Advances in
Cognitive Behavioral Therapy
Newsletter

Publication of: The Academy of Cognitive & Behavioral Therapies (A-CBT) & The International Association of Cognitive Behavioral Therapy (IACBT)

The International Association of Cognitive Behavioral Therapy is a proud member of The World Confederation of Cognitive and Behaviour Therapies

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A-CBT'S PRESIDENT'S COLUMN

Jamie L Schumpf, Psy.D.
Clinical Associate Professor of Psychology
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I am honored to begin my tenure as President of the Academy of Cognitive Behavioral Therapy, a group I've cherished since becoming certified as a postdoctoral fellow. It was this organization, above all, where I found my professional home of colleagues passionate about providing, researching, and teaching evidence-based treatment. The group would not be the presence it is today without the heavy lifting of its former presidents and leaders, and to them I am endlessly grateful. With their guidance, we've expanded our mission of dissemination and public service, launched a new online training self-study program, and highlighted the need for a more clarified governance of our board's policies and procedures. Only with a firm commitment to best practices, transparency, open dialogue, and professional ethics can we continue to fulfill our larger mission and solidify the Academy's leading role within our rich, dynamic field.

I begin my tenure as President having served previously on multiple committees: as Editor of our journal, Advances in Cognitive Therapy, a joint publication with the IACBT; Chair of the Marketing Committee; and an early member of the Diversity Action Committee (DAC). Under the Chair of Dr. Lizbeth Goana, the DAC published a vital race-based trauma fact sheet and organized multiple symposia and ticketed workshops at ABCT. There's still much more work to be done–it is of utmost importance that we continue to pay closer, more serious attention to evidence-based approaches with marginalized and underrepresented communities, and to expand our membership to practitioners from those communities. This is not just aspirational; we must actively recruit new voices, promote new leaders, and push beyond our comfort zones—not simply because we feel the Academy has something to teach underrepresented communities, but because those communities have something equally important to teach us.

We strive for inclusivity in other ways as well. Ours is a membership that boasts mental health professionals from across the entire discipline—not just doctors, but social workers, counselors and researchers. And this diversity—one of many—is reflected in our Board as well. Moreover, as the borders of CBT shift and expand, we've expanded with it. We've been able to attract an influx of new credentialed practitioners from around the globe, practicing traditional Beckian CT, DBT, REBT, and ACT. We're also delighted to be able to offer this expanded membership, more specialty training in our contracts, and continuing education through our self study program. To that end, we anticipate future improvements to our online presence so as further engagement and make our many membership benefits that much more accessible and meaningful.

Academy members set an exceedingly high bar through their professional accomplishments, international renown, and exemplary leadership. It's an honor to be able to preside over such an amazing group. Together, and alongside our esteemed Board—President-Elect Scott Waltman, Treasurer Mudita Bahadur, Secretary Janeé Steele, and Members at Large, Lizbeth Goana, Joel Becker and Steven Hollon—I'm confident that ours is a bright future.

Thank you,
Jamie

Academy of Cognitive and Behavioral Therapies

IACBT'S PRESIDENT'S COLUMN

Lynn M McFarr, Ph.D.

Three years ago, the board of the IACBT had a series of strategic planning meetings to regroup and reset. What emerged was a new mission. We decided to add CBT to our name and focus on modern integrative CBT being accessible, and charitable. This change has driven our actions as a board under my presidency and I am delighted to say several pieces have fallen together. One, we were approved as a non-profit 501c3 in the United States which means contributions to the IACBT are now tax deductible. Please consider IACBT in your end of year giving and estate planning!

Second, along with out training mission, we were recently approved by the American Psychological Association as approved continuing education providers. This will allow us to move forward with our training initiatives including our inaugural Global Ambassador webinars, in conjunction with the World Confederation of CBT. Our first speaker will be Scott Waltman, Psy.D. who will be speaking on Socratic Questioning. If you have ever seen Dr Waltman talk, you know he is both informative and engaging. Not to be missed! Please check our website for updates www.I-ACBT.com

Speaking of training, we are thrilled to report that the contracts are signed and we are good to go! The IACBT Conference 2025 (formerly ICCP) will be held in Nashville Tennessee! Aaron Brinen, Psy.D. from Vanderbilt University will serve as Program Chair. The conference website can be found here. https://iacbtnashville.com Dr Brinen has fantastic plans including a lively social program.
We are looking forward to seeing you all there!

Our affiliation with the World Confederation of Cognitive Behavioral Therapy grows stronger. IACBT board member and Past President, Dr. Lata McGinn, has taken the helm as President of the WCCBT (http://www.wccbt.org/). You all may recall that the WCCBT was the brainchild of Dr. McGinn, who worked with CBT leaders around the world to form the organization. Hearty Congratulations Dr. McGinn! The WCCBT has a global mission to promote and advocate for CBT, including a partnership forged with the World Health Organization. Congratulations are also due to Mehmet Sungur, M.D. who was recently elected to serve on the executive committee representing training. Kudos to you!

Our journal, *The International Journal of Cognitive Therapy* (https://link.springer.com/journal/41811) is also going places. We recently received word that our impact factor continues to grow. This is an incredible achievement and no doubt due to the ongoing efforts of both the outgoing editor, John Riskind, Ph.D. and the incoming editor Edward Selby, Ph.D. Please join me in congratulating them on their efforts and be sure to submit!

Here is hoping for a peaceful and joyous holiday season for you and yours.

IACBT

HAVE YOU REGISTERED FOR OUR NEW SITE?

In order to access your Membership Account, it is important to note that your old login credentials will not work on the new website. Even if you have held a Membership account in the past, you will be required to Register and 'Sign-Up' for the new website as indicated in the step-by-step instructions detailed below.

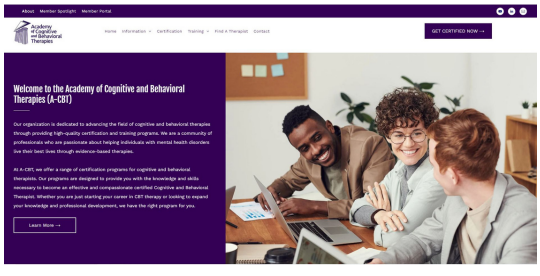
Please, follow the steps below to Register for the new website and update your Member Profile.

Step One: Click the icon to the left to Register and 'Sign-Up' for the new A-CBT Website using the email you typically use for Academy of CBT related business and matters.

Click the orange 'sign-up' button upon accessing the new member portal to ensure you register your account properly. Upon signing up, you will receive a confirmation email which will direct you to activate your new member account. Once activated, come back to this message and follow the next step.

Step Two: Update your membership information. Click on the icon to the left to update your member information. Please use the same email that you used to Register for your Member Profile. If you happen to be a non-practicing member, please email us at info@academyofcbt.org and we will help you set up your account.

Step Three: Save your login credentials. You will need these to access the 'Members-Only' portion of the website.



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NAVIGATING CHALLENGES IN TREATING COMORBID EATING DISORDERS AND OBSESSIVE-COMPULSIVE DISORDER

Melissa Harrison, LPC

For close to 15 years, my business partner and now co-author and I have been treating eating disorders (ED) and related issues in a suburb outside of Philadelphia. As clinicians that value practicing with evidence-based models, we have stayed on top of the most effective, evidence-based practices for the disorders we treat. However, we found that certain comorbidities complicated treatment. Specifically, comorbid obsessive-compulsive disorder (OCD) was a common presentation that created complexities; however, we found very little written or researched to dictate treatment (Simpson et al., 2013). Our book, *Comorbid Eating Disorders and Obsessive-Compulsive Disorder: A Clinician's Guide to Challenges in Treatment*, emerged from these challenges that we faced trying to treat a comorbidity where there has been little to no guidelines indicating what clinicians ought to do with this presentation in clinical practice to improve outcomes.

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Melissa is the co-founder and director of operations for the Center for Hope and Health. She specializes in evidence-based treatments for eating disorders, OCD, PTSD, phobias, other anxiety disorders and the behavioral and psychological management of Polycystic Ovary Syndrome (PCOS). She is also co-author of the upcoming book, Comorbid Eating Disorders and Obsessive-Compulsive Disorder: A Clinician's Guide to Challenges in Treatment, due out this month.

Practicing as a licensed professional counselor in Pennsylvania and Delaware, she has additional credentials in CBT as a Diplomate CBT-Certified Therapist, as a Certified Prolonged Exposure Therapist and Supervisor through the University of Pennsylvania, and in Cognitive-Behavior Therapy-Enhanced from the Centre for Research on Eating Disorders at Oxford. Melissa has also completed a specialized fellowship in Cognitive-Behavioral Therapy for a variety of disorders and clinical issues through the University of Pennsylvania's Center for Cognitive Therapy. She presents her expertise at professional conferences and continuing education workshops, contributes to local media outlets, along with providing supervision and consultation to other clinicians. Melissa is a Trainer/Consultant through the Academy of Cognitive and Behavioral Therapies where she provides consultation and training in CBT, eating disorder treatments, and Exposure-Response Prevention for OCD. She obtained her degree in Clinical Psychology from West Chester University in 2011 and began her career in eating disorders by working as both a primary therapist and treatment team leader over the course of 5 years at the Renfrew Center. Melissa is also a clinical facilitator at the Minding Your Mind Foundation where she focuses on prevention and advocacy in the community and schools.

NAVIGATING CHALLENGES IN TREATING COMORBID EATING DISORDERS AND OBSESSIVE-COMPULSIVE DISORDER (CONTINUED)

Melissa Harrison, LPC

As it turns out, it was not just our practice that was frequently seeing EDs comorbid with OCD. Some studies indicate a lifetime prevalence of up to 60% (Kaye et al., 2004; Godart et al., 2003; Halmi et al., 2005; Godart et al., 2002). This high prevalence further complicates the already intricate landscape of ED treatment. It quickly became evident that training in exposure-response prevention (ERP) for OCD was a necessity. Surprisingly, despite having formal training in front-line treatments for EDs, such as cognitive-behavioral therapy-enhanced for eating disorders (CBT-E), ERP training for OCD actually enhanced our ability to treat EDs. ERP provided a deeper understanding of exposure therapy, the ability to better identify individual maintenance mechanisms and covert avoidance, and increased our confidence (or perhaps courage) to guide our clients to lean fully into their fears which proved invaluable in achieving successful treatment outcomes. Still, significant challenges persisted in our treatment of comorbid EDs and OCD.

These challenges were also not limited to our practice. ED clients with comorbid OCD often experience less successful outcomes in evidence-based treatments (Byrne et al., 2017; Lock & Le Grange, 2019; Vall & Wade, 2015; Wentz et al., 2009). One notable example of this complexity in this comorbidity is the tendency of OCD to attach to the client's values, a pertinent issue given that EDs are typically egosyntonic. A common manifestation of this can arise in the later stages of change for EDs, such as action or maintenance (Norcross et al., 2011), where clients may begin to have intrusive thoughts related to relapsing. This may initially appear encouraging to the average therapist, as clients seem to align with recovery behaviors. However, these thoughts can swiftly become obsessive and become maintained by compulsions that are challenging to identify (e.g., consuming every last morsel of their meal, adhering rigidly to meal times, and frequently weighing themselves to ensure no weight loss).

Successfully addressing this comorbidity may necessitate therapists to deviate from current evidence-based manuals for EDs and implement a ritual prevention intervention. For example, it may be necessary for a client not to see their weight (a practice typically unsupported in the literature for EDs, as most ED manuals indicate that clients should see or know their weight) in order for the client to build tolerance to the uncertainty that they may have lost some weight and have begun to relapse. Overtime, we began to see that our ability to treat EDs and OCD greatly increased. This process, and understanding the challenges faced along with the high comorbidity rates, led us to embark on writing a clinician's guide, aiming to offer insights, highlight common pitfalls, and suggest evidence-informed interventions based on our clinical observations and the current literature.

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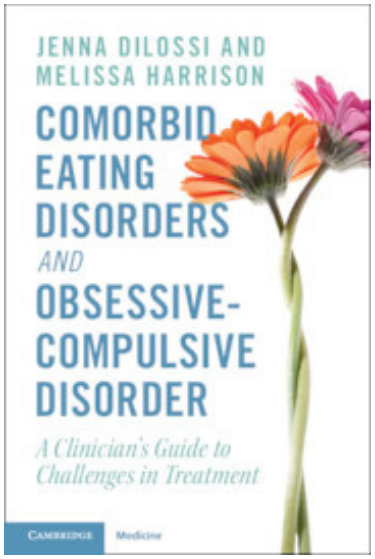

NAVIGATING CHALLENGES IN TREATING COMORBID EATING DISORDERS AND OBSESSIVE-COMPULSIVE DISORDER (CONTINUED)

Melissa Harrison, LPC

Below are some key points for consideration:

1. **Conceptualization and Assessment:**
   a. **The comorbidity's interdependence necessitates a functional assessment – for example, restricting food may be due to a body image dissatisfaction or it could be due to a gluttony and morality concern (absence of body image)**
   b. **A focus on the impact of malnutrition and weight loss on the patient is imperative**
   c. **Prioritize medical risk in treatment planning, considering the exacerbation of obsessive thinking in cases of malnourishment.**
2. **Treatment Barriers:**
   a. **CBT-E's self-monitoring and meal planning may become compulsive; creativity is essential to tailor this procedure meaningfully without sacrificing clinical data (e.g., encourage client to not eat at exactly same time every day)**
   b. **Weighing can be challenging due to rigidity and reassurance needs; closed weights or forgoing weight graphs may be considered**
   c. **Comorbid OCD can exacerbate ED behaviors like body checking and scale avoidance**
   d. **Societal messaging about virtue and morality linked to certain foods and body types can exacerbate comorbid OCD with a morality domain**
3. **Interventions**
   a. **Distraction and the encouragement of eating similar things to gain weight or to make eating easier is common in the ED community; however, this can become problematic and can undermine mechanisms of action in exposure (e.g., attribution, inhibitory learning)**
   b. **Encouraging clients to feel their anxiety while eating or stepping on scale is beneficial in the long run**
   c. **Have clients eat different foods in different locations/situations to encourage learning**

Treating these disorders can be challenging and require creativity, knowledge of and training in evidence-based treatment, and awareness of the intricate interplay of this presentation. Our hope is that our book will serve as a supplemental resource (as it is not empirically tested) for clinicians to use in treatment alongside existing empirically-supported treatment manuals when the comorbidity is present. By addressing the unique challenges posed by this comorbidity, clinicians can enhance their treatment approach and improve outcomes for their clients, which is our ultimate goal.

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CLASSIC CBT WITH PERSONALITY DISORDERS?

By James Pretzer

In a recent discussion, one participant suggested that "classic CBT" isn't effective with personality disorders and recommended using DBT or EMDR instead. Is he right? The treatment of personality disorders is a complex and important topic. There is considerable evidence that the presence of a co-occurring personality disorder has a significant impact on treatment and, since substantial portion of clients in many outpatient settings meet criteria for a personality disorder diagnosis, if classic CBT can't be used effectively with personality disorders that would be a real problem.

The answer depends on what you mean by "classic CBT." If by "classic CBT" you mean Beck's Cognitive Therapy of Depression (behavioral activation followed by identifying and modifying dysfunctional thoughts, addressing dysfunctional beliefs and assumptions, then finally working on relapse prevention), then he's right. Cognitive Therapy of Depression is designed for treating depression (hence it's name), not for treating personality disorders. However, there is much more to Cognitive Therapy than just Cognitive Therapy of Depression.

Cognitive Therapy approaches the treatment of personality disorders a bit differently than it approaches the treatment of depression. The same principles apply, but treatment needs to be tailored to the problem (and individual) being treated rather than trying to treat every problem in the same way as we would treat depression. How do we approach the treatment of personality disorders? Back in 1990 Dr. Barbara Fleming and I proposed some principles for CBT with personality disorders that seem to hold up fairly well. They are:

1. Interventions are most effective when based on an individualized conceptualization of the client's problems. Clients with personality disorders are complex, and the therapist is often faced with choosing among many possible targets for intervention and a variety of possible intervention techniques. Not only does this present a situation in which intervention can easily become confused and disorganized if the therapist does not have a clear treatment plan, but the interventions which seem appropriate after a superficial examination of the client can easily prove ineffective or counterproductive.

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James Pretzer, Ph.D. is the Director of the Cleveland Center for Cognitive Therapy and is an Assistant Clinical Professor of Psychology in the Department of Psychiatry at the Case Western Reserve University School of Medicine. He received his Ph.D. in Clinical Psychology from Michigan State University, completed post-doctoral training with Aaron T. Beck M.D. at the University of Pennsylvania, and is a Founding Fellow of the Academy of Cognitive Therapy.
Dr. Pretzer has more than 35 years experience in cognitive-behavioral therapy with a broad range of individuals and families. He is a co-author of Clinical Applications of Cognitive Therapy (with Barbara Fleming, Arthur Freeman, and Karen Simon) and of Cognitive Therapy of Personality Disorders (with Aaron Beck, Arthur Freeman, and associates).Dr. Pretzer also has authored and co-authored numerous journal articles and book chapters. His work has been translated and published in German, Swedish, and Japanese. Dr. Pretzer has presented his work at conferences of the American Psychological Association, the Association for the Advancement of Behavior Therapy, and the World Congress of Cognitive Therapy. He has provided advanced training in Cognitive Therapy for mental health professionals locally, regionally, and nationally. His posts on topics in contemporary CBT can be found at https://www.facebook.com/pg/CleveCCT/posts/

CLASSIC CBT WITH PERSONALITY DISORDERS? (CONTINUED)

By James Pretzer

2. It is important for therapist and client to work collaboratively towards clearly identified, shared goals. With clients as complex as those with personality disorders, clear, consistent goals for therapy are necessary to avoid skipping from problem to problem without making any lasting progress. However, it is important for these goals to be mutually agreed upon in order to minimize the non-compliance and power struggles which often impede treatment of clients with personality disorders. It can be difficult to develop shared goals for treatment since clients with personality disorders often present many vague complaints and, at the same time, may be unwilling to modify some of the behaviors which the therapist sees as particularly problematic. However, the time and effort spent developing mutually acceptable goals can be a good investment.

3. It is important to focus more than the usual amount of attention on the therapist-client relationship. Behavioral and cognitive-behavioral therapists are generally accustomed to being able to establish a fairly straightforward therapeutic relationship at the outset of therapy and then proceeding without paying much attention to the interpersonal aspects of therapy. However, this is generally not the case when working with clients who have personality disorders because the dysfunctional interpersonal behaviors which the clients manifest in relationships outside of therapy are likely to interfere with the therapist-client relationship as well. When the client's interpersonal difficulties are manifested in the therapist-client relationship, the therapist is provided with the opportunity to do in-vivo observation and intervention (Freeman, et al., 2004; Linehan, 1987c; Mays, 1985; Padesky, 1986).

4. Consider beginning with interventions that do not require extensive self-disclosure. Many clients with personality disorders are quite uncomfortable with self-disclosure due to a lack of trust in the therapist, discomfort with even mild levels of intimacy, fear of rejection, etc. While it is sometimes necessary to begin treatment with interventions which require extensive discussion of the client's thoughts and feelings, at times it can be more useful to begin treatment by working on a problem which can be approached through behavioral interventions which do not require extensive self-disclosure. This allows time for the client to gradually become more comfortable with therapy and for the therapist to gradually address the client's discomfort with self-disclosure (Freeman, et al., 2004, Chapter 8).

5. Interventions which increase the client's sense of self-efficacy often reduce the intensity of the client's symptomatology and facilitate other interventions. Albert Bandura (1977) has written at length regarding the concept of self-efficacy, the individual's appraisal of his or her ability to meet the demands of a particular situation. Many individuals with personality disorders manifest extreme emotional and behavioral responses in part because they doubt their ability to cope effectively with particular problem situations. If it is possible to increase the individual's confidence that he or she will be able to handle these problem situations if they arise, this often lowers the client's level of anxiety, moderates his or her symptomatology, and makes it easier to implement other interventions (Freeman, et al., 2004, Chapter 7; Pretzer, Beck, & Newman, 1989).

6. Do not rely primarily on verbal interventions. The more severe a client's problems are, the more important it is to use behavioral interventions to accomplish cognitive as well as behavioral change (Freeman et al., 2004, Chapter 3). A gradual hierarchy of "behavioral experiments" not only provides an opportunity for desensitization to occur and for the client to master new skills but also can be quite effective in challenging unrealistic beliefs and expectations.

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CLASSIC CBT WITH PERSONALITY DISORDERS? (CONTINUED)

By James Pretzer

7. Try to identify and address the client's fears before implementing changes. Clients with personality disorders often have strong but unexpressed fears about the changes they seek or are asked to make in the course of therapy, and attempts to induce the client to simply go ahead without addressing these fears are often unsuccessful (Mays, 1985). If the therapist makes a practice of discussing the client's expectations and concerns before each change is attempted, this is likely to reduce the client's level of anxiety regarding therapy and improve compliance.

8. Anticipate problems with compliance. Many factors contribute to a high rate of non-compliance among clients with personality disorders. However, rather than simply being an impediment to progress, episodes of non-compliance can provide an opportunity for effective intervention. When non-compliance is predictable, addressing the issues beforehand may not only improve compliance with that particular assignment but also prove helpful with other situations where similar issues arise. When non-compliance arises unexpectedly, it provides an opportunity to identify issues which are impeding progress in therapy so that they can be addressed.

9. Do not presume that the client exists in a reasonable environment. Some behaviors, such as assertion, are so generally adaptive that it is easy to assume that they are always a good idea. However, clients with personality disorders are often the product of seriously atypical families and live in atypical environments. When implementing changes, it is important to assess the likely responses of significant others in the client's environment rather than presuming that they will respond in a reasonable way.

10. Attend to your own emotional reactions during the course of therapy. Interactions with clients with personality disorders can elicit emotional reactions from the therapist ranging from empathic feelings of depression to strong anger, discouragement, fear, or attraction. It is important for the therapist to be aware of these responses so that they do not unduly influence or disrupt the therapist's work with the client, and so that they can be used as a source of potentially useful data. Since emotional responses do not occur randomly, an unusually strong emotional response is likely to be a reaction to some aspect of the client's behavior. Since a therapist may respond emotionally to a pattern in the client's behavior long before it has been recognized intellectually, accurate interpretation of one's own responses can speed recognition of these patterns.

11. Be realistic regarding the length of therapy, goals for therapy, and standards for self-evaluation. Many therapists using behavioral and cognitive-behavioral approaches to therapy expect to accomplish results quickly and can easily become frustrated, pessimistic, or self-critical when therapy proceeds slowly, as it often does when working with clients with personality disorders. Clinical reports suggest that behavioral and cognitive-behavioral interventions can accomplish substantial, apparently lasting changes in some clients with personality disorders, but more modest results are achieved in other cases, and little is accomplished in others (Freeman, et al., 2004; Turkat & Maisto, 1985). When therapy proceeds slowly, it is important to neither give up prematurely nor perseverate with an unsuccessful treatment approach. When treatment is unsuccessful, it is important to remember that therapist competence is not the only factor influencing the outcome of therapy.

With appropriate adjustments “classic” Cognitive Therapy can work well with a broad range of personality disorders. For a concise introduction to Cognitive Therapy with personality Disorders see the chapter that Dr. Beck and I wrote for Major Theories of Personality Disorder (Pretzer and Beck, 2005, available at https://www.researchgate.net/publication/335796551_A_Cognitive_Theory_of_Personality_Disorder).

Now, don’t get me wrong. DBT (Dialectical Behavior Therapy) also is an excellent cognitive-behavioral approach to treating personality disorders. It has considerable research support as a treatment for borderline personality disorder and, if you have the resources to provide individual therapy accompanied by skills-training groups and a consultation group for therapists, DBT has some real advantages. On the flip side, Cognitive Therapy also has empirical support, has a practical advantage in that it can be applied effectively by a solo practitioner, and is applicable to the full range of personality disorders.

OBSESSIVE THOUGHTS ARE NOT BELIEFS TO RESTRUCTURE

By Justin K. Hughes, MA, LPC

Obsessive thoughts are not beliefs to restructure.

There's one thing in my specialized practice working with Obsessive Compulsive Disorder (OCD) that Cognitive Behavioral Therapists have a poor reputation around—and it's sometimes warranted. The crucial mistake lies in how clinicians have treated "beliefs" in OCD.

A Brief History Lesson

Let's first consider our heritage. Before Cognitive Behavioral Therapy, OCD was untreatable. Sure, Freud claimed to have "cured" a case of obsessional neurosis—yet no successful protocols were developed until the 1980s—or, as my teens will say, "last century."

Once Aaron Beck, Albert Ellis, and others revolutionized treatment by addressing cognition in therapeutic ways, one of the behaviorists, Victor Meyer, released the first known paper detailing what would develop into ERP (1966). ERP was to become one of the most effective of all mental health treatments.

When OCD was only treated strictly behaviorally, it lacked essential components—particularly cognitive interventions—required to treat Obsessive Compulsive Disorder. Behavioral avoidance maintains fear, as do cognitive processes—beliefs and especially mental rituals in OCD (checking, reassurance-seeking, rumination, neutralization/suppression, avoidance—including distraction—and many others).

Missing a Functional Analysis

Fast forward to the present—the irony is that some clinicians misapply the cognitive interventions part of the gold standard treatment: Exposure and Response Prevention (ERP). Some have all but abandoned the behavioral components. For those utilizing Cognitive Therapy for OCD (evidence-based, but not "gold standard"), behavioral experiments are essential to this model. The type of Cognitive Restructuring (CR) to be applied is very specific to the illness.

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Justin K. Hughes, MA, LPC, owner of Dallas Counseling, PLLC, is a clinician and writer, passionate about helping those impacted by OCD. He serves on the IOCDF's OCD & Faith Task Force and is the Dallas Ambassador for OCD Texas. Working with diverse clients, he is dual-trained in psychology and theology, regularly helping anyone to understand the interaction between faith and OCD, most commonly Christians. Check out www.justinkhughes.com to stay in the loop and get free guides/handouts!

OBSESSIVE THOUGHTS ARE NOT BELIEFS TO RESTRUCTURE (CONTINUED)

By Justin K. Hughes, MA, LPC

Case Vignettes
Mary is a patient with OCD and depression, whose obsessive thoughts center on contamination and a fear of getting sick. Her depression increased the more she compulsed, and she was nearly homebound. She was highly critical of herself and grew up in a high-performing family that spoke about "lazy fat asses" who laid in bed all day. She did have both core beliefs and regular automatic thoughts around this, even when she was high-performing prior to her disability. Cognitive Restructuring was essential for her to build her motivation and improve her mood (referencing Beck's Negative Triad).

Mary, before CR: *I'll never get better.*

Mary, after CR: *I feel sad and discouraged; I have gotten better before, and it's possible I can improve again. I have never done this treatment, which statistically works for most people.*

Pradeep, a patient with OCD and Panic Disorder, experienced obsessions around harming others, and whenever he felt a bump on the road in his car, he obsessed over hitting someone. Frequent violent and bloody images occurred in his thoughts around loved ones; in such cases, he would panic and immediately leave. The panic became so bad he preemptively avoided environments linked to past panic.

The clinician assessed the function of his thoughts and discovered quickly he often asked "What if?" This was identified as an egodystonic recurrent doubt—an obsession. Given the working diagnosis of OCD, the clinician and Pradeep identified the phrase as something he ruminated on, looking for proof it might not be true. Cognitive Restructuring was contraindicated because there was an obsessive fear of this being true, not a patterned distortion needing restructuring. Other clinicians previously spent many sessions attempting to "get him to be more realistic." He significantly improved through ERP, including exposure scripting, practicing acceptance, and mindfully observing his internal experiences.

Pradeep before ERP: *What if I never get better?*

Pradeep after ERP: *Maybe I won't, maybe I will. I notice I'm having the thought that I won't get better.* [Followed by proceeding to the next thing he was doing.]

Don't Make It Worse:
Here are just a few common responses of therapists that play into the OCD Cycle:

- *Is that realistic? Let's look at the evidence.*
- *What is the alternative?*
- *What is the likelihood of that occurrence?*
- *Look at these outcomes; a vast majority improve significantly with treatment.*
- *Your prior history would indicate a cognitive error.*

Here are some sample responses supporting recovery with an obsessive thought:

- *Maybe, maybe not.*
- *How are you responding to this thought? What sort of reactions or mental rituals might you be doing?*
- *Observe your ABC in short form (no more than a few sentences).*
- *Have you done your exposure practices?*

It is essential to say that the content of obsessive thoughts can bring up core beliefs to restructure, but not inherently —they must be carefully assessed.

Effective Treatment
Effective treatment for OCD was one of the latest to the game. Let me encourage you today to stand on the shoulders of those who have contributed so much to highly effective treatment, and, in the meanwhile, don't perpetuate misinformed approaches that have already been tried and found wanting. Obsessive thoughts are not beliefs to restructure.

COLOR-CODED PROBLEMS HIERARCHY (CCPH) AND COLOR-CODED GOALS/ASPIRATIONS HIERARCHY (CCGH): QUANTITATIVE APPROACHES TO TRACKING PROGRESS IN COGNITIVE BEHAVIOR THERAPY

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Introduction

Tracking progress over time, which is essential for ensuring that a treatment plan is effective in helping patients achieve their therapeutic goals, is one of the challenges of cognitive behavior therapy (CBT) (Kilbourne et al. 2018). Traditional methods of tracking therapy progress include outcome measures and symptom checklists, which can be useful but do not provide a complete picture of a patient's progress (Jensen-Doss et al, 2018). The Color-Coded Problems Hierarchy (CCPH) and the Color-Coded Goals/Aspirations Hierarchy (CCGH) were created as part of Trial-Based Cognitive Therapy (TBCT) to address this issue.

TBCT is a CBT model that was created to make traditional CBT techniques more accessible to patients and therapists alike by providing a clear, step-by-step approach to cognitive and behavioral techniques that are easily remembered and implemented (de Oliveira, 2014).

Color-Coded Problems Hierarchy (CCPH)

The CCPH employs a color-coding system ranging from light blue (score of 0) to red (score of 5). A score of 0 indicates that the problem is minor and easy to solve (or that it no longer exists), whereas a score of 5 indicates that the problem causes so much distress that the patient is unable to see a solution. This method allows both the patient and the therapist to stay organized and focused on the most important issues while also tracking progress over time. As such, the CCPH could make a significant contribution to the field of CBT.

Fig. 1 depicts a patient with obsessive-compulsive disorder as well as several other difficulties that receive CCPH scores.

Once the CCPH list of existing problems has been collaboratively created, the spreadsheet's resulting figures and graphs provide visual representations of the patient's progress over time, as well as the total score and the number of distressing problems. Therapists and patients can identify areas where progress has been made as well as areas that still require attention by tracking changes in the scores over time.

For example, if the OCD rituals were initially scored as a 4, but have since dropped to a 2, this can indicate that progress is being made in that area. Conversely, observing an increase in score can then be used to inform the therapist's treatment plan and help them decide whether to continue using the same techniques or try something new. Furthermore, using color-coded scales in the CCPH may aid in making the patient's progress more tangible and visible. Patients may find it beneficial to see their progress represented visually, as small improvements can be difficult to notice when they occur slowly over time.

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COLOR-CODED PROBLEMS HIERARCHY (CCPH) AND COLOR-CODED GOALS/ASPIRATIONS HIERARCHY (CCGH): QUANTITATIVE APPROACHES TO TRACKING PROGRESS IN COGNITIVE BEHAVIOR THERAPY (CONTINUED)

Irismar Reis de Oliveira,1 MD, PhD, and Noah Clyman,2 LCSW, LCSW-R, A-CBT, BICBT-CMC

The CCPH may be useful in identifying patterns in a patient's problems in addition to tracking progress. For example, if a patient consistently scores a specific problem as distressing (4 or 5), this may indicate that this issue requires more attention and focus in therapy. Similarly, if a patient consistently scores a specific problem as a 0 or 1, this may indicate that the problem has already been addressed and can be deprioritized in future therapy sessions.

Color-Coded Goals/Aspirations Hierarchy (CCGH)

Modern CBT approaches, such as recovery-oriented CBT (Beck et al, 2020) and TBCT (de-Oliveira, 2014), place greater emphasis on goals and aspirations, highlighting the importance of working towards positive outcomes rather than solely addressing problems. The Color-Coded Goals/Aspirations Hierarchy (CCGH) is a complementary technique to the Color-Coded Problems Hierarchy (CCPH) and was developed to provide a structured, quantitative approach to tracking progress towards a patient's therapeutic goals and aspirations during cognitive behavioral therapy (CBT). The CCGH is designed to work in tandem with the CCPH, allowing patients and therapists to monitor progress not only by examining the resolution of problems, but by assessing the achievement of goals and aspirations as well.

The CCGH also utilizes a color-coding system that ranges from light blue (score of 0) to red (score of 5). A score of 0 indicates that the goal or aspiration is easy and comfortable to achieve, or that it has already been achieved, whereas a score of 5 indicates that the goal or aspiration is so distressing that the patient cannot imagine themselves attempting it. This system allows both the patient and therapist to prioritize goals and aspirations based on the level of difficulty and discomfort associated with achieving them, while also tracking progress over time.

The CCGH figure depicts a patient's list of goals and aspirations, as well as the scores assigned to each goal based on the level of difficulty and discomfort (Fig. 2).

Once the list of goals and aspirations has been collaboratively created, the spreadsheet's resulting figures and graphs provide visual representations of the patient's progress over time, using color-coding to indicate changes in the scores assigned to each goal or aspiration. This visual representation helps therapists and patients to identify areas where progress has been made, as well as areas where additional focus and effort may be required.

The CCGH can help patients and therapists maintain motivation and engagement in therapy by illustrating progress and achievements. It can also assist therapists in adjusting treatment plans according to the patient's evolving needs and aspirations.

Limitations

Both the CCPH and the CCGH have potential issues since they rely on patient self-reporting, with a risk of bias or inaccuracy in the data. Thus, the color-coded scales may not always accurately reflect the severity of a particular problem or the difficulty or discomfort associated with achieving a particular goal or aspiration. Another limitation is that these tools may not be suitable for all patients or problems (CCPH) or goals/aspirations (CCGH). For example, patients with important cognitive impairments or developmental disorders may struggle to understand or use the scales effectively. Additionally, the CCPH may not be appropriate for patients who have more complex or nuanced problems that are difficult to categorize on a simple scale.

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Irismar Reis de Oliveira,1 MD, PhD, and Noah Clyman,2 LCSW, LCSW-R, A-CBT, BICBT-CMC

Conclusions

The CCPH and the CCGH are new tools developed as part of TBCT to provide structured and quantitative approaches to tracking therapy progress (de-Oliveira, 2015). These tools, which employ color-coded scales and visual representations, may assist both patients and therapists in remaining organized, focused, and motivated during therapy. While they have limitations, the CCPH, on one side, may be especially useful in treating patients with more straightforward problems and, on the other side, the CCGH provides a structured and quantitative approach to tracking progress towards the patient's therapeutic goals and aspirations. When used in conjunction, these tools may offer a comprehensive approach to monitoring progress in CBT.

Acknowledgments

We thank Katie Zoborsky, who read the original manuscript and gave important suggestions.

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COLOR-CODED PROBLEMS HIERARCHY (CCPH) AND COLOR-CODED GOALS/ASPIRATIONS HIERARCHY (CCGH): QUANTITATIVE APPROACHES TO TRACKING PROGRESS IN COGNITIVE BEHAVIOR THERAPY (CONTINUED)

Irismar Reis de Oliveira,1 MD, PhD, and Noah Clyman,2 LCSW, LCSW-R, A-CBT, BICBT-CMC

Figure 1. Excel CCPH spreadsheet with color-coded anchors ranging from 0 to 5, as well as a patient's list of problems and their evolution over time.

A	B	C	D	E	F	G	H
0. Problem is small and its solution is easy (or it is not a problem anymore)							
1. Problem elicits discomfort, but its solution is relatively easy							
2. Problem elicits clear discomfort, and/or its solution is difficult	Color-Coded Problems Hierarchy						
3. Problem elicits much discomfort, and/or its solution is very difficult							
4. Problem elicits distress, and its solution is very difficult							
5. Problem elicits so much distress, that I can't see a solution							
METAS/ASPIRAÇÕES↓ DATAS→	06/10/22	07/08/22	08/12/22	09/16/22	10/14/22	11/18/22	12/09/22
1 - My OCD	5	4	3	4	3	3	2
2 - Fear of taking medicines	4	3	1	0	0	0	0
3 - Frequent conflicts with my husband	4	4	3	3	2	2	2
4 - Compulsive shopping	3	2	3	2	2	1	0
5 - Difficult work routine	3	4	3	3	2	1	1
6 - Worries related to my son's school performance	2	1	2	1	1	1	0
7 - Insomnia	4	4	3	3	2	3	2
8 -							
9 -							
10.							
Total score	**25**	**22**	**18**	**16**	**12**	**11**	**7**
Number of problems eliciting distress	**4**	**4**	**0**	**1**	**0**	**0**	**0**
Percentage of total score improvement	0	12,00	28,00	36,00	52,00	56,00	72,00
Percentage improvement of distressing problems	0	0,00	100,00	75,00	100,00	100,00	100,00

COLOR-CODED PROBLEMS HIERARCHY (CCPH) AND COLOR-CODED GOALS/ASPIRATIONS HIERARCHY (CCGH): QUANTITATIVE APPROACHES TO TRACKING PROGRESS IN COGNITIVE BEHAVIOR THERAPY (CONTINUED)

Irismar Reis de Oliveira,1 MD, PhD, and Noah Clyman,2 LCSW, LCSW-R, A-CBT, BICBT-CMC

Figure 2. Excel CCGH spreadsheet with color-coded anchors ranging from 0 to 5, as well as a patient's list of goals and aspirations and their evolution over time

0. This goal/aspiration is easy and comfortable to achieve (or I have already achieved it)
1. This goal/aspiration is not so easy or comfortable to achieve
2. This goal/aspiration is difficult or uncomfortable to achieve
3. This goal/aspiration is very difficult and/or uncomfortable to achieve
4. Achieving this goal/aspiration is distressing and/or really hard
5. Achieving this goal/aspiration is so distressing that I cannot imagine myself trying

Color-Coded Goals/Aspirations Hierarchy

METAS/ASPIRAÇÕES↓ DATAS→	06/10/22	07/08/22	08/12/22	09/16/22	10/14/22	11/18/22	12/09/22
1 - Sleep 7-8 hours per night	4	4	3	2	3	2	3
2 - Exercise at least 3 times a week	3	4	3	3	2	2	3
3 - Study 3 times a week	4	3	3	2	1	1	0
4 - Reduce and stop compulsive shopping	4	2	3	2	2	1	0
5 - Have enjoyable social time with my husband	5	4	5	4	3	3	1
6 - More quality time with my son	3	1	2	1	1	0	0
7 - Free myself from OCD	4	4	4	3	2	2	3
8 - Improve conjugal intimacy	5	4	3	4	2	1	0
9.							
10.							
Total score	**32**	**26**	**26**	**21**	**16**	**12**	**10**
Number of goals eliciting distress to achieve	**6**	**5**	**2**	**2**	**0**	**0**	**0**
Percentage of total score improvement	0	18,75	18,75	34,38	50,00	62,50	68,75
Percentage improvement of distressing goals	0	16,67	66,67	66,67	100,00	100,00	100,00

TRAINERS' CORNER: IMPROVING YOUR SOCRATIC SKILLS

By Scott Waltman, PsyD, ABPP

Creating a Shared Definition

What does it mean to be a good person? How do we define being a loser? What is a good mother? What does it mean to be successful?

Consider a client who has recently lost their job or had a failed business venture, and they present with a self-narrative of being a failure. The wise clinician knows that an immediate evaluation of the evidence of whether they are a failure will be challenging because the current circumstances are not favorable. The wise clinician can also see that the individual is confusing their overall identity with their current time-limited external circumstances. One of my favorite Socratic strategies is one I learned from James Overholser and involves creating a shared definition of the construct early in the therapeutic dialogue. Before asking a client for the evidence that they are a failure, I'll first ask them how they are defining what it means to be a failure and then I'll work with them to reshape that definition into something we both agree on. Typically, this involves moving their concept from an experience of failing to a behavior of giving up, and then not giving up can be framed as the path towards resilience.

This strategy mirrors that of Socrates, the ancient Greek Philosopher. In preparation for my latest book, the self-help workbook version of my Socratic Questioning therapist manual, I reread all the original texts to get a deeper understanding of how Socrates himself used Socratic Questioning. When Socrates would have a Socratic Dialogue with someone, he would first identify the core concept and then work to evaluate the definition of that concept. For example, when speaking with someone about courage, their initial narrow definition of standing your ground no matter what, was enlarged to be facing your fears and doing what is wise to meet your objective. In a clinical context, this reshaped definition would be more useful as it would allow for an emphasis on doing what is effective.

Consider the example below of a pseudo-client named Zora who was working to get sober and get her children back, after they were removed from her by Child Protective Services. Zora and her therapist identified a belief that she was a bad mother. Prior to evaluating this thought, the therapist suggested they make a universal definition of bad mother to help them have a fair evaluation.

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

TRAINERS' CORNER: IMPROVING YOUR SOCRATIC SKILLS

By Scott Waltman, PsyD, ABPP

Therapist: Zora, we identified this very painful thought of being a bad mother Before we get into evaluating it, I want to first make a shared definition of what a bad mother is that we both agree on. Is that alright with you?

Client: Yeah, I guess so.

Therapist: So, how should we define this concept of being a bad mother?

Client: Well, a bad mother does do drugs. She does get her children taken away. She is a junkie (*starting to tear up*)

Therapist: Zora, I want to pause for a second. Clearly, this is a difficult topic and I think it's important that we honor that. What I hear you doing is listing out all the reasons you think you are a bad mother. I don't want to do that. I don't think that will be helpful. I think you already do that a lot when I'm not around. I want to make a general definition, a universal definition of bad mother so we can look at this belief you have. Maybe it will be easier to define the two extreme definitions of perfectly good mom and completely bad mom. Does that sound OK?

Client: *(taking a resolute breath)* Yes, I can do that.

Therapist: Good, we are already doing a good job with this. Let's define the perfect mother then.

Client: She cooks, she cleans, she irons, her kids have food.

Therapist: Probably, like really good food like organic and healthy and carb balanced and naturally sourced, and that whole GMO thing.

Client: (slight chuckle) Yeah, and everything is neat and clean.

Therapist: How about the kids' emotional needs?

Client: Oh, right, they love their children and let them know they love them.

Therapist: They make their children important.

Client: Yes, your children have to be the most important thing.

Therapist: So, there's a practical needs item, emotional needs item, prioritizing item; what else?

Client: Being a mom, you just have to do your best and they always need you.

Therapist: So, being a good mom is a long-run issue. You don't hit a point where you do enough and don't have to try anymore?

Client: Nope, it's a forever job.

Continued on next page

TRAINERS' CORNER: IMPROVING YOUR SOCRATIC SKILLS

By Scott Waltman, PsyD, ABPP

Therapist: So, all the things we talked about with an across time perspective.

Client: Yes, it's exhausting.

Therapist: Sounds like it. What about on the other extreme. How do we define the completely bad mom?

Client: The completely bad mom doesn't care about her kids. She puts herself first.

Therapist: Is it just about caring? Are there actual bad things a mom can do to harm her children?

Client: Like not being there for them because they were taken away because the mom is a user.

Therapist: Maybe that's one example, but I'm sure you've heard or could think of other examples.

Client: Yeah, one of the women I bunk with was saying her mom would pimp her out for money, so her mom could get high.

Therapist: That sounds like it belongs on our list. What else could be bad mom behavior?

Client: I guess abusing your kids.

Therapist: Maybe, also abandoning your kids. Deliberately harming your kids?

Client: Yeah, there are some really disturbing stories out there.

Therapist: So, we have content for our definition. It sounds like the all-good mom does all good things all the time, and the bad mom puts herself first and hurts her children. We need to set the criteria. How good do you have to be to be good? How many mistakes can you make before you are bad? Once you're bad, are you forever bad? Or is there a path for redemption?

Client: I don't know.

Therapist: These are big questions. How many moms do you know are all-good moms? Like, all the way all the time?

Client: Uh...like that I actually know, or I just think are good?

Therapist: Yeah, how many confirmed cases of perfect moms are there?

Client: Probably none. Kids are so hard. And things that work with one kid, might not work with the next.

Therapist: So, let's define the good-enough mom.

Client: The good enough mom is someone who works hard to make sure her kids have what they need.

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TRAINERS' CORNER: IMPROVING YOUR SOCRATIC SKILLS

By Scott Waltman, PsyD, ABPP

Therapist: She loves them and works to put them first.

Client:She doesn't deliberately hurt her kids.

Therapist: And, she never gives up. How does that sound?

Client: That sounds like a good mom, but like a realistic good mom.

Therapist: What about the question about redemption? Can a mom make mistakes, and get back on track and be good enough again?

Client: I think so...I hope so.

Therapist: What is going to make it easier to focus on what you have to do to get your kids back?

Client: Having a path to redemption, getting back to being good enough.

Therapist: OK, so we have a shared definition that we both agree on, and I've written down. Let's look at where you've been in the past, where you are now, and where you are trying to get to.

Curiosity is the key to this whole process. If you want to learn more about Socratic Questioning check out this lecture I gave for the NYC-CBT Association now freely available on YouTube https://www.youtube.com/watch?v=-rm1DqY5AH0 and also there are some great books on the topic, see references above:

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

Updates from the *International Journal of Cognitive Therapy*—the official journal of the International Association of Cognitive & Behavioral Therapies

Volume 16, issue 3, September 2023

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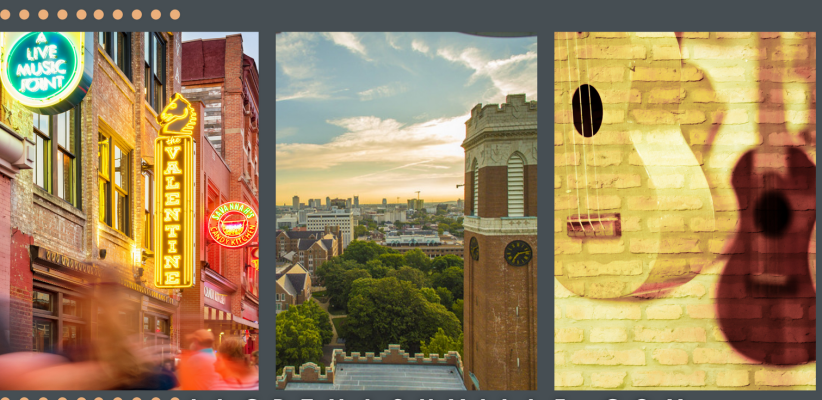

11TH INTERNATIONAL ASSOCIATION OF COGNITIVE BEHAVIORAL THERAPY CONFERENCE

Summer 2025

Cognitive Behavioral Therapy as a Tool for Recovery

NASHVILLE, TENNESSEE

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On behalf of the organizing committee of the 11th International Association of CBT Conference, we would like to welcome you to Music City, Nashville Tennessee, United States of America in Summer 2025. We are eager to reconvene this engaging and passionate conference for the first time since the pandemic. As such, we are hard at work developing a challenging and engaging scientific program designed to expand our minds, kindle new collaborations and foster cross-research conversations.

The theme of the Congress is "CBT as a Tool for Recovery". We will emphasize that embracing evidence based, high fidelity CBT is a systematic approach for achieving durable recovery. In his 1976 book, Cognitive Therapy of the Emotional Disorders, the late Tim Beck wrote that Cognitive Therapy acts by "helping the patient draw on his own problem solving apparatus.," and prioritizes his own view of his life. Almost five decades later, CBT researchers have refined interventions to relieve distress and free people to move forward in life. The continued improvements in our treatments allow CBT providers to better partner with individuals to return to the lives of their choosing. Until the end of his life Tim Beck focused on extending the concept of recovery to as many people as possible.

As the first North American site of this great meeting, we are thrilled to host this great meeting in Nashville, Tennessee – known for its electric downtown, music and entertainment, historical landmarks, and close access to nature. We look forward to seeing you in 2025!

https://iacbtnashville.com/

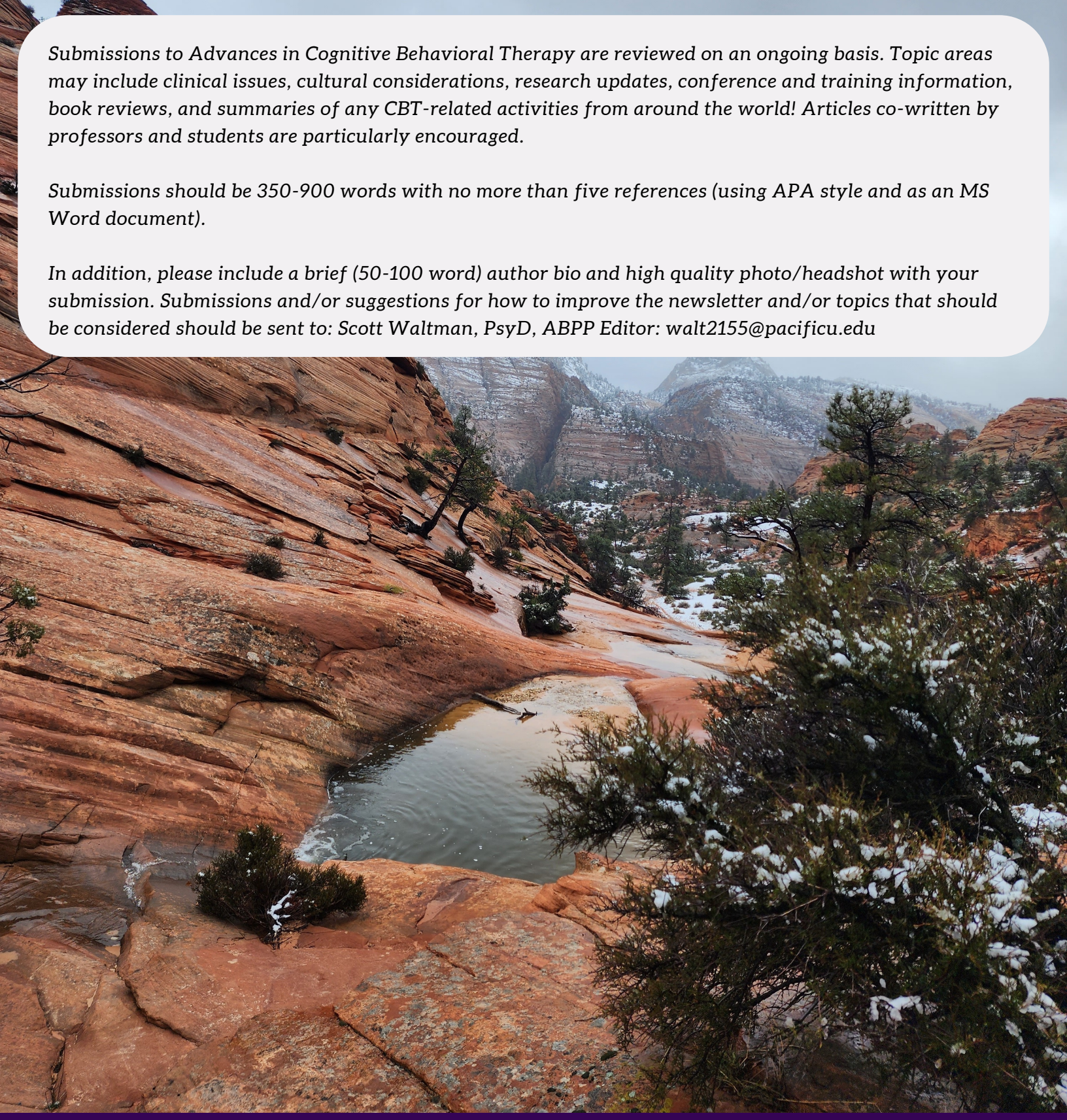
Advances in Cognitive Behavioral Therapy Newsletter

Advances in CBT
Winter 2023 Issue

Submissions to Advances in Cognitive Behavioral Therapy are reviewed on an ongoing basis. Topic areas may include clinical issues, cultural considerations, 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.

Submissions should be 350-900 words with no more than five references (using APA style and as an MS Word document).

In addition, please include a brief (50-100 word) author bio and high quality photo/headshot with your submission. Submissions and/or suggestions for how to improve the newsletter and/or topics that should be considered should be sent to: Scott Waltman, PsyD, ABPP Editor: walt2155@pacificu.edu



Advances in
Cognitive Behavioral Therapy
Newsletter

Advances in CBT
Winter 2023 Issue