York: Springer. **(**Go to www.pcit.org for a list of the PCIT literature, as well as the treatment integrity manual for conducting PCIT.)

Friday 12:30 – 2:30 p.m.

Master Clinical Seminar 3

Spirituality/Religion and Behaviorism: From Theory to Practice

David H. Rosmarin, McLean Hospital/Harvard Medical School

Basic level of familiariaty with the material

While several laboratories have successfully integrated spirituality/religion (S/R) into CBT, many perceive S/R to be at odds with the core principles of behaviorism. For example, prayer may be construed as an emotion avoidance strategy, and belief in "unfalsifiable" spiritual ideas may be viewed as anathema to an empirical framework. As a result, practitioners of empirically supported treatments are often reticent to address or utilize patient S/R in the course of treatment. Needless to say, this is a barrier to the dissemination of CBT as S/R is highly common in the general population and can play a central role in patients' lives—particularly in times of distress. More fundamentally, though, congruence between S/R and behavioral theory is underappreciated.

The first part of this seminar will involve a didactic presentation on points of theoretical intersection between S/R and behaviorism, including: (a) how reinforcement contingencies for spiritual practice (typically variable ratio) may buffer against impulsivity, anxiety, and depression; (b) how spiritual practice can be utilized in behavioral activation and emotion regulation; (c) how prayer can be used to facilitate both acceptance and avoidance of emotions; and (d) how spirituality uniquely highlights the importance of collaborative empiricism. Case examples will be utilized where appropriate to illustrate key points.

The second portion of this seminar will present a mock demonstration of a brief clinical intervention to assess for patient interest in spiritually integrated CBT, discuss the psychological functions of spiritual belief/practice, and facilitate the inclusion of spiritual activity into treatment where appropriate. As well, participants will take part in partially scripted role-plays to practice this intervention.

You will learn:

• Points of theoretical intersection between S/R and behaviorism

• How spiritual practice can facilitate behavioral activation, emotion regulation, and acceptance

• A brief clinical intervention to integrate patient spiritual practice into CBT

Recommended Readings: Pargament, K.I. (2007). *Spiritually integrated psychotherapy: Understanding and addressing the sacred*. New York: Guilford Press. Rosmarin, D.H., Auerbach, R.P, Bigda-Peyton, J., Björgvinsson, T., & Levendusky, P. (2011). Integrating spirituality into cognitive behavioral therapy in an acute psychiatric setting: A pilot study. *Journal of Cognitive Psychotherapy, 25,* 287-303. Rosmarin, D.H., Pargament, K.I., & Robb, H. (2010). Spiritual and religious issues in behavior change. *Cognitive and Behavioral Practice, 17,* 343-347.

Friday 2:45 – 4:45 p.m.

Master Clinical Seminar 4

Cognitively Focused Treatment for OCD

Maureen L. Whittal, University of British Columbia

Basic to Moderate level of familiariaty with the material

Exposure and response prevention (ERP) treatments for OCD are effective for the majority who complete treatment and most maintain their gains in follow-up studies. However, ERP can be a difficult treatment to tolerate (approximately 25% refusal and dropout rates in many randomized trials). Moreover, the average decline in symptom severity is about 55%, which implies that many participants are leaving treatment with residual symptoms. Cognitively focused treatments offer an alternative to exposure-based treatments and produce similar effect sizes to ERP. Dropout rates, however, are slightly lower with cognitive treatments. The purpose of this seminar is to introduce participants to the cognitive model for OCD and the importance of the appraisal process. The ubiquity of intrusive thoughts will be discussed as well as the central cognitive processes (e.g., overimportance of thoughts, inflated responsibility, overestimation of threat) implicated in the maintenance of OCD. Through didactic presentation and audio and video clips, participants will learn strategies to assess for and cognitively challenge appraisals associated with intrusive thoughts. In keeping with the spirit of the seminar, the focus will be on clinical information but the empirical support for the treatment will also be reviewed.

You will learn:

• How to introduce the cognitive model for the maintenance of OCD and illustrate the importance of the appraisal process
• How to become familiar with the interpretations and beliefs associated with various OCD presentations and how to cognitively challenge these appraisals
• How to tailor treatment to the heterogeneous presentation of the OCD patient

Recommended Readings: Whittal, M.L., & Robichaud, M. (2012). Cognitive treatment for OCD. In G. Steketee (Ed.), *Handbook of obsessive compulsive and spectrum disorders* (pp. 345-364). New York: Oxford University Press. Whittal, M.L., Robichaud, M.L., & Woody S.R. (2010). Cognitive therapy of obsessions: Using video components to enhance dissemination. *Cognitive and Behavioral Practice*, *17*, 1-8. Whittal, M.L., Woody, S.R., McLean, P.D., Rachman, S., & Robichaud, M. (2010). Treatment of obsessions: A randomized controlled trial. *Behaviour Research and Therapy*, *48*, 295-303

Saturday 8:00 – 10:00 a.m.

Master Clinical Seminar 5

Modifying Core Beliefs

Judith S. Beck, Beck Institute for Cognitive Behavior Therapy and University of Pennsylvania

Moderate level of familiariaty with the material

In this master class, I will focus on core beliefs through lecture, discussion of a video with a real client, and role-play.

Core beliefs are clients' most deeply held ideas about themselves, their worlds, and other people—overgeneralized, global, rigid cognitions that originate in childhood and develop as a result of the meaning they ascribe to their early experiences. When children or adolescents have had either blatant or subtle (but chronic) trauma, these beliefs are often highly negative and dysfunctional, but accepted as true. Once these beliefs become entrenched, clients begin to view their subsequent experiences through the lens of these powerfully negative ideas. They become part of the client's identity. (Beck et al., 2004; J. Beck, 2005).

Therapists must first develop a cognitive conceptualization of individual clients, identifying their central patterns of dysfunctional cognition and behavior. They then use this conceptualization to plan treatment and solve therapeutic problems. To begin the process of core belief modification, it is essential to educate clients about their core beliefs, explaining how it is that they can hold a belief extremely strongly, yet how that belief could be untrue, or largely untrue. An information-processing model illustrates to clients how they automatically and selectively abstract negative data (that supports the core belief) from the environment while discounting or failing to process positive data. A variety of both intellectual and experiential techniques is then necessary to help clients modify their cognitions at both the "intellectual" and "emotional" levels and develop more functional, reality-based beliefs about themselves, their worlds, and other people.

This presentation will demonstrate how to conceptualize clients' core beliefs, how to present an information-processing model, and how to use several advanced interventions for modifying core beliefs.

You will learn:

• How to identify clients' core beliefs

• How to educate clients about their core beliefs

• How to use specialized techniques to modify core beliefs

Recommended Readings: Beck, A.T., Freeman, A., Davis, D., & Associates. (2004). *Cognitive therapy of personality disorders, 2nd ed.* New York: Guilford. Beck, J.S. (2005). *Cognitive therapy for challenging problems: What to do when the basics don't work.* New York: Guilford.

Saturday 10:15 a.m. – 12:15 p.m.

Master Clinical Seminar 6

Strategies for Handling Treatment Failure Successfully

Jacqueline B. Persons, San Francisco Bay Area Center for Cognitive Therapy

Polina Eidelman, San Francisco Bay Area Center for Cognitive Therapy

Basic level of familiariaty with the material

Treatment failure is common; all clinicians, even the most skilled, encounter it. We present strategies that will help cognitive-behavior therapists identify treatment failure or lack of progress promptly, and work effectively with the patient to overcome it. We describe tools, including scales that are in the public domain and an online tool developed by Jackie Persons and Kelly Koerner (an SBIR-funded online tool for progress monitoring: Online Progress Tracking or OPT), that clinicians can use to monitor progress at every session in order to identify lack of progress. We teach therapists to use these tools to identify lack of progress, initiate a conversation about it with the patient, and systematically develop and evaluate hypotheses about the lack of progress. This work can lead to interventions that turn a failing therapy into a successful one. We present video role-play demonstrations and our own case examples, and will lead participants in practice exercises. We ask participants to bring at least one example of a patient who is not making progress in therapy, and to come prepared to participate in role-play exercises.

You will learn:

- Tools for monitoring progress at every session
- A systematic strategy for developing and testing hypotheses about the causes of treatment failure
- Tips for initiating a discussion with the patient about treatment failure

Recommended Readings: Kazdin, A. E. (1993). Evaluation in clinical practice: Clinically sensitive and systematic methods of treatment delivery. *Behavior Therapy, 24*, 11-45. Persons, J. B., & Mikami, A. Y. (2002). Strategies for handling treatment failure successfully. *Psychotherapy: Theory/Research/Practice/Training, 39*, 139-151.

Saturday 12:45 – 2:45 p.m.

Master Clinical Seminar 7

Behavioral Approaches to Treating Trichotillomania and Skin Picking

Douglas W. Woods, University of Wisconsin-Milwaukee

John Piacentini, UCLA Semel Institute for Neuroscience and Human Behavior

All levels of familiarity with the material

Recent studies have begun to demonstrate the relatively high prevalence and significant psychosocial impact associated with trichotillomania and other "body-focused repetitive behaviors" such as self-injurious skin picking. Likewise, it is clear that when individuals seek treatment for these disorders, they are likely to seek the help of a psychologist or other therapist before any other profession. Unfortunately, data also suggest that a vast majority of mental health professionals do not understand these disorders, are unfamiliar with the assessment of the symptoms, and lack knowledge about available effective treatments. In this Master Clinician Seminar, Drs. Woods and Piacentini will describe and demonstrate the core elements of behavior therapy for trichotillomania and chronic skin picking in children and adults. In addition to briefly reviewing the overall structure of the interventions and the data regarding its efficacy, Drs. Woods and Piacentini will demonstrate, through video clips and live demonstrations, habit reversal training, stimulus control, and acceptance-based intervention components.

You will learn:

- The core components of behavior therapy for trichotillomania and chronic skin picking;
- The evidence base supporting the efficacy of behavior therapy for trichotillomania and chronic skin picking;
- The essential elememts of habit reversal, stimulus control, and acceptance-based interventions for trichotillomania and chronic skin picking.

Saturday 3:00 – 5:00 p.m.

Master Clinical Seminar 8

Cognitive-Behavioral Therapy for Coping With the Experience of Unemployment

Robert L. Leahy, American Institute for Cognitive Therapy, New York

Basic level of familiariaty with the material

The unemployed face increased risk for binge drinking, depression, anxiety, and suicide, with rates of mortality 2 ½ times higher than those never unemployed over a 23-year period. Many of the unemployed carry the "scar" throughout their lives, with significantly higher rates of future unemployment, and increased risk of cardiovascular disease and suicide. Unemployment is one of the leading "life crises" and is often accompanied by shame, isolation, passivity, self-criticism, rumination, worry, and family conflict.

We will consider how the cognitive behavioral therapist can assist the unemployed in validating emotions without getting stuck in being a victim, learn to accept what is "given"—but commit to change and action, decrease rumination, use behavioral activation to accomplish valued goals , modify destructive self-talk, reduce shame, overcome passivity and isolation, and develop a more balanced approach to this time "in between." The unemployed in the United States spend 31 minutes per day looking for a job, with this time ranked the most depressing time of the day by respondents.

The CBT approach to unemployment is based on three key assumptions: (a) your job is to find a job; (b) your second job is to take care of yourself; and (c) you need to focus on what you can control. For some, the period of in-between is a time for reexamining the values of materialism, relationships, and social support. Format includes lecture and role-play.

You will learn:

• How to evaluate the major risk areas for patients (e.g., rumination, passivity, stuck as a victim, shame, hopelessness, etc.)
• How to develop a strategic self-help plan customized to patients
• How to implement in-session and between-session interventions

Recommended Readings: Leahy, R. L. (2009). Unemployment anxiety. *the Behavior Therapist, 32*, 1-2. McKee-Ryan, F. M., Song, Z., Wanberg, C. R., & Kinicki, A. J. (2005). Psychological and physical well-being during unemployment: A meta-analytic study. *Journal of Applied Psychology, 90*, 53-76.