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EDITOR
Jamie Schumpf, Psy.D.

ACT PRESIDENT'S MESSAGE

Over 40 million American adults suffer from an anxiety disorder, over 14 million live with major depression, over 6 million live with bipolar disorder, and over 2 million American live with schizophrenia. Almost 25 million adolescents and adults in the US suffer from substance abuse. Anxiety, depression, and substance abuse are the most common mental illnesses and come at a huge cost to the person who suffers, as well as to their family, friends, and to our society at large. Collectively, anxiety disorders are the most common illnesses today and cost us over 42 billion dollars in the United States alone. The figures for depression and suicide are even more dismal. Depression is the leading cause of disability in the world, costing our society upwards of 1 trillion dollars across the globe. The mental health needs of our youth have also begun to climb at an astonishing rate. Suicide is the second leading cause of death for adolescents and young adults and the rate of suicide has increased rapidly over the years. On average, one person commits suicide every twelve minutes.

The growth of evidence-based mental health treatments has improved the prognosis for sufferers. Of all the psychotherapies, cognitive behavior therapies have amassed the largest amount of evidence demonstrating that they decrease the pain of mental illness and improve quality of life for those who suffer. Cognitive behavioral researchers work tirelessly to understand these conditions, to understand what makes people more likely to develop them, to develop and test interventions to prevent and treat them, and to train a younger generation of professionals to continue advancing the field. However, the truth it is, these efforts are simply not enough - we need to do more.

There are just not enough people to effectively treat mental illnesses and there is a disconnect between the scientists who research these illnesses and those who require treatment. This divide continues to this day, where departments of psychology advance science, but may not work in tandem with the counseling centers in the same university to ensure that the students who suffer get the latest treatments. Additionally, professionals who completed their studies before training in CBT was adopted into graduate curricula, find it harder to obtain the comprehensive training they need to effectively treat people using these approaches. The field of dissemination and implementation science holds promise as an evidence-based method of spreading the reach of CBT treatments developed in academic settings to school, clinical, and community settings. Online CBT treatments have also proliferated and have the potential to close the gap between what we know is effective in treating patients

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and what is currently being delivered in practice and community settings.

Disseminating the value of CBT approaches to consumers, professionals, governmental agencies, and insurance companies is also essential. Despite the fact that CBT therapies have the greatest number of controlled scientific studies supporting their efficacy in comparison to other psychotherapies, some recent articles written by proponents of other therapies suggest that CBT may not be the gold standard and that the efficacy of CBT may have fallen in recent years. If the efficacy has indeed fallen, many reasons may account for this finding. Original studies may have placed a greater emphasis on therapist fidelity and training than later trials. Lower adherence to manuals or poorer therapist competence in later studies may also explain such findings. Many later trials often fail to describe treatment content or to report the level of training received by study therapists, thus making it a challenge to assess treatment integrity. However, it may also be that CBT is a victim of its own success. Cognitive behavioral principles have likely "bled" into other psychotherapy treatments over the years, and may mask CBT's effects in trials that compare it to other psychotherapy treatments. CBT is also now increasingly available to the public through the media, self-help books, and the Internet. As a result, the "falling" efficacy may in fact be the result of ceiling effects observed secondary to CBT's success in being widely disseminated. Although it is possible that early effects were inflated or that modifications in recent years have made CBT less effective than early iterations, what remains clear is that the need to improve CBT interventions to prevent and treat mental illnesses remains a priority.

Beyond improving the strength of current interventions, future research is needed to target those who do not respond to CBT, further maximize the effects of CBT following therapy discontinuation, and to understand its mechanisms of action. The Research Domain Criteria (RDoC) offers opportunities for greater integration between disciplines for the betterment of mental health, especially if the contributions of genomics and neuroscience are balanced with the contributions of behavioral science research. Greater integration of CBT with biological approaches, cognitive science, systemic approaches, motivational interviewing, and strengths-based approaches hold great promise to enhance the effectiveness of CBT in the future. Recent transdiagnostic approaches may also better address the needs of severely ill, multi-problem individuals in clinical setting presentations who may not respond as well to manualized approaches intended for single symptom presentations.

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

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MEHMET Z. SUNGUR, MD
PRESIDENT OF THE INTERNATIONAL ASSOCIATION FOR COGNITIVE PSYCHOTHERAPY (IACP)

Dr. Sungur received training in cognitive behaviour therapy (CBT), sexual and marital therapies at the Institute of Psychiatry, Maudsley and Bethlem Royal Hospitals in London. He was accredited as a cognitive behaviour therapist by the UK Council of Psychotherapy and British Association of Behavioural and Cognitive Psychotherapy (BABCP). His clinical practice covers a wide range of clinical syndromes with a special emphasis on cognitive behavioural treatment of anxiety disorders, depression, schizophrenia, posttraumatic stress disorder and sexual and marital problems. He published numerous articles in national and international scientific journals and presented workshops and keynotes in hundreds of national and international congresses. He played a leading role in the dissemination of the practice of CBT and sex therapy in Turkey.

Dr. Sungur has received some national and international awards, the first one being "Schizophrenia Reintegration Award" and the recent one being "Gold Medal from European Federation of Sexology" which was presented to him at the 16th Congress of the European Society of Sexual Medicine (ESSM) joint by 12th Congress of European Federation of Sexology (EFS) in january 2014. He also received "Julia Heiman Honorary Award" and recently "Lo Piccolo Award" for his contributions in the area of sex therapy. He has published more than 100 papers mainly about Cognitive Behaviour Therapy and sexual disorders. He has also written books and book chapters mainly about CBT.

Dr. Sungur is a Professor of Psychiatry, Psychiatry Dept of Marmara University Hospital, Istanbul, President of the Turkish Association for Cognitive Behaviour Psychotherapy (TACBP), Former President of European Association of Behaviour and Cognitive Psychotherapy (EABCT), Diplomate, Founding Fellow Academy of Cognitive Therapy (ACT) ACT Certified Supervisor, Trainer and Consultant, World Association of Sexology MESHC Member World Sexual Health Country Coordinator, and Executive Board Member of the European Federation of Sexology (EFS).

LOOK FOR DR. SUNGUR'S COLUMN İN OUR NEXT İSSUE FOR UPDATES FROM THE IACP.

STANDING ON THE SHOULDERS OF GIANTS
ROBERT L. LEAHY, PH.D.

Robert L. Leahy Ph.D. has authored and edited 26 books on cognitive therapy and psychological processes and is the Past President of the Association for Behavioral and Cognitive Therapy (ABCT), the International Association for Cognitive Psychotherapy, and the Academy of Cognitive Therapy and Clinical Professor of Psychology in Psychiatry at Weill Cornell Medical School. His books have been translated into 21 languages. His recent books include Cognitive Therapy Techniques, 2E (2017), Science and Practice in Cognitive Therapy (2018), and The Jealousy Cure (2018). He is the Director of The American Institute for Cognitive Therapy in NYC (www.cognitivetherapynyc.com) and the recipient of the Aaron T. Beck Award for Outstanding Contributions in Cognitive Behavioral Therapy.

When I look back at my life at this moment of reflection I wonder how I got to where I am and to what extent luck had a lot to do with it—both good luck and bad luck. Because I think that what helps us cope is to realize it's up to us to use the luck that we are given, since life can throw a lot of things our way. Obstacles can either kill the spirit or bring it to life. When I was 18 months old my mother moved my brother and me from Alexandria, Virginia back to New Haven to live with her and my Italian grandparents. My father was an alcoholic and the chaos and even violence that he was capable of was something that our mother protected us from. I saw my father only once, in a diner for one hour, and from that day forward he never provided a penny to support us. For two years we lived with our grandparents but I think that this laid the foundation for nurturance and love and acceptance that gave me strength to this day. When Paul Gilbert asks us to do the compassionate imagery exercise I visualize my Italian grandmother and tears come to my eyes.

We then moved from a completely Italian home to an Irish working-class housing project—poor—but relatively happy—since we always had kids to play with and we felt loved. When I was 13 I decided that I didn't want to be poor for my entire life and I realized that my school would never prepare me sufficiently so I wrote out a plan to get into Yale, which was the only college I knew much about. I kept track of my reading outside of homework, got into positions of leadership, and focused on my goals while maintaining a balance with friends and sports. I realized looking back that I was practicing CBT on myself—before there was CBT. I would like to say I had a role model, but I didn't. I think this is a stroke of genetic good luck.

During college and during my early time in graduate school at Yale I was fascinated with psychoanalysis. I read almost all of Freud's major works, I was enamored with the Rorschach, and I thought that I had found a roadmap to understanding culture and the human psyche. Perhaps it was something that was replacing Catholicism for me. This worked well with my interests in literature, tragedy, existentialism, and history but my disillusionment grew as I realized that the limited outcome data of the time did not support this approach. I turned my interest to social development, social cognition and the interface between cognitive level and psychopathology and began focusing on empirical research. I was especially influenced by Piaget's structuralism and my first edited book was The Child's Construction of Social Inequality. During my time at Yale I was fortunate to learn from Edward Zigler, Irvin Child, Charles Kiesler, and Richard Nisbett in psychology, but also from my undergraduate experience as a beginning English Literature major—especially from Richard B. Sewall whose course on tragedy inspires me to this very day. I recall when I completed my doctoral degree at Yale I said to myself, "Don't become too narrow—keep reading in the humanities—keep learning beyond the field of psychology." This is what keeps driving me—curiosity, appreciation for what I don't know, and the realization that people with more wisdom than I will ever have struggled with profound questions for thousands of years. And that there are more questions than there are answers.

When I first began in academics—teaching at Catholic University of America (where I first met Marsha Linehan), the Graduate Faculty of the New School for Social Research, and then The University of British Columbia—I thought I was doing fairly well in the traditional academic model. I had an NIMH grant, was publishing in good journals, and had two book contracts, but there was something missing for me, something that I thought I needed. I began to shift back into clinical work while still doing the academic thing. Then one afternoon when I was sitting in my office in Vancouver an old friend from Yale Child Study Center- Sara Sparrow- called and told me that our friend, David, had committed suicide. That call still runs through my broken heart whenever I think of it. But it changed me, it gave me the impetus to commit myself to train with Aaron Beck and to dedicate my life to the hope that I might prevent this tragedy from happening to someone else.

My interests have always gone beyond the usual categories. Earlier in my career I was particularly interested in how people made moral judgments, how they inferred the personality characteristics of other people and how they developed what we now call "Theory of Mind". Of particular relevance to the cognitive model was the work in attribution theory—and its application by Seligman, Alloy and Abramson. But although my work was based primarily in the cognitive model I also realized that how we think about and respond to our emotions and those of others is a fundamental part of human existence. Indeed, without emotion there is no meaning and choices are a matter of personal indifference. This emotional component seemed to be underdeveloped in the traditional model

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THE THERAPEUTIC RELATIONSHIP WITH SUICIDAL ADOLESCENTS: WHAT WENT WRONG IN THE COUNSELOR SCENE IN "13 REASONS WHY (13RW)"

CORY NEWMAN, PH.D.

Cory F. Newman, Ph.D., is Director of the Center for Cognitive Therapy, Professor of Psychology, in Psychiatry at the University of Pennsylvania Perelman School of Medicine, and Adjunct Faculty at the Beck Institute for Cognitive Behavior Therapy. Dr. Newman is a Diplomate of the American Board of Professional Psychology, and a Founding Fellow of the Academy of Cognitive Therapy. Dr. Newman has served as a protocol therapist and supervisor in a number of large-scale psychotherapy outcome studies, including the Penn-Vanderbilt-Rush Treatment of Depression Projects and the NIDA Multisite Collaborative Study on Treatments for Cocaine Abuse. Dr. Newman is an international lecturer, having presented more than 200 cognitive-behavioral therapy workshops and seminars across the USA, as well as in twenty other countries internationally. Dr. Newman is the lead or solo author on dozens of articles and chapters on cognitive therapy for a wide range of clinical issues (including suicide prevention), and has authored or co-authored six books, including Choosing to Live: How to Defeat Suicide Through Cognitive Therapy, Core Competencies in Cognitive-Behavioral Therapy, and Supervision Essentials in Cognitive-Behavioral Therapy.

Much has been written in the months since 13RW – the series about a teen suicide -- was premiered on Netflix, and it has inspired a great deal of discussion. Allow me to add additional commentary, specifically with regard to the importance of the therapeutic relationship with suicidal adolescents, and how the depiction of the scene between Hannah and her high school guidance counselor provides a disturbing cautionary tale about what can go wrong.

Working with young suicidal patients is often difficult and frightening. Forming a healthy therapeutic relationship can be impeded by the patient's reluctance to entrust deeply personal information to an authority, and by the therapist's lack of access to contextual information that would otherwise inform him or her about the level of gravity of the situation. In 13RW, by the time that Hannah initiated a meeting with Mr. Porter (her high school guidance counselor) she had already taken several concrete steps in her suicidal plan, she was highly ambivalent about sharing her thoughts, and therefore presented as vague and reticent. This is understandable, especially if we consider that a patient such as Hannah may fear:

- Being labeled as "crazy."
- Being judged as manipulative.
- Being dismissed as seeking attention.
- Being hospitalized against her will.
- Having her secrets disclosed to loved ones and others.

It is with this in mind that we as therapists need to be explicit in communicating empathy, and not to become frustrated when the patient is not fully engaging. Unfortunately, Mr. Porter became impatient, inserting his own assumptions into the therapeutic dialogue, implying that Hannah regretted something she did (in the area of sexual behavior), when in fact she had been victimized, felt alone, and had already planned an imminent suicide attempt. Mr. Porter did not ask Hannah for feedback, did not express contrition for saying something that may have been inaccurate and/or unhelpful, and (most importantly) never explicitly and thoroughly assessed Hannah for suicidality.

Hannah described herself as having no friends, but Mr. Porter quickly contradicted her, citing his observation of the other students with whom he often saw her spending time in the hallways. Thus, he came across as invalidating of Hannah's feelings, rather than understanding that Hannah was engaging in depressive thinking, and rather than trying to understand her subjective sense of detachment and isolation. When Hannah said, "Clay Jensen hates me" (referring to the classmate with whom she had her closest relationship), Mr. Porter simply said that Clay was not the type of person who would hate anyone, rather than saying something such as, "I had no idea you felt that way. Can you tell me what happened between the two of you? I'd really value hearing what you have to say about this, and I hope it's okay if I ask you more questions so we can understand this situation better." This sort of inquiry would have had a better chance of opening up a much-needed dialogue, rather than shutting it down.

Once Hannah was able to explain that she had been sexually assaulted by an unnamed student, Mr. Porter presented her with an "all-or-none" choice; either press official charges against the offending student, or "move on" and get over it. Although Mr. Porter may have felt pressure to fulfill a mandate (to report an offending student to the police if Hannah made an official charge), it was unnecessary and highly iatrogenic to offer Hannah two extreme choices, on the spot, take it or leave it. Instead, what was required was a comment such as, "Clearly you have been traumatized, and we need to make sure you get the help you need, including exploring trauma-related therapy outside this office. Right now, I just want to listen and understand, and make sure that you're safe." When Hannah reacted incredulously to Mr. Porter's suggestion that she "put it all behind [her] and move on," he needed to recognize that the alliance had been ruptured and then respond by doing all he could to repair it. Additionally, Mr. Porter did not do a suicide risk assessment even though Hannah was presenting with dysphoria and hopelessness. Patients such as Hannah need to be handled with great care, as befits their vulnerability.

Finally, Hannah left the office prematurely, and Mr. Porter did not extend himself to pursue her. We discover that Hannah had waited outside Mr. Porter's office for a minute, hoping that he would come

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IMPROVING ACCESS TO CBT TRAINING ONLINE COURSES FROM BECK INSTITUTE

JUDITH S. BECK, PH.D.

Judith S. Beck, Ph.D., is President of Beck Institute for Cognitive Behavior Therapy in Philadelphia, a non-profit organization that provides a variety of training programs to health and mental health professionals worldwide, and Clinical Professor at the University of Pennsylvania. She has authored over 100 chapters and articles and several books, including Cognitive Behavior Therapy: Basics and Beyond, which has been translated into over 20 languages, and Cognitive Therapy for Challenging Problems. She divides her time among teaching, clinical work, supervision, administration, program development and consultation, writing—and most recently, developing online courses.

The non-profit Beck Institute for Cognitive Behavior Therapy was established in 1994, primarily to provide state-of-the-art training in CBT. It had been a challenge to figure out how to properly teach health and mental health professionals who were unable to travel to Philadelphia for our workshops. Until recently, we relied on educating clinicians through our publications, webinars, distance supervision and consultation programs, presentations at national and international conferences, and large-scale trainings for other organizations.

In 2016, we started releasing online training programs, designed to improve competence and clinical effectiveness in CBT. Current courses are 4-8 weeks, with approximately two hours of video content per week. So far, our offerings include Essentials of CBT, CBT for Depression, CBT for Anxiety Disorders, and CBT for Personality Disorders. We intend to offer additional courses every year for quite a long time, as well as short webinars on a wide variety of topics. Participants can take courses on their computer, cell phone, tablet, or other device, at any time of the day or night. Each course includes an extra month at the end to catch up, review material, and re-watch the videos.

In each course, I teach the nuts and bolts of cognitive conceptualization and treatment in a step-by-step manner. For example, one entire week in the Essentials course is devoted to Action Plans, what we used to call homework. Participants watch short "talking head" videos (where the speaker is talking to the camera) on various topics--such as how to collaboratively create good assignments, motivate clients to do the assignments, specify where, when, and for how long to do an assignment, identify potential obstacles (related to practical problems and/or the client's cognitions), check on the likelihood of completion, review the Action Plan, and conceptualize why a client is resistant to creating an Action Plan or fails to complete an assignment. These videos are often accompanied by animation and b-roll (supplemental footage intercut with the image of the speaker) to hold the attention of the learner.

And each course contains much more. There are video clips of therapy sessions as well as entire therapy sessions. There are videos of Dr. Aaron Beck and case discussions with the expert clinicians at the Beck Institute. The courses include clinical tips, reflection questions, and practice exercises. A virtual library contains enrichment material and resources. A course manual has worksheets, diagrams, and summaries of important points.

Creating these online courses has been incredibly challenging and interesting. An excellent training experience requires much more than just carefully crafted lessons. Support and open discussion are also crucial. An online Forum gives trainees the opportunity to answer reflection questions, comment on what they're learning, and post questions to their fellow learners. Our faculty also responds to comments and questions and helps with difficulties trainees have in applying their new skills to their clients. The Forum itself creates a rich, interactive experience.

We have been so pleased by the overwhelming response we have received. People from 94 countries have taken more than 4,000 courses in the past year and a half. Contributions to our non-profit institute have allowed us to grant scholarships to students and to people in developing countries. Thanks to new technology, we have been able to train far more people, some in very far-flung places, than we ever have.

For more information, please visit www.beckcbtonline.org.

Submissions to Advances in Cognitive Therapy are reviewed on an ongoing basis. Topic areas may include clinical issues, research updates, conference and training information, book reviews, and summaries of any CBT-related activities from around the world! Articles co-written by professors and students are particularly encouraged.

The next deadline for submission is January 15th, 2018. 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.

COGNITIVE THERAPY AND THE SOCRATIC METHOD

JAMES C. OVERHOLSER, PH.D., ABPP

James Overholser, Ph.D., ABPP is a Professor of Psychology at Case Western Reserve University. He serves as the Editor-in-Chief for the Journal of Contemporary Psychotherapy, and Senior Associate Editor for the Journal of Clinical Psychology. He has published empirical studies, theoretical papers, and treatment guidelines for depression and suicide risk. His published works include a six-part series on the Socratic Method as a form of cognitive psychotherapy, as well as separate articles on the Socratic Method in clinical supervision and college teaching. Dr. Overholser provides clinical training and supervision through Case Western's graduate training program in clinical psychology. In addition to his responsibilities on campus, Dr. Overholser serves as a staff psychologist at a local charity clinic, providing psychotherapy to impoverished adult psychiatric outpatients. His approach to treatment relies on cognitive therapy with a special emphasis on the Socratic method.

Cognitive Therapy has become the premiere format for contemporary psychotherapy. Cognitive Therapy has been supported by numerous empirical studies, and its application has expanded across therapists, training centers, and a diverse range of psychiatric problems. However, current approaches to training and research rely on structured treatment manuals to guide the therapist's actions in session. There is a risk that manualized therapy may focus heavily on the transmission of information, reducing the therapeutic alliance, individualized nature, and collaborative exploration that play pivotal roles in effective psychotherapy.

Cognitive Therapy can be integrated with the Socratic method to provide a useful format for therapy sessions (Overholser, 2010). Most therapists are familiar with the use of systematic questioning to guide the client along a process of guided discovery (Overholser, 2013). It can provide a natural flow to the conversation when a therapist relies on a series of thoughtful questions. To be effective, each question should involve a sincere search for new information, avoiding the process whereby a therapist imposes a "guess what I'm thinking" exam onto the dialogue. The process relies on inductive reasoning to use the client's own opinions, personal values, and life experiences as the source for exploring new ideas and identifying adaptive coping strategies that remain aligned with the client's pre-existing tendencies. Therapy discussions can help clients to learn new strategies for regulating emotional reactions and resolving difficult situations. The therapeutic process relies on guided discovery and collaborative empiricism (Overholser, 2011).

Beyond these basic elements, the Socratic method also encourages a disavowal of knowledge (Overholser, 1995), whereby both therapist and client are encouraged to accept the limits of their knowledge so as to begin a search for new ideas based on logical consistency across beliefs. Both therapist and client can view their ideas as hypotheses to be tested instead of facts that should be trusted. A disavowal of knowledge serves to shift the role of the therapist from expert teacher to collaborative peer, encouraging the two people to work together with the clients as they explore recurrent problems and search for new ways to approach difficult situations. However, the goal is to focus more on recurrent problems and ingrained tendencies instead of specific problems. Instead of focusing on recent events or crisis management strategies, therapy sessions maintain a gentle but persistent focus on broad issues and general coping strategies that transcend any specific problem situation.

When conducting therapy that relies on the Socratic method, the treatment goals often move beyond attempts to confront and remove a specific diagnostic problem. Instead, the therapist aims to help each client to grow as a mature and thoughtful person. In some sessions, the therapist helps to identify, clarify and rectify the client's misuse of broad terminology, trying to explore and develop universal definitions that extend beyond particular events in the client's life (Overholser, 1994). Thus, instead of examining specific complaints about problems at work or home, the therapist may confront the broader notion of what constitutes "a good relationship" or "a good job." Furthermore, the therapist sometimes examines issues related to virtue ethics (Overholser, 1999). Thus, the notion of courage can help to distinguish trivial worries from legitimate fears. Likewise, the notion of moderation can help clients to appreciate the benefits of a balanced lifestyle, whether it pertains to healthy eating, recreational alcohol use, or balancing time to work and pleasure. The therapy can explore important issues related to broad life goals and important personal values. An overarching goal of therapy involves cultivating wisdom as it pertains to personal development across an individual's lifetime.

Conclusions

The Socratic Method provides a theoretical framework to help extend the philosophical rationale and practical use of Cognitive Therapy. Psychotherapy according to the Socratic Method tends to focus more on the person than their problems or diagnoses. Therapy emphasizes a collaborative approach that is based in modesty and exploration, aiming for better solutions to common struggles. The treatment aims to help each client to become a more reasonable person, i.e., to have a clear and justifiable reason for all behaviors. In addition, the treatment strives to help each client to become a well-balanced person, i.e., to learn to seek a middle ground and avoid extremes in attitudes, emotions, or behaviors. Thus, there is less risk that the therapist will focus on identifying the problem and trying to fix it. Instead, there will be a focus on

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SIX PRINCIPLES TO ENHANCE COGNITIVE BEHAVIORAL THERAPY WITH YOUR SEXUAL MINORITY CLIENTS

CHARLES L. BURTON, PH.D. AND JOHN E. PACHANKIS, PH.D.

Charles Burton, Ph.D. is a National Institute of Mental Health Postdoctoral Fellow at Yale University's Center for Interdisciplinary Research on AIDS and a clinical supervisor on the ESTEEM project, a randomized clinical trial of affirmative psychotherapy for high-risk sexual minority men. His research examines people's innate ability to flexibly regulate their emotions and coping behaviors, stigma and other stressors that can reduce this flexibility, and interventions that can improve it. He received his PhD in clinical psychology from Columbia University, where he received several awards for his teaching and research.

John Pachankis, Ph.D. is an Associate Professor of Public Health at Yale University. He has authored more than 70 research articles and chapters related to the mental health of sexual and gender minorities. He and his team recently developed and tested the efficacy of the first evidence-based mental health intervention for LGBT people to address the psychological consequences of minority stress. He has developed, delivered, and tested the efficacy of similar treatments for LGBT people via novel technologies (e.g., smartphones), in diverse settings (e.g., Eastern Europe), and with diverse segments of the LGBT community (e.g., rural youth). He has received several national awards, including the Distinguished Scientific Contribution Award from Division 44 of the American Psychological Association. His research is funded by grants from the National Institutes of Mental Health.

If you are a practicing therapist whose clients include individuals presenting with mood, anxiety, or substance use disorders, chances are at least one of your clients has identified as lesbian, gay, bisexual (LGB), or a sexual orientation other than heterosexual. Here's the bad news – mental health disparities remain alarmingly high among this population largely due to minority stress, a term that refers to all the additional stress that comes from having a stigmatized identity. But here's the good news – cognitive and behavioral interventions can help. CBT is well-suited for sexual minority clients because it situates maladaptive behaviors within the social/developmental context in which they developed (such as minority stress) and empowers clients to cope with environmental stressors (like stigma and discrimination).

Our clinical research group, in the first ever randomized controlled trial of LGB-affirmative CBT, has begun to identify specific ways that CBT can be adapted to be even more helpful to your LGB clients (Millar, Wang, & Pachankis, 2016; Pachankis, 2014; Pachankis, Hatzenbuehler, Rendina, Safren, & Parsons, 2015). The next time you see one, consider including the following LGB-affirmative principles into your sessions:

1. Mood and anxiety symptoms are normal responses to minority stress. Normalize your client's mental health symptoms in the context of the added stress they face – this helps reduce the added stigma of needing mental health services, and helps them understand they are not alone.
2. Childhood and adult experiences of minority stress teach LGB persons negative lessons about themselves. Many of the unhelpful and potentially maladaptive coping behaviors used by LGB clients were likely shaped by social environments where the client was taught to see themselves as "less than" or "wrong." Constantly anticipating rejection from others, for example, may have at one point been a reasonable expectation. But if these powerful schemas are generalized to adult social and occupational contexts, they can serve as self-fulfilling prophecies. Help your clients connect the dots between early experiences of stigma to how they handle stress now, with the goal of changing outdated and unhelpful self-beliefs.
3. LGB persons can be empowered to effectively cope with the unfair consequences of minority stress. While LGB clients may have struggled to varying degrees with the additional hurdles that accompany minority stress, there's always room for improvement. Instilling hope and opportunity for change is crucial for motivating clients to learn and practice CBT techniques, which can reduce how much future experiences of minority stress exacerbate mental health symptoms. The cognitive, behavioral, and mindfulness techniques you use to help your typical client to implement new and healthier ways of responding to stress can also be used to help LGB clients find new and healthier ways of responding to minority stress. For example, using the downward arrow technique with an LGB client may identify negative core beliefs shaped by minority stress, and reappraisal training can help the client notice and challenge identity-salient cognitive distortions during social interactions. Substance use, social isolation, and perfectionistic behaviors are all common forms of emotional avoidance in LGB clients. Therefore, keep an eye out for emotional avoidance behaviors and help your client experiment with new ways of sitting with unpleasant emotions that might stem from minority stress.
4. LGB persons possess unique strengths. Despite a history steeped in societal persecution and the HIV crisis, the LGB community has demonstrated remarkable resilience. LGB clients have accomplished a remarkable journey of self-development just by acknowledging their sexual orientation, not

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to mention the creativity and courage required to navigate the coming-out process or enter romantic relationships often without readily available role models. Have your clients affirm their own personal strengths by imagining what they would say to help someone who was struggling with their sexual orientation. They might surprise themselves with how far they've come and how much they have to offer.

5. Sex is healthy. At the end of the day, working with LGB clients requires a sex-positive approach. Clients who internalize negative attitudes toward same-sex sexual activity can experience a variety of problems such as using substances during sex to reduce feelings of shame, not asserting sexual preferences with partners (including safer-sexual practices), and experiencing sex as something that is compulsive or out of the client's control. Simply discussing sex in an accepting and matter-of-fact way with your clients can help them appreciate that sex is healthy and pleasurable.
6. Genuine relationships are essential for sexual minorities' health. LGB clients have likely struggled with rejection from a variety of social spheres, even from within the LGB-community itself, which can make it difficult for them to form intimate relationships. Helping your LGB clients prioritize improving current relationships and/or making new ones is essential to ensure that your client has adequate social resources to help buffer the effects of minority stress. Assertiveness training is one particularly helpful technique, as it can help clients who previously feared to express themselves to develop effective communication skills. Doing so also helps them identify healthy and realistic relationship needs and goals.

Not every LGB client who presents with mental health symptoms has been disowned by their parents or is the victim of a violent hate crime, but the impact of minority stress on mental health can be both subtle and obvious. Incorporating these six basic principles can give your therapy an extra boost when working with this increasingly visible population. For more tips, exercises, and techniques to help your LGB therapy clients, see Burton, Wang, & Pachankis, (In Press).

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COGNITIVE THERAPY AND THE SOCRATIC METHOD CONTINUED FROM PG. 8

understanding clients as unique individuals and helping them to grow toward maturity, flexibility, and tolerance. Therapy may involve a slower process to implement the changes, but the internal locus of change may help to create longer lasting effects on the client's values, emotions, and rational choices.

Although lacking in empirical support, the Socratic method is well documented in its philosophical foundation. The integration of contemporary cognitive therapy with concepts from ancient philosophy provides many thoughtful ideas for extending the strategies available in most psychotherapy sessions. When integrated with the Socratic method, Cognitive Therapy appears useful for many people seeking personal growth through self-exploration, self-regulation, and various forms of self-improvement.

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ADAPTING CBT FOR JUSTICE-INVOLVED CLIENTS

RAYMOND CHIP TAFRATE, PH.D., DAMON MITCHELL, PH.D., AND DAVID J. SIMOURD, PH.D., C.PSYCH.

Raymond Chip Tafrate, Ph.D. completed his Ph.D. at Hofstra University. He is currently a Professor in the Criminology and Criminal Justice Department at Central Connecticut State University. He co-chairs the Forensic Issues and Externalizing Behaviors special interest group for the Association for Behavioral and Cognitive Therapies, is a Fellow and Supervisor at the Albert Ellis Institute, and a member of the Motivational Interviewing Network of Trainers. He frequently consults with criminal justice agencies regarding difficult-to-change problems such as anger dysregulation and criminal behavior. His research has been presented throughout North America, Europe, Asia, and Australia. His most recent books are: Forensic CBT: A Handbook for Clinical Practice, Anger Management for Everyone, and the forthcoming CBT with Justice-Involved Clients: Interventions for Antisocial and Self-Destructive Behaviors.

Damon Mitchell, Ph.D. completed his Ph.D. at Kent State University. He is a Professor of Criminology and Criminal Justice at Central Connecticut State University. As a criminal justice consultant, he has developed and delivered training workshops related to forensic assessment and treatment, and conducted evaluations of criminal justice programs. He was co-editor and a contributor to Forensic CBT: A Handbook for Clinical Practice and also a contributor to Cognitive Therapy of Personality Disorders- Third Edition. His most recent book, CBT with Justice-Involved Clients: Interventions for Antisocial and Self-Destructive Behaviors, will be published in 2018.

David J. Simourd, Ph.D., C.Psych. completed his Ph.D. at Carleton University. His psychology practice is based in Kingston, Ontario, Canada and he has been involved in forensic psychological assessment and treatment since 1992. In addition to his clinical work, Dr. Simourd has published articles, delivered training workshops, and served as a consultant on offender assessment and treatment to a variety of correctional organizations throughout North America, Asia, and the Caribbean. He is on the editorial board of Criminal Justice and Behavior and is a member of the Ontario Review Board, the civil commitment board for mentally disordered offenders in Ontario. He is an author of the forthcoming CBT with Justice-Involved Clients: Interventions for Antisocial and Self-Destructive Behaviors.

The science and practice pertaining to most CBT models (e.g., REBT, ACT, exposure & response prevention, social skills training) typically follows a trajectory that begins with a focus on internalizing syndromes such as depression and anxiety and later extends to externalizing problems such as substance misuse (Beck, Wright, Newman, & Liese, 2001; Bishop, 2001, 2014), anger dysregulation (Deffenbacher & McKay, 2000; Tafrate & Kassinove, 2009; Kassinove & Toohey, 2014), and personality pathology (Beck, Davis, & Freeman, 2015). Because the majority of CBT models are so strongly embedded within a mental health context, such interventions are typically oriented toward DSM diagnoses, session-by-session treatment manuals, and individualized therapy meetings.

Although CBT is a large collection of interventions applicable to diverse client groups, attention to justice-involved clients (JICs) is more limited. This is noteworthy because justice-involvement among the general population has reached similar prevalence rates as common mental health problems such as anxiety disorders (National Institute of Mental Health, 2014; Tafrate & White, 2016). For example, in the United States, approximately 1 in 33 adults are under some type of justice-related supervision (Bureau of Justice Statistics, 2014a, 2014b). For this reason, community-based CBT practitioners may have increased opportunities to work with clients whose antisocial thinking and behavior patterns can produce chronic justice-involvement. CBT has shown to be effective with forensic clientele (Hoffman, Asnaani, Vonk, Sawyer & Fang, 2012; Landenberger & Lipsey, 2005; Lipsey & Cullen, 2007; Lipsey, Chapman, & Landenberger, 2001), although significant adaptations of cognitive and behavioral principles are often required for this client group. We will cover three of the most significant adaptations necessary to make CBT effective with JICs.

Focus Treatment on Criminal Risk Domains (Not Mental Health Symptoms)

The primary emphasis for practitioners working with individuals suffering from common mental health disorders (such as an anxiety and depression) is a focus on symptom reduction because that approach allows the client to feel and function better. For forensic practitioners, the top therapeutic priority is to reduce future criminality. If the JIC's anxiety and/or depressive symptoms are unrelated to their antisocial behavior, then symptoms become a secondary concern. Reducing further justice-involvement requires a focus on the specific risk factors that facilitate criminal behavior. The approach underlining case formulation and treatment planning in forensic treatment is generally geared toward criminal risk reduction rather than symptom reduction (Tafrate, Mitchell, & Simourd, in press).

The Risk-Need-Responsivity (RNR: Andrews, Bonta, & Hoge, 1990) model and its emphasis on the "Central Eight" risk domains

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for criminal behavior now guide much of the assessment and rehabilitation work conducted with JICs around the world (Bonta & Andrews, in press). RNR emerged from a social learning model of criminality and emphasizes a constellation of treatment targets that go well beyond mental health symptoms and focus on clients' history and functioning within broader domains linked with antisociality (e.g., *History of criminal/antisocial behavior, criminogenic thinking, antisocial orientation, antisocial companions, dysfunctional family/romantic relationships, lack of connection to work/school, aimless use of leisure time, and substance abuse/misuse*). CBT interventions that successfully attend to these (mostly) dynamic risk factors are associated with reduced recidivism (Andrews & Bonta, 2010; Andrews et al., 1990; Smith, Gendreau, & Swartz, 2009). Focusing on functioning within these criminal risk domains is a key component in case formulation with JICs and offers the best chance for reducing reoffending. For a more detailed discussion of the differences between symptom and risk-reduction conceptualizations and the complex relationship between mental health symptoms and risk domains see Mitchell, Wormith, and Tafrate (2016).

The above-mentioned focus on criminal risk reduction does not discount the relevance of other mental health disorders in the lives of JICs. In fact, prevalence rates of mental disorders in justice-involved populations typically exceed those in the general population (Steadman, Osher, Robbins, Case, & Samuels, 2009). However, an emerging body of research indicates that focusing on mental health needs alone will have little impact on reducing future criminality (Bonta, Blais, & Wilson, 2014; Guzzo, Cadeau, Hogg, & Brown, 2012). Surprisingly, mental health symptoms, even those of psychosis, rarely precede criminal or violent activity with estimates linking mental health symptoms to criminal behavior less than 20 percent of the time (Peterson, Skeem, Kennealy, Bray, & Zvonkovic, 2014; Skeem, Kennealy, Monahan, Peterson, & Appelbaum, 2016).

Try this personal experiment (#1). Since few people have a pristine life, think of a recent example where you did something that was potentially harmful and destructive to someone else (and maybe yourself). If you need prompting to come up with an example consider these general scenarios:

> Lied or told a half-truth to someone, used work time for personal business, got "creative" with your tax return, "borrowed" office supplies for personal use, drove a car after having a few drinks, failed to meet an obligation or come through for someone, flirted with someone who was not your partner, attempted to manipulate a situation for personal gain, or broke a promise.

Now ask yourself, to what extent was your "bad" behavior driven by worry or sadness versus an array of more complicated contextual, historical, and dispositional factors (e.g., reinforcement history, attitudes, social influences)? Of course, this is an analog experiment and specific factors will vary from person to person, but the point is that mental health symptoms are not as central to antisocial behavior as many practitioners may believe.

Foster Motivation for Change in Risk-Relevant Life Areas

Client motivation has not been significantly emphasized in traditional CBT formulations because such concerns were less pertinent to the problems for which the models were developed (e.g., very few people want to stay depressed or overly anxious). This may be different in forensic settings due to the degree of coercion that may bring JICs to services. That is, many JICs perceive treatment as non-optional with a common statement that they, "Must attend a treatment program as a condition of probation or go to jail." Although a great deal of variability exists among JICs in terms of intrinsic motivation, the subjective distress and awareness that often motivates behavior change among mental health clients may be lacking among the justice-involved. In fact, JICs may consider their current destructive patterns as enjoyable and worth continuing. They may also view their difficulties as created by other people or institutions and regard themselves as victims rather than perpetrators. For these reasons, motivational interviewing (MI; Miller & Rollnick, 2013) offers a critical component that can be integrated into forensic CBT interventions. The main objectives in using MI in forensic practice are to promote engagement in the treatment process and to elicit and explore JICs' own motivations to change their thinking and behavior in their relevant criminal risk domains. MI was not originally designed to be a stand-alone intervention (Miller & Rollnick, 2009) and strategies for blending MI with established forensic models (e.g., MI-RNR) have been proposed elsewhere (Owens & Tafrate, 2016; Tafrate, Hogan, & Mitchell, in press; Tafrate, Mitchell, & Simourd, in press).

Personal experiment (#2). Consider again your "bad" behavior identified above and answer the following questions with "yes" or "no." If others confronted you on your "bad" behavior, would your initial reaction involve some level of: (a) justification? (b) minimization? (c) excuse making? If your answered "yes" to a, b, or c, congratulations! You have a good grasp of the mindset of most JICs when they first enter treatment.

Address Maladaptive Thinking Patterns Related to Criminal Behavior

The identification of specific cognitions associated with problematic emotional reactions and avoidance behaviors is at the core of cognitive therapy. If CBT interventions aimed at reducing justice-involvement are to match the effectiveness of those developed to reduce anxiety and depression, a focus on thinking patterns that drive criminal behavior is critical. For example, Beck (1967) and Ellis' (1962) well known irrational beliefs and cognitive distortions such as awfulizing (exaggerating the consequences or level of hardship associated with difficult or challenging situations), fortune telling (predicting the future negatively), and personalizing (attributing a disproportionate amount of blame to oneself rather than considering other factors) are not as broadly applicable to forensic clientele as they are for those suffering from traditional

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mental health disorders. Those with chronic justice-involvement do not seem prone to harshly criticize or blame themselves when they receive negative feedback, as is the pattern for depressives. Nor is their problem that of awfulizing or overestimating negative outcomes, as is central for those suffering from anxiety. At the heart of many JICs problems is a general tendency to minimize responsibility for negative outcomes and to underestimate danger and risk in favor of distortedly optimistic and self-serving predictions (Kroner & Morgan, 2014; Maruna & Mann, 2006; Walters, 2014).

Effectively conceptualizing cognitions that facilitate criminal and self-destructive behavior involves an alternative constellation of thinking targets, known as criminal or criminogenic thinking patterns. An empirical literature has emerged related to self-report assessment instruments that measure criminal thinking: the Psychological Inventory of Criminal Thinking Styles (PICTS; Walters, 1995), Criminal Sentiments Scale—Modified (CSS-M; Simourd, 1997), Measure of Criminal Attitudes and Associates (MCAA; Mills, Kroner, & Forth, 2002), Texas Christian University Criminal Thinking Scales (TCU CTS; Knight, Garner, Simpson, Morey, & Flynn, 2006), Measure of Offender Thinking Styles (MOTS; Mandracchia, Morgan, Garos, & Garland, 2007), Criminogenic Thinking Profile (CTP; Mitchell & Tafrate, 2012), and Criminogenic Cognitions Scale (Tangney et al., 2012). When considered as a whole, this literature reveals 13 broad-spectrum thinking patterns that can be useful in guiding treatment with JICs (see Table 1). In terms of case formulation, it's essential to identify those specific thinking patterns that drive destructive behaviors within, and across, criminal risk domains among JICs. For a more detailed description of criminal thinking see Mitchell, Tafrate, and Freeman (2015) and Tafrate, Mitchell, and Simourd (in press).

Personal experiment (#3): Consider again your "bad" behavior identified the first personal experiment. What did you tell yourself before you engaged in that behavior? What did you say in your head to give yourself permission to do it? See if the things you told yourself match up with one or two of the criminal thinking patterns from Table 1. In most cases, you will notice that traditional cognitive treatment targets, more suited to anxiety and depression, do not adequately capture your thinking in this scenario and that a different set of beliefs, such as those captured in Table 1 provide a better fit.

Final Comments

For practitioners accustomed to treating anxiety and depression, the shift to treating antisocial patterns involves more of a modification of CBT practices than a paradigm shift. Case formulation and treatment planning will focus on criminal risk reduction rather than clinical symptom reduction. The ingredients common to the formation of a working alliance are similar, but more time may need to be spent fostering engagement and motivation for change. Automatic thoughts and intermediate beliefs will need to be addressed in treatment but the nature of those thoughts and beliefs will be criminogenic. When treatment is completed, success may not be measured in clients feeling better, but rather in their removal from the cycle of criminal justice involvement that can destroy the health and productivity of their lives and that of victims.

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Table 1. 13 Criminal Thinking Patterns to Consider in JIC Case Formulation

Identifying with Antisocial Companions		
Disregard for Others	Power and Control	Justifying and Minimizing
Emotionally Disengaged	Demand for Excitement	Path of Least Resistance
Hostility for Criminal Justice Personnel	Exploit	Inability to Cope
Grandiosity and Entitlement	Hostility for Law and Order	Underestimating

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BOOK REVIEW: *EMOTION EFFICACY THERAPY: A BRIEF, EXPOSURE-BASED TREATMENT FOR EMOTION REGULATION INTEGRATING ACT AND DBT* (NEW HARBINGER—JUNE, 2016) BY MATTHEW MCKAY AND APRILIA WEST

TULLIO SCRIMALI, MD, PH.D.

Tullio Scrimali, MD, Ph.D. is a Physician, Psychologist, Psychotherapist and Clinical Neuroscientist. He teaches both at University of Catania and at ALETEIA International, European School of Cognitive Therapy School of which he is the founder and the Director. Dr. Scrimali carries out research and didactics on Cognitive and Behavioural Therapies in several countries, spanning over four continents. He organised and headed the first official Training in Cognitive Psychotherapy held in Poland and he also supported the foundation of the Polish Association of CBT. Dr. Scrimali authored 172 scientific articles and several monographs. Notable books are: Entropy of Mind and Negative Entropy, a cognitive and complex approach to schizophrenia and its therapy (Karnac Books, 2008) and Neuroscience-Based Cognitive Therapy (Wiley-Blackwell, 2012). Dr. Scrimali developed new CBT protocols for schizophrenia and eating disorders, based on Applied Neuroscience and Biofeedback.

In the path of Scientific Psychotherapy, the interest of researchers first was focused on behavior (Skinner 1938, Watson, 1913) and then on cognition (Beck, 1972). More recently, the theme of emotion is becoming central to the reflection of the Therapies inspired by CBT approaches.

I would like to quote, for example, Stefan Hofmann, one of the most active and respected exponents of the latest generation of US therapists within CBT. In his Emotion in Therapy (EET), recently released, he makes central in his reflection the topic of emotion in CBT (Hofmann, 2016). In the field of neuroscience, the world of emotion has also begun to become central in theoretical reflection and laboratory research, as evidenced by the beautiful volume of Panksepp on Affective Neuroscience (Panksepp, 1998).

The theme of emotion and its regulation in therapeutic relationship and in real life of the patient was central, in the work of Guidano and Liotti from the early 1980s (Guidano, Liotti, 1983). Perhaps, as a clinical neuroscientist and psychotherapist, I have placed the theme of emotion at the center of my studies and reflections since the second half of the 1970s when I started studying biofeedback (Scrimali, 2012). This is an instrumental tool for implementing an approach to psychotherapy based on the concept of reciprocal inhibition, formulated, and successfully tested, in laboratory and with patients, by John Wolpe (Wolpe, 1968).

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Therefore, with great pleasure, I read the very interesting book by McKay and West.

It is evident that the Acceptance and Committment Therapy (Hayes, 2004) and Dialectical and Behavioral Therapy Linehan (Linehan, Dimeff, 1997), rather than the Standard Cognitive Therapy, have been the conceptual basis of EET. Since the theme of emotions is typically dimensional and transdiagnostic, rather than categorical and nosographic, McKay and West define their method in the same way, as transdiagnostic.

In this regard, it should be underlined that in Psychiatry is actually in place, confirmed by DSM *5*, a reflection on the need to formulate the categorical diagnosis when working in the clinical setting. This last one is rather useful for statistical, scientific and medical-legal purposes. What a clinician needs is a more dimensional evaluation and a transdiagnostic treatment. One of the dimension to be considered is obviously constituted by the emotional dynamics exhibited by each individual patient.

Emotion Efficacy Therapy (EET) is composed by five components such as:

- emotion awareness
- mindful acceptance
- valued-based action
- mindful coping
- exposure-based skills practice

As you can easily see, the influence of the ACT is high, together with the classic topics of the exposure and coping, which are well connected with the classic tradition of Wolpe (1968) and Lazazus and (1966). The proposed EET protocol is based on eight-session. A detailed work plan is given and it is very useful for any young therapist and for trainee of any CBT course. Many very useful materials are provided both for clinical application of EET and for research such as assessment tool and outcome evaluation tools.

McKay and West have written a good book. Clear, well organized, perfectly documented and easy to be read and remembered. Personally, I consider this book perfectly coherent with my proposal of integrating biofeedback and neurofeedback into cognitive therapy (Scrimali 2012). According to my clinical and research experience, Emotion Efficacy Therapy can be implemented by using the monitoring of some parameters connected with emotion such as the electrodermal activity (EDA) and the heart rate variability (HRV).

A good book, innovative, well written and interesting that I suggest to any CBT Therapist and mainly to any trainee of our CBT courses.

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ACT PRESIDENT'S MESSAGE

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STANDING ON THE SHOULDER'S OF GIANTS

CONTINUED FROM PG. 3

and I began expanding into the areas of emotional processing, emotion socialization, and emotional intelligence. As my patients and people in my personal life taught me, validation is an essential part of any relationship with depth and I began to explore this in my work on resistance in CBT (Leahy, 2001).

Over the many years since I have seen how my interest in social cognition has been helpful in my attempt to extend a CBT model to understanding "emotional schemas"—how people think about and respond to their emotions and those of others (Leahy, 2015). This work owes a great deal to the metacognitive model advanced by Adrian Wells—my model could be viewed as a meta-emotional model or a model of implicit theories of emotion. I have come to realize that we can often become too formulaic, too technique

driven, and that the emotional turmoil, the inevitable empathic failures, and the often insolvable problems in life are the very focus of what we do. Rather than let the psychoanalysts criticize us for not dealing with the "important issues," I have tried to help shed some light on the importance of emotion, resistance, transference and counter-transference, and the cultural context of emotion—all from an integrated CBT perspective. My most recent book is The Jealousy Cure (Leahy, 2018)—one of the 26 books that I have published thus far.

The giants? I have learned so much from so many different people in our field—from Aaron Beck, Adrian Wells, Marsha Linehan, David Clark, Jeff Young, Steve Hayes, Paul Gilbert, John Gottman, Dennis Tirch, and our entourage of comrades in arms at the ABCT conferences. But I keep bringing myself back to the patients I see every week, the people who have often been maligned for their feelings, marginalized from any meaning and connection that could sustain them—who have come to me, out of the shadows of their darkened existence—to give me a moment, a chance, to help them find a path that leads out of that cavern of hopelessness. It is on their shoulders that my vision is often based. Because, I guess when it comes down to what we do, we are the interpreters of maladies-we are the place that can at last feel safe. And that is a place I want to be in.

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out to talk to her again. While it would have been ideal if Hannah had not left the office, hopelessness can make patients give up too soon. There is evidence that patients who end therapy in a hopeless state are relatively more at risk (Dahlsgaard, Beck, & Brown, 1998), and that therapist outreach can reduce risk (Brown, Wright, Thase, & Beck, 2012; Motto & Bostrom, 2001). Therapists in such situations must be willing to go out of their way to make (and/or retain) contact with at-risk patients who are ambivalent about getting help.

I acknowledge that assessing and treating suicidal teens presents special considerations and difficulties. Two excellent resources for providing CBT to young patients are Kendall (2017), and Creed, Reisweber, & Beck (2011), which specifically describes how CBT may best be utilized in a school setting. Books such as these do justice to the description of CBT for adolescents. Unfortunately, people who watched 13RW did not see the sort of therapeutic interaction that would instill confidence in the field of mental health, and that would encourage an at-risk person to seek help. To the extent that 13RW provokes discussion of this issue, we can take the opportunity to educate the public.

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