ADVANCES IN Cognitive Therapy newsletter

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Publication of the Academy of Cognitive & Behavioral Therapies (ACBT) and the International Association of Cognitive Psychotherapy (IACP)

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PRESIDENTS COLUMN
LYNN MCFARR, PHD

Dear Academy Diplomates, Fellows and Members of IACP, Until Jan 2021, I will be pulling double duty as President of both the Academy and IACP. What a very odd time in history to be doing both. With the virus calming down some in other parts of the world, we continue here in the states to have rising cases and deaths, particularly in some states. It has affected every part of our lives. And we send our best wishes and concerns to our members from both organizations who continue to suffer.

The CBT community has risen to the occasion, developing resources from across the spectrum of CBT. The Academy has a Covid Resource page (https://www.academyofct.org/page/covid19) please feel free to send us resources that you would like to have included. The IACP has two seats with the The World Confederation of CBT, the "United Nations" of regional CBT organizations. The WCCBT has put together an excellent newsletter with links to multiple CBT focused Covid resources. (https://www.wccbt.org/Downloads/WCCBT_e-News_March-2020.pdf).

In the wake of the civil unrest here in the states, the Academy instituted the Diversity Action Committee (DAC) led by Lizbeth Gaona, Ph.D (Dr. Lisa Bolden has opted to serve as a consultant). The DAC has been tasked with developing items for both the Cognitive Therapy Rating Scale (CTRS) and the Cognitive Conceptualization Rating Scale (CRRS) to specifically assess cultural responsiveness in the context of CBT. We will be piloting this in our LACROCBT program which has been extended for several more years. We have converted completely to an online training platform. Many thanks to Troy Thompson and Leslie Sokol and the Academy Administrative team for pivoting so quickly and effectively. We hope to compare the outcomes of our protocol before and after the switch and contribute to the implementation literature.

In other IACP news we have some hellos and goodbyes. Stefan Hofmann, Ph.D. Has rolled off the board after his term as Past-President came to a close in June. Niko stepped down as Treasurer, and David Clark, Ph.D. will also be rolling off the board in November. Mehmet Sungar, MD assumed the office of Past-President, and I become President. Leslie Sokol, Ph.D.

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EDITOR'S NOTE

Greetings. You might notice that this issue of Advances in Cognitive Therapy is larger than usual. Following the Board's Official Statement on Racism and Injustice (see the most recent issue of our newsletter), a Diversity Action Committee was formed, and it was decided to dedicate this issue to that cause. In addition to that, recently a beloved major figure in our organizations, Arthur Freeman, passed away and we decided to have a special tribute to him as well. Consequently, this is a double special issue. Both topics are deserving of extra space and attention. We would encourage you to share this issue across your social medias (#cbtworks) and other professional networks.

Scott Waltman, PsyD, ABPP, editor, Advances in Cognitive Therapy

STANDING ON THE SHOULDERS OF GIANTS
JACQUELINE B. PERSONS

I feel honored to be invited to write for this column, and grateful for the opportunity to reflect on my career and recognize some of the many individuals who have influenced and helped me.

My husband, Jeffrey Perloff, deserves the lead position here. I met Jeff when I was 18 years old because we were in alphabetical order at the orientation session at the University of Chicago. I studied Anthropology, which had two intellectual traditions, one based in science and one that was more like literature. Jeff, who came to undergraduate school with a goal to become an economist and academic, was clear that science was the way to go, and his thinking was an important influence.

I was extremely fortunate (I was rejected by 11 of the 13 programs I applied to) to be admitted to the clinical psychology Ph.D. program at the University of Pennsylvania. I feel forever grateful for my time in that remarkable community of scholars. Julius Wishner took a chance on me and helped me get started. I spent my first year carrying out a research project in his lab studying long term memory in schizophrenia. I presented my results to a committee led by Henry Gleitman, a cognitive psychologist. Henry asked me, "Jackie, does it seem to you that the symptoms you observe in your schizophrenic research subjects are the result of deficits in long term memory?" Henry's question changed my life. It encouraged me to think for myself, to trust my own judgment. This concept was simultaneously thrilling and terrifying. (My answer to Henry's question was "No, it does not.") I knew that if I followed Julie's lead, I could finish the program with a Ph.D. If I followed my own ideas, I had no such confidence.

Nevertheless, I abandoned the long term memory research program and struck on my own. Jonathan Baron, a cognitive psychologist in the Psychology Department, very generously agreed to help me devise some empirical studies to test some of the hypotheses described in Chapman and Chapman's amazing book, Disordered thinking in schizophrenia. I'd meet with Jon, we'd talk about my ideas, I'd write up a document fleshing them out and put it in Jon's mailbox, and the next day I'd find the document with Jon's penciled comments on it in my mailbox (this was 1976, before e-mail). Jon helped me develop both my ideas and my confidence that they were worth pursuing. And of course my thinking about the cognitive mechanisms underpinning symptoms of schizophrenia paved the way for my thinking about case formulation years later.

Aaron T. Beck was also a key support. He accepted my application to receive some training in his Depression Clinic in 1977; Beck, Rush, Shaw & Emery's Cognitive therapy of depression was being passed around in mimeographed form, and, as Steve Hollon said recently when we talked about it (he was a postdoc at Penn then), we all had a sense that something exciting was happening. And it most definitely was! After I left Philadelphia, Dr. Beck kept up with what I was doing. I have in my files to this day, letters he wrote me (actual letters!) offering thoughtful and encouraging comments about papers I published about cognitive theory and therapy. David Burns was my first clinical supervisor. I learned so much from David that I attached myself to him and did not leave until I left Philadelphia. I attended supervision meetings he generously hosted for a small group of students at Penn, and later collaborated with him on several research studies.

I spent a postdoctoral year at Joseph Wolpe's Behavior Therapy Unit at Eastern Pennsylvania Psychiatric Institute, where I learned from him and many others, especially Edna Foa, who was an amazing model of a brilliant scientist and scholar.

At Penn I was trained to be a researcher and academic. But when I finished my training, I didn't go on the academic job market. Instead, I moved to California with my husband Jeff, who had been offered an academic position at UC Berkeley. Jeff's family lived in California, and he considered California to be "the land of milk and honey." (It is.)

I got my license, and looked for a clinical job. But I didn't get any offers, and eventually I realized that I didn't really want to work for anyone else. Fortunately, I had the financial and emotional support from Jeff to develop a professional career that entailed seeing patients in my private practice, conducting research, writing, and doing teaching, training, and supervision that I have followed since that time, now for almost 40 years.

Soon after I arrived in the Bay Area, Ricardo Munoz invited me to join the clinical faculty at the Department of Psychiatry at

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CULTURAL COMPETENCY IN COGNITIVE THERAPY

DORIS F. CHANG, PHD, ASSOCIATE PROFESSOR, NEW YORK UNIVERSITY, SILVER SCHOOL OF SOCIAL WORK

***Editor's note: This was originally published in our March 2007 issue. Included again with the permission of the author.*

Dr. Doris F. Chang is a licensed psychologist and Associate Professor at NYU Silver School of Social Work. Her research seeks to improve the well-being of racial and ethnic minorities by a) clarifying the role of race, ethnicity, language and culture in shaping mental health and quality of care; b) identifying strategies for improving interracial processes and outcomes; and c) developing inclusive, culturally-grounded interventions for clinical and educational contexts that integrate mindfulness and other contemplative traditions. She has particular expertise in interracial dynamics and Asian American mental health and is a Co-Investigator at the Center of Excellence for Cultural Competence, New York State Psychiatric Institute. In 2018, she was awarded a PEACE grant from the Mind and Life Institute to develop and pilot a mindfulness-based critical consciousness training program for K-5 teachers.

Previously, Dr. Chang was Director of Clinical Training and Associate Professor of Psychology at the New School for Social Research (2004-2019). She is a Fellow of the Asian American Psychological Association and the Mind and Life Institute, and is a Fellow and member of the Executive Committee of the APA's Society for the Psychological Study of Culture, Ethnicity, and Race. In 2006, she received the Early Career Award from the Asian American Psychological Association. She maintains a private practice at Soho CBT + Mindfulness Center.

Over the past several decades, global streams of immigration have changed the face of most societies, requiring therapists to become more sensitive to the role of culture and context in the therapy relationship. Many of us regularly find ourselves sitting across the room from a client who does not share our background. Regardless of whether those differences are cultural, racial, ethnic, or socioeconomic, it is important to acknowledge those differences by carefully attending to cues that our own beliefs, values, and assumptions may not be shared equally by our clients. In this article, suggestions for successful application of CBT to culturally diverse populations will be provided, with examples focusing on treating Asian American and African American clients.

One of the key advantages of cognitive-behavioral therapy in working cross-culturally is that the theoretical assumptions of the approach are made explicit early on in the therapy. During the initial socialization phase and over the course of treatment, however, it is important to engage the client in a dialogue to assess how their own understanding of their problem, including its cause and cure, compares to that of the cognitive model. The discussion can help to clarify expectations and reduce ambiguity regarding the process of therapy and the roles and responsibilities of the therapist and client.

For example, recent reviews of the research on treating Asian Americans suggest that Asian American clients' preference for structured and directive approaches in therapy make them particularly amenable to CBT (Leong, Chang, & Lee, 2006; Lin, 2001). However, the cultural emphasis on respect and deference to authority may make it difficult for them to challenge the therapist or express disagreement, often resulting in premature dropout from treatment (Chen & Davenport, 2005). A similar dynamic has been observed in individuals with low levels of income or education. As a result, it is important to actively solicit both verbal and written feedback from the client over time, assessing their comfort with the therapy process, and showing interest in their unique experience of their problem and treatment.

As the therapy progresses, particular beliefs held by the client may be identified as underlying maladaptive behaviors. However, when those beliefs are linked to core cultural values that have been passed down from generation to generation, the client may resist applying a rational approach to evaluating their validity. Among individuals who come from collectivistic cultures such as Asian and Latinx cultures, this reluctance may stem from a belief that by examining and challenging these beliefs, one is being disrespectful to one's elders. Indeed, they may feel like they have a responsibility to honor their parents and respected family members by upholding sacred family values, even if they are no longer adaptive.

Chen and Davenport (2005) cautioned that in working with Asian Americans in particular, the emphasis on filial piety and the hierarchical family structure may produce resistance to confronting beliefs considered important to maintaining family harmony. For example, one of my Chinese American patients was reluctant to challenge her belief that one can only trust people within the family, a belief inherited from her parents, both survivors of the Cultural Revolution.

In such cases, it may be helpful to acknowledge that these beliefs may have been adaptive during certain periods in one's family history, but may no longer be applicable today. In my client's case, it was helpful to acknowledge the origin of her parents' beliefs and their desire to protect her from the traumas that they experienced first-hand. This helped her to recognize that she could hold different beliefs that were more valid given her own life circumstances, without labeling her parents' worldview as inherently "irrational" or "dysfunctional."

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INTERNALIZED RACISM IN AFRICAN AMERICAN CLIENTS: A CBT APPROACH

JANEÉ M. STEELE, PHD, LPC

Janeé M. Steele is a licensed professional counselor and certified CBT therapist. Dr. Steele has been a professional counselor for 15 years, specializing in the treatment of depression and anxiety. In addition to her work as a counselor, Dr. Steele has also been a counselor educator for the past 10 years, and is currently a member of the core faculty at Walden University. Her most recent publication titled, "A CBT Approach to Internalized Racism Among African Americans," published in the International Journal for the Advancement of Counselling, describes cognitive conceptualization and treatment planning using CBT and a proposed cognitive model of internalized racism.

Recent world events highlight the impact of racism and other forms of oppression on the psychological wellbeing of all individuals, especially people of color and the communities to which they belong. Through decades of both conceptual and empirical research, mental health professionals have developed a unique understanding of this impact, and as such, have opportunity through their professional roles to identify and challenge conditions that perpetuate oppression within historically marginalized communities. For clinicians who see African American clients, this opportunity is important not only in terms of the profession's social responsibility, but also in terms of providing direct services to African American clients. Research shows that African Americans experience higher levels of daily psychological distress due to racial oppression (i.e., racism), particularly internalized racism. In my work with clients, I've found CBT provides a useful framework for both conceptualizing and treating internalized racism and its psychological correlates in this population. CBT's emphasis on personal empowerment, attention to client strengths and support systems, and affirmation of one's own sense of identity makes this form of therapy well suited for individuals from culturally diverse backgrounds (Hays & Iwamasa, 2006). In the paragraphs below, I define internalized racism and describe its relationship to mental health among African Americans. I conclude with a description of a cognitive model of internalized racism and a discussion of case conceptualization and treatment planning considerations.

What is Internalized Racism?

Most simply defined, internalized racism is a negative view of oneself based on the perceived inferiority of one's own race. According to Bailey et al. (2014), there are four dimensions of the construct, which include: "(1) belief in a biased representation of history; (2) alteration of one's physical appearance; (3) internalization of negative stereotypes about African Americans; and (4) changing one's hair texture and style to fit a more European aesthetic" (p. 145). Bivens (1995) expands on this common conceptualization of internalized racism, arguing that not only does internalized racism describe a negative view of oneself based on stereotyped messages received from society, but in a much broader sense, internalized racism describes attitudes and behaviors that ultimately undermine the power of one's own racial group.

The Relationship Between Internalized Racism and Mental Health Among African Americans

Several studies link internalized racism to poor mental health outcomes among African Americans. Some of these outcomes include skin color dissatisfaction, low self-esteem, low career aspirations, and various forms of psychological distress (Brown & Segrist, 2016; Maxwell et al., 2015; Parham & Helms, 1985; Szymanski & Gupta, 2009; Wester et al., 2006). Mouzon and McLean (2017), for example, found that internalized racism was a statistically significant predictor of depressive symptoms among the African American, U.S.-born Black Caribbean American, and foreign-born Caribbean Black participants of their study. Similarly, Graham et al.'s (2016) study of self-identified Black university students found a statistically significant relationship between internalized racism and anxious arousal, as well as between internalized racism and generalized anxiety symptoms. When explored as a mediating variable, internalized racism was even found to fully mediate the effect of racism experienced over the past year for both anxious arousal and generalized anxiety; that is, when internalized racism was accounted for, the relationship between past-year racist experiences and anxious arousal and generalized anxiety became statistically non-significant.

Culturally Adapted Cognitive Conceptualization

Traditional cognitive conceptualization from a Beckian perspective suggests individual childhood experiences affect the beliefs people develop about themselves, other people, and their world, as well as the assumptions and rules they establish to guide their behavior in light of these beliefs (Beck, 2011). In my culturally adapted model, intermediate beliefs are not only affected by childhood experiences, but by societal influences as well. For African American clients, these influences include historical and contemporary factors such as slavery, Black codes, segregation, colorblind racial attitudes, microaggressions, and the media. Once developed, beliefs and assumptions specific to the racially stereotyped messages received from society are reinforced through interpersonal interactions that strengthen the internalized sense of inferiority, shame, and powerlessness experienced within this group. Resulting race-related beliefs and continued exposure to racist interpersonal interactions,

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MY PERSONAL THOUGHTS, FEELINGS, STRUGGLES, AND GROWING EDGES WITH CULTIVATING ANTIRACISM: PERSPECTIVES OF A FELLOW TRAVELER

CARMELLA TRESS, PSYD

Carmella Tress, PsyD, is a psychologist, educator, and CBT trainer. She currently works in the VHA system where she is involved in direct patient care, quality improvement initiatives, and clinical training in CBT and ACT. She previously worked as a CBT trainer for the Beck Community Initiative at the University of Pennsylvania. She is also involved with the Association for Contextual Behavioral Science where she is the CO-facilitator of the Leadership, Organization Behavior Management and Public Policy SIG. Mostly, Carmella focuses on trying to walk the walk and live the values she fosters in others as well as herself. In regards to the topic of this article, she acknowledges that she doesn't have all the answers, and is just a fellow traveler trying to work to bring about intrapersonal and systematic change.

James Baldwin famously said "Not everything that is faced can be changed, but nothing can be changed until it is faced" (1962). Regardless of discipline, likely all psychologists would agree with this premise. Many, like myself, may even espouse strongly held values about personal growth and the significance of being a lifelong learner. Yet, we find ourselves in a precarious position in 2020, quarantined from many of the things that would have garnered our attention and forced to connect to the world through screens. Technology has become a primary means of interaction, shifting aspects of our attention and our access to information. The headlines read "215,000 dead," (CDC, 2020) and we witness Black person after Black person killed in contexts that may provoke outrage, grief, or confusion.

As a white psychologist, I found myself asking the question "What has contributed to my limited understanding of the extent of systematic racial injustice?" Perhaps we could expand this question to "Why have I (or we?) not been bothered, concerned or outraged that four percent of psychologists in America in 2015 were Black, while 86 percent were white?" (Lin, Stamm, & Christidis, 2018). Perhaps we could allow ourselves to become curious about the impact of underrepresentation in psychology on Black persons, Indigenous persons, Persons of Color (BIPOC) and white persons. The Cognitive Behavioral traditions purport that encountering information provides opportunity to reconcile that information within our existing structure of beliefs, reflecting on what shifts may be required. There is an emphasis on the importance of cultivating curiosity, exploration and perspective-taking, rather than closing oneself off to experience. Perhaps we have before us an opportunity to consider dynamics that have contributed to or maintained the status quo of white privilege and racial oppression, including in the field of psychology. Perhaps, in light of immeasurable loss, we have an invitation to face what must be changed within ourselves.

We may begin by recognizing the process of belief development; that in explicit and implicit ways our expectations and assumptions are shaped by factors such as the interpretation and retelling of history. It is indisputable that American history is one of stealing Indigenous land, subjugating Black people into forced labor and bondage, and disempowering persons whom were perceived as threatening to those in power (from internment camps of Japanese persons during and after World War II, to the asyluming of those experiencing mental health challenges). Ibram X Kendi notes that "racist ideas make people of color think less of themselves, which makes them more vulnerable to racist ideas. Racist ideas make white people think more of themselves, which further attracts them to racist ideas" (p. 6, 2019). It is reasonable to conclude that people of all races have been affected by this cycle. As Layla Saad exhorts, "The system of white supremacy was not created by anyone who is alive today. But it is maintained and upheld... whether or not you want to agree with it." "We must face the fact that racism is essential to the culture we have inherited and are subtly recreating every day (Magee, 2019)" The alternative that Saad, Kendi, and many others propose is not passivity or to simply "not be racist," but rather to actively dismantle white supremacist ideologies and consistently choose to move toward antiracism.

You may wonder where to begin, as I continue to, while realizing how deep the roots of racism have taken hold in my life. It may be helpful to take time to consider what has gotten in the way of our dismantling racism, including avoidance of the topic itself (after the previous paragraph you might have considering skipping the rest of this column). There are countless triggers for discomfort associated with white supremacy and racism that may precipitate avoidance behaviors, such as beliefs that we are not racist, a definition of racism that excludes subtle and implicit forms of racism, guilt or shame about the impact of racism or the benefits that we may have had from policies anchored in racism, or fear about what may be required of us if we acknowledge internalized racism within us (Kanter, Corey, Manbeck, & Rosen, 2020; Saad, 2020). Kanter et al. discuss the cycle that occurs in which anxiety related to race may be automatically elicited in certain contexts and subsequently interpreted as proof that one is racist, resulting in further anxiety or shame (2020). Intensifying the aversive features of stimuli may intensify the pull toward avoidance of these stimuli. Yet, it is impossible to actively dismantle something that one is not willing to face. This may be a facet of what Ibram X Kendi is referring to when he says that "Denial is the heartbeat of racism" (2019).

Ironically, as Kanter et al. point out, many of the intellectual approaches to addressing racism may contribute to the avoidance cycle by training persons to attend to thoughts or beliefs that are

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BEYOND PRONOUNS: WORKING AFFIRMATIVELY WITH TRANSGENDER AND GENDER DIVERSE CLIENTS

DEBRA A. HOPE, PH.D., UNIVERSITY OF NEBRASKA-LINCOLN

Debra A. Hope, Ph.D. is Aaron Douglas Professor of Psychology at the University of Nebraska-Lincoln. She was a Beck Scholar and is a certified trainer/consultant for the Academy. Much of research career focused on assessment and treatment of anxiety disorders, especially social anxiety. More recently, her work has turned to health and mental health disparities for sexual and gender minorities. She is co-founder of Trans Collaborations, a community-academic partnership to address disparities for transgender and gender diverse people in underserved areas. Dr. Hope has over 125 peer-reviewed papers and books. She has three decades of experience giving workshops, teaching and supervising CBT. She maintains a small private practice. In understanding this column, note that Dr. Hope writes from the perspective of her identities as a white queer cisgender woman.

Individuals whose gender identity differs from the sex they were assigned at birth are increasingly visible in the media and in our therapy offices. Individuals in this broad and diverse community use many identity labels to reflect their own understanding of their gender. For the purposes of this column, I will use transgender and gender diverse (TGD) as an umbrella term, recognizing it is not reflective of everyone's choice for their own identity. For many years, mental health services for TGD clients centered on specialty care related to their gender identity. Historically this included well-intentioned but horrific practices to force their gender identity to match their sex assigned at birth. A somewhat more enlightened approach focused on helping transgender clients to transition from one side of the gender binary to another. In part due to the influential voices of clients, clinicians, and researchers who themselves identified as TGD, more recent models of care better reflect the range of TGD identities and needs. In our own work at Trans Collaborations, a community-academic partnership to address TGD mental health disparities, we have focused on TGD-adaptations for evidence-based psychological services for general mental health care, not just gender affirmation care. I will share some of what we have learned from our qualitative and quantitative research over the last 5 years and from clinical services we provide.

There is not a single clinical trial outside of the HIV literature that evaluates a psychosocial intervention with an exclusively TGD sample. The best evidence base at this point is a growing clinical literature from CBT clinicians, including our own experience in our clinic, which indicates CBT should be effective for TGD clients seeking treatment for anxiety, depression, and other common outpatient presenting problems. However, there is a substantial literature that TGD clients often have been marginalized in therapy sessions, even by well-intentioned clinicians, and this column is intended to reduce that marginalization. This column is not focused on the specialty service of supporting gender affirmation, see Chang, Singh, and dickey (2018) in resources for a good primer on that topic. In addition, our experience is primarily with adults but much of this information applies to older adolescents as well.

TGD-Specific Knowledge. The foundation of competency for working with TGD clients is knowledge about TGD identities in general and specific to the community where you practice. Sometimes called Trans 101, this includes knowledge about TGD identities, terminology, social, legal, and medical gender affirmation, health disparities, intersectionality with other identities such as race and ethnicity, and understanding one's own gender identity and TGD biases. As when working with any marginalized community, it is crucial to understand the local context including any legal protections against discrimination, available resources, and how to help your client access the local TGD community if they have not connected to it. The volume by Chang, Singh, & dickey (2018) is an excellent resource for *Trans 101.*

First Impression Matter. TGD clients are likely to get a first impression of your practice from your website and intake paperwork. Website images that appear to be only of cisgender people or do not mention services for TGD clients send a message that your practice may not be TGD affirming. Paperwork that asks only for binary gender (male/female) erases TGD gender identities. A good alternative is to request "gender" and leave a space to write in a response. If electronic medical records require a specific set of options, this can be discussed at the intake. Also requesting pronouns on initial paperwork ("What pronouns do you use?") conveys a message of inclusion. An inquiry about what name to use gives TGD clients an opportunity to convey their current name, even if their legal name differs.

Mistakes with Names and Pronouns. Sharing your own pronouns in introductions, email signatures, and on your website conveys that you understand that assuming pronouns based on physical appearance is privilege not shared by all. Once you meet your client, it is crucial to use the correct pronouns and names, even if it is different from the legal name that may appear on the medical record. This is easier if you practice it every time you think, talk, or write about the client. If you are supervising therapists, practicing using only the correct names and pronouns in supervision. Instruct office staff to do the same and follow-up if they do not. Despite best intentions, we all make an occasional mistake. When that happens, just correct yourself and move on, vowing to yourself to do better. Avoid long apologies or explanations that put your TGD client in a

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SELF-REFLECTION EXERCISE: MULTICULTURAL AWARENESS, KNOWLEDGE, AND SKILLS SURVEY – COUNSELOR EDITION - REVISED (MAKSS-CE-R)

Greetings. The Diversity Action Committee (DAC) of the Academy of Cognitive & Behavioral Therapies is seeking to aid our membership in cultivating knowledge, skills, and abilities consistent with cultural humility and culturally responsive care. As a part of that endeavor, we are including a self-reflection activity in the current newsletter. The creators of the following measure have graciously agreed to allow us to include it for self-practice and reflection. We encourage you to take a few minutes and sincerely fill this out. Note, there are psychometrics for the scale, however, we opted to leave out an interpretive range. Our hope was to foster introspection and to aid us in identifying our growing edges.

We hope that you find this activity valuable and invite you to provide feedback and/or any ideas on focus areas for the DAC. You may submit your feedback to the newsletter editor at: walt2155@pacificu.edu.

Reference

Kim, B. S. K., Cartwright, B. Y., Asay, P. A., & D'Andrea, M. J. (2003). A revision of the Multicultural Awareness, Knowledge, and Skills Survey – Counselor Edition. Measurement and Evaluation in Counseling and Development, 36, 161–180.

Before the MAKSS-CE-R is copied or distributed, permission must be obtained from one of these authors: Michael J. D'Andrea, Ed.D.: michael@hawaii.edu, Bryan S. K. Kim, Ph.D.: bkim@education.ucsb.edu

TAKE THE SURVEY

(Link Text: https://academyofct.co1.qualtrics.com/jfe/form/SV_5j0L6fzSAt8ZbIF)

DISCUSSION AND SELF-REFLECTION QUESTIONS FROM THE SPECIAL ISSUE ON DIVERSITY

Below are questions to guide self-reflection and if you are willing, discussion on our list-serv.

Dr Chang's writes that when working with members of marginalized groups, they may hold beliefs that may appear to be irrational to an outsider. Yet, "it is important to consider the possible adaptive function that such vigilance may serve, as well as the potential psychological and interpersonal costs to the individual." Given the increased attention to police brutality and racial bias embedded in our criminal justice system, as well as the increased numbers of Covid-19 cases in certain parts of the country, how might you imagine working with a Black teenage boy who has developed a significant fear of leaving his home?

How do you assess, conceptualize, and treat internalized biases (i.e., racism) in your clients?

What thoughts and feelings came up as you read about Dr Tress's personal journey with Antiracism?

Do we as therapists have a social justice responsibility?

How can we provide increased support, power, and visibility to our Black persons, Indigenous persons, Persons of Color (BIPOC) colleagues?

How might consideration of gender identity, especially in the context of other intersectional identities, influence case conceptualization and then treatment for a client you have seen recently?

How do you think about your own gender identity and gender role(s) into which you were socialized? Has this changed over time? How might your own gender identity and gender roles you enact influence your work with a transgender or gender diverse client?

Most of us were socialized to organize the world into a man/woman gender binary. How can you expand your understanding of and comfort with gender to include clients who have a gender identity that does not fit the binary or is fluid over time?

What diversity topics would you like to see more attention paid to?

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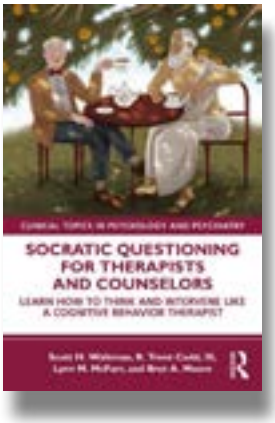
Submissions to Advances in Cognitive Therapy are reviewed on an ongoing basis. Topic areas may include clinical issues, research updates, conference and training information, book reviews, and summaries of any CBT-related activities from around the world! Articles co-written by professors and students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

The next deadline for submission is January 15th, 2021. 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, Editor: walt2155@pacificu.edu.



BOOK REVIEW: SOCRATIC QUESTIONING FOR THERAPISTS AND COUNSELORS

SCOTT TEMPLE, PH.D.

Scott Temple, Ph.D. is Clinical Professor in the Departments of Psychiatry & Medicine at the University of Iowa. He is a Founding Fellow in the Academy of Cognitive Behavior Therapy and is certified by the Academy as a Trainer/Consultant. He is the author of two books on CBT, most recently Brief Cognitive-Behavior Therapy for Cancer Patients: Re-Visioning the CBT Paradigm.

I'm guessing that I'm like many seasoned trainers and teachers in the Academy. I collect CBT texts. I'm constantly searching for 'the ultimate' single-volume training text, one that will be useful to graduate students in psychology and social work, and for training psychiatry residents. Ideally, a good text is also suited to therapists from other traditions who are looking to retrain, as well as experienced CBTers who are looking to upgrade their skills. My office bookshelves are lined with books by the Becks, Greenberger & Padesky, Leahy, as well as many texts by the British CBT community. Socratic Questioning for Therapists and Counselors, the new book by Scott Waltman, Trent Codd, Lynn McFarr and Bret Moore is going on that shelf. It's that good.

It provides a 'next generation' look at the heart and soul of CBT, written in a way that is highly practical and teachable. And it serves all the purposes I look for in an overall CBT text. It will appeal to those who teach and supervise graduate students in psychology and social work, directors of residency training in psychiatry, trainers of community clinicians, and seasoned therapists who simply want to get better at this demanding and rapidly changing practice of Cognitive-Behavior Therapy.

The book provides a thorough description of one of the most difficult but essential skills in the CBT toolkit: Socratic Questioning and Guided Discovery (SQ/GD). The authors provide updated evidence about why SQ works, and they offer a novel framework for doing effective SQ/GD. Over the course of four chapters specifically devoted to their "4-step model", the authors unfold the model, which despite its simplicity, has considerable power and elegance. These steps include: 1) identify and target key content 2) develop a phenomenological understanding of the cognition 3) foster a collaborative curiosity, and 4) create a summary and synthesis. In Step 1, the reader learns a model for identifying the most relevant targets for interventions from the myriad clinical data that can easily overwhelm and confuse the novice therapist. Step 2 involves validation of the patient, and helping the patient understand, nonjudgmentally, and without stigma or shame, the hidden logic of their beliefs, however maladaptive those beliefs may prove to be. Step 3 fosters a collaborative process of curiosity, as new ways of thinking and behaving are explored and cultivated. Step 4 involves cementing new learning by creating clarity and focus, and by implementing new learning in relevant adaptive contexts in the patient's life.

Although its title suggests that Socratic Questioning and Guided Discovery is the main subject, the book has a broader focus, and provides a much more comprehensive look at doing CBT than the title indicates. For example, there is a chapter that describes why people often cannot spring free of their own mental traps without help, and a cogent overview of the Generic Cognitive Model. There is a vivid and compelling section on how to adhere to session structure in a way that preserves warmth and humanity. In terms of CBT change strategies, the authors link SQ/GD to two widely used methods in CBT: thought records and behavioral experiments. Detailed descriptions of both methods are provided, and the authors walk the reader through steps to implement both procedures.

The book's structure effectively supports its learning objectives. The chapter selections are relevant, and they unfold in a logical sequence. After describing the model they put forth, there are chapters that tailor training to both general and specialized purposes, including psychiatry residents and self-therapy applications.

Each chapter is organized so that the reader more easily can learn and retain key principles. For example, each chapter provides lists of key questions that the therapist can use to address the material being covered in that chapter. Diagrams and tables are usefully sprinkled throughout the chapters, including innovative case formulation diagrams, forms to assess adherence to session structure, and others, all of which can be printed out for use by clinicians and trainees. Each chapter contains case descriptions, and most demonstrate how to implement techniques via sample therapy transcripts. I found the vignettes of transcripts to be especially vivid, entertaining, and compelling. Finally, each chapter ends with a summary statement.

Although rooted in Beckian Cognitive Therapy, the authors put forth an integrative model. It links Beckian CBT with emerging science and with other therapies within the CBT community, such as ACT and DBT. For example, Step 2 of the 4-step

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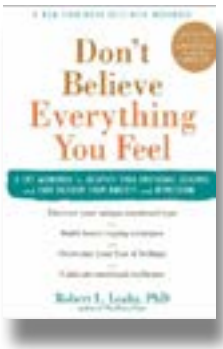

BOOK REVIEW: BOB LEAHY'S DON'T BELIEVE EVERYTHING YOU FEEL

BY SCOTT WALTMAN, PSYD, ABPP, A-CBT

Scott Waltman, PsyD, ABPP, is the editor of Advances in Cognitive Therapy. He is a clinician, international trainer, and practice-based researcher. His interests include evidence-based psychotherapy practice, training, and implementation in systems that provide care to underserved populations. He is a full fellow and certified as a qualified Cognitive Therapist and Trainer/Consultant by the Academy of Cognitive & Behavioral Therapies. He is also a board member of the International Association of Cognitive Psychotherapy. He also is board certified in Behavioral and Cognitive Psychology from the American Board of Professional Psychology. Currently, he works as a clinical psychologist in private practice and a managed care system, where he is a frontline clinician and practice-based researcher.

If you have not heard yet, Bob Leahy has come out with another workbook that is sure to become an instant classic. The book is titled Don't Believe Everything You Feel, it could just as easily be called everything you wish you learned about emotions when you were growing up but didn't. It is like an owner's manual for feelings. It is beautifully written and organized in a practical manner. It has everything we have come to expect from a Leahy workbook. It is both profoundly deep and sublimely lighthearted (in a way that few others could pull off). It has a wealth of worksheets and handouts that follow the typical format you would find in Leahy's other texts. It is written in a manner where an individual could work through it on their own, or it could be used in conjunction with individual or group therapy.

Sometimes, clinicians from other schools of therapy will describe a strawman of CBT, where emotions are devalued and suppressed. This text is the perfect corrective learning for those misinformed assumptions. The book is aimed at helping people evaluate their beliefs and attitudes towards their feelings (i.e., emotional schema) and guiding people to living lives that are full and open to the complete range of emotions. I will often say to my clients, "The absence of bad, isn't the presence of good," and this book is a great example of CBT focused on not just reducing symptoms but enhancing and enlarging lives. Readers of Don't Believe Everything You Feel will learn that feelings are not dangerous. To quote the first chapter of the book, "The goal is to live a real life—not aim for a life without negative feelings. The goal is enrichment, openness, and balance—not emotional perfectionism, cynicism, or disillusionment." Isn't this what we want for all of our people?

I, being a person who highly values hypothesis testing, set out to test my hypothesis that this was a useful text by introducing it to my clients. I picked a handful of folks on my caseload at various ages, presentations, and emotional awareness and I suggested we incorporate this workbook into our work. Universally, it was helpful. All my clients had a positive response to it. It presented familiar ideas and new concepts in a practical manner, with useful diagrams, and lots of heart. I actually really enjoyed it myself.

Therapists who have read Leahy's other books on the topic of Emotional Schema Therapy, will be excited to have more practical tools to enhance their work. The book is skillfully written, where it could also serve as an introduction to Emotional Schema Therapy for therapists who already have a background in the Cognitive and Behavioral Therapies. I view it as having a broad applicability to both clinical and nonclinical populations. Really, if I could get this in the hands of a teenage me, it could have been very helpful.

This workbook will help people understand more about what their emotions are, how the cognitive and behavioral model relates to our emotions, how our beliefs about and relationship with our emotions affects us, emotion regulation strategies, and value-based living activities. The text also touches things that often come up in therapy but are not typically addressed in treatment manuals such as emotional ambivalence and seeking closure. Additionally, there is added value in chapters like "Understanding How Other People Feel." This chapter is useful for empathy building, assertive communication training, and improving relationship dynamics.

I whole heartedly recommend this book. It goes on a very short list of books like The Feeling Good Handbook and The Happiness Trap that I recommend to family and friends, as well as clients.

https://www.newharbinger.com/dont-believe-everything-you-feel

PRESIDENT'S MESSAGE

CONTINUED FROM PG. 1

was elected President-Elect. Joining the board again will be former IACP President, Lata McGinn, Ph.D., as well as Scott Waltman,

Psy.D. and Cadges Okyu Memis, MD. Welcome!

The ICCP conference will be held in Rome (still in person as of printing although, we are following in person conference capabilities closely). To find out more about this conference please visit www.iccp2021.com. IACP members receive a steep discount, so Academy members interested in attending would do well to become IACP Members. www.the-iacp.com.

We are also looking at alternatives to our annual meeting in November given that the ABCT conference is now virtual. We hope to have a lively and fun event and look forward to including many diplomates who may otherwise be unable to attend. To our larger CBT Community we wish you health and safety.
Lynn McFarr, Ph.D.

1980-2020: FORTY YEARS OF COGNITIVE THERAPY

FROM STANDARD APPROACH TO COMPLEXITY THEORIES AND METHODS

A WORLDWIDE (IN PERSON AND VIRTUAL) CONFERENCE

TULLIO SCRIMALI

UNIVERSITY OF CATANIA AND ALETEIA INTERNATIONAL, CATANIA, ITALY – MAIL TO: TSCRIMA@TIN.IT

Acicastello (Catania), Italy, Aula Gianni Liotti (in person) – The World (in streaming on Internet), July 24, 2020

Tullio Scrimali MD, PhD: Physician, Psychotherapist and 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. He has been carrying out and still carries out research and didactics on Cognitive and Behavioural Therapies in several foreign countries of four Continents, among which the United States, Canada, Mexico Japan, China, Korea, Brazil, Uruguay, Argentina, Egypt and various European countries. He organised and headed the first Training in Cognitive Psychotherapy held in Poland. Tullio Scrimali authored 180 scientific articles and several monographs. Their most important books, in English, are: Cognitive Therapy Towards a New Millennium. New York: Springer Entropy of Mind and Negative Entropy, a cognitive and complex approach to schizophrenia and its therapy. London: Karnac Books, 2008. Neuroscience-Based Cognitive Therapy. Wiley-Blackwell, Oxford, 2012.

PREMISE

This article is dedicated to my friend and Maestro Arthur Freeman who recently passed away. It is just a very small but instant tribute to a giant of CBT. I am planning to dedicate to Art an Auditorium at ALETEIA International, European School of Cognitive Therapy and my next book on Complex Therapy.

Arthur loved a lot my Sicily where he was always very happy! It is really sad and difficult to continue my scientific adventure without him! He was my mentor and Maestro and he always prefaced by books.Ciao, Art!

INTRODUCTION

The conference held in Catania, in presence, at ALETEIA International, European School of Cognitive Therapy and worldwide on Internet has been successful. People from four continents attended (Asia, Africa, Europe and America). Authors of four continents lectured. The development of Cognitive Therapy in different Countries and from different perspectives has been presented and commented. In this short article I report my presentation, proposed during the Conference. I describe here my forty years journey from Behaviorism to Cognitivism and finally to Complex Therapy.

Forty years ago, I started teaching Cognitive Therapy (CT) at the Medical School, University of Catania. This was a seminal event in the history of CT in Italy, because, in 1980 I became the first university chair of Cognitive Therapy at an Italian University. Still nowadays I continue to teach Cognitive Therapy at the Medical School of Catania University. The following is a chronology of my scientific and professional achievements in CBT:

1980: I established a Chair of Cognitive Therapy at University of Catania, Resident School of Psychiatry.

1990: I instituted the ALETEIA School of Cognitive Therapy, then recognized by the Italian Minister of University for specializing in Psychotherapy. Some hundred physicians and psychologists, until now, specialized there!

1992: I founded a scientific journal named Complessità & Cambiamento (Complexity and Change)

1999–2003: I organized and directed the first course of Cognitive Therapy in Warsaw, Poland. From this work, the development of the Polish Association of Cognitive and Behavioural Therapy grew into

(CONTINUED PG. 26)

SLEEPLESS IN THE DESERT

KELLY N. KIM, SOPHIE WARDLE-PINKSTON, DANIEL J. TAYLOR, MICHAEL A. GRANDNER.
DEPARTMENT OF PSYCHOLOGY, UNIVERSITY OF ARIZONA, TUCSON, AZ

Kelly Nayeon Kim, B.S., is a Research Assistant in the Department of Psychology at the University of Arizona, where she is a member of the Insomnia and Sleep Health Laboratory. She received her bachelors degree in Psychology and Creative Writing from Carnegie Mellon University in 2020. Email address: kellykim@arizona.edu.

Sophie Wardle-Pinkston, MS, is a doctoral student in the Clinical Psychology program at the University of Arizona. She received her M.S. from the University of North Texas where she conducted a meta-analysis on the impact of insomnia status on daytime cognitive performance for her thesis project. She has worked on a variety of grant-funded projects investigating the assessment and treatment of insomnia to include assisting on the development of a web-based provider training for CBT-I. Sophie's current research focuses on the assessment and treatment of sleep disorders comorbid with PTSD with an emphasis on military considerations.

Dr. Taylor is a Professor of Psychology at the University of Arizona. He is a licensed psychologist and a Diplomate of both Sleep Medicine and Behavioral Sleep Medicine. He has significant expertise in both the epidemiology and treatment of comorbid sleep disorders, primarily insomnia, nightmares, and circadian rhythm disorders. His past federally funded observational research has examined the interface of insomnia and sleep disturbance with inflammation, disease risk, and immune function (5R01HL109340, 1R15AI085558, 1R15AI085558). His past clinical trial research has focused on the efficacy and effectiveness of treating insomnia comorbid with other disorders (1R03AR053266, W81XWH-10-1-0828, and W81XWH-13-2-0065/1I01CU000144-01). Dr. Taylor is currently the PI of an NIH R01 investigating "Sleep and Vaccine Response in Nurses (SAV-RN)" a DoD grant "Web-based provider training for cognitive behavioral therapy of insomnia (CBTi)" and a PAC-12 grant "The PAC-12 Student-Athlete Health and Well-Being Mental Health Coordinating Unit (MHCU)."

Dr. Michael Grandner is a licensed clinical psychologist, board-certified in Behavioral Sleep Medicine. He is the Director of the Sleep and Health Research Program at the University of Arizona and Director of the Behavioral Sleep Medicine Program at the Banner-University Medical Center in Tucson. Dr. Grandner is Associate Professor of Psychiatry, Psychology, Medicine, Nutritional Sciences, and Clinical Translational Science at the University of Arizona. He is an internationally recognized expert in sleep health, has over 150 academic publications, and frequently consults with health, technology, athletics, and nutritional companies and organizations regarding sleep, health, and performance. Read more about him at http://michaelgrandner.com.

The Behavioral Sleep Medicine (BSM) Training at the University of Arizona (UA) is administered through the Clinical Psychology Doctoral program, overseen by Daniel Taylor, PhD. There is substantial and increasing levels of overlap between the UA Clinical Psychology BSM program and the University of Arizona Health Sciences (UAHS) Department of Psychiatry accredited BSM postdoctoral training program, overseen by Michael Grandner, PhD MTR. The UA program is primarily focused on training graduate students through the Clinical Psychology Doctoral Program and occasionally accepts postdoctoral students typically working on Dr. Taylor's research grants. The UAHS program is a minimum 1-year program designed for postdoctoral fellows, junior faculty, and professionals seeking further BSM experience in preparation for the BSM board certification exam, though occasionally graduate students will also complete the program.

Students in the UA and UAHS BSM Training Programs participate in a variety of didactics, depending on level and location. Graduate students taking part in the UA BSM experience complete at least one course in BSM (postdoctoral students are invited to attend as well), in addition to broad and general didactics in Clinical Psychology, typically with an emphasis in Clinical Health Psychology. Postdoctoral students (UA or UAHS) complete didactics throughout their training with Dr. Grandner's weekly BSM seminar (graduate students are invited to attend as well). The BSM course and seminars provide comprehensive training in the identification and diagnosis of sleep disorders, administration of assessment tools and clinical interviews, and treatment of sleep disorders using non-pharmacologic techniques, such as cognitive behavioral therapy for insomnia (CBT-I).

The graduate and postdoctoral students must also complete at least 500 BSM practicum hours (described below). The BSM training programs are affiliated with several clinical facilities, including

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UPDATES FROM *THE INTERNATIONAL JOURNAL OF COGNITIVE THERAPY*—THE OFFICIAL JOURNAL OF THE INTERNATIONAL ASSOCIATION OF COGNITIVE PSYCHOTHERAPY

VOLUME 13, ISSUE 3, SEPTEMBER 2020

Shapiro, M. O., Gros, D. F., & McCabe, R. E. (2020). Intolerance of Uncertainty and Social Anxiety while Utilizing a Hybrid Approach to Symptom Assessment. *International Journal of Cognitive Therapy*, *13*(3) 189-202. https://doi.org/10.1007/s41811-020-00068-5

Abstract

Intolerance of uncertainty (IU) is a dispositional characteristic wherein individuals interpret uncertainty in a negative fashion. No research has investigated the relationship between the IU subfactors, inhibitory (IU-I) and prospective (IU-P) IU, and symptoms of social anxiety disorder while utilizing a hybrid approach of symptom assessment. The current study examined the associations between IU-I and IU-P and social anxiety while utilizing a hybrid index of social anxiety, the Multidimensional Assessment of Social Anxiety (MASA). Participants (N = 684) were recruited from an outpatient psychiatric clinic. Baseline anxiety was included as a covariate for all analyses. Results found that both IU subscales were significantly associated with the MASA anhedonia and physiological arousal and avoidance subfactors. IU-I displayed specificity with the MASA functional impairment, coping with substances, and behavioral avoidance subscales. IU-P was associated with the MASA thought avoidance subfactor at trend level, whereas IU-I was not. Clinical implications and future directions are discussed.

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Fisak, B., Bryant, A., & Klein, K. (2020). Self-Focused Attention as a Predictor of Post-event and Anticipatory Processing: Examination of a Moderation Model. *International Journal of Cognitive Therapy*, *13*(3) 203-217. https://doi.org/10.1007/s41811-020-00072-9

Abstract

Clark and Wells (1995) developed a cognitive model of social anxiety, in which a number of cognitive processes are proposed to be related to the development and maintenance of social anxiety. Previous studies have consistently found an association between two of the most extensively studied components of this model, self-focused attention and post-event processing. The purpose of the current study was to examine potential moderators of this association using a moderated moderation model, in which maladaptive self-beliefs and social anxiety were hypothesized to moderate the association between self-focused attention and post-event processing. Based on responses to self-report measures completed by a large, non-referred sample, support was found for the moderated moderation model. As expected, negative self-beliefs moderated this association, with social anxiety emerging as a secondary moderator. Interestingly, the model also applied to the association between self-focused attention and anticipatory processing. Overall, the findings provide insight into the cognitive processes associated with engagement in post-event processing and may inform clinicians working with individuals with social anxiety.

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Schenkel, L. S., & Towne, T. L. (2020). Maladaptive Cognitions and Attributional Styles Among Youth with Pediatric Bipolar Disorder. *International Journal of Cognitive Therapy*, *13*(3), 218-232. https://doi.org/10.1007/s41811-020-00080-9

Abstract

Although studies have examined cognitive styles among adults with bipolar disorder (BD), less is known about this issue in pediatric samples. Therefore, we investigated negative cognitions and attributional styles in pediatric patients with BD and healthy controls (HC). Participants completed measures about their views of themselves, the world, and the future and causal attributions for positive and negative events. Compared to HCs, youth with BD displayed greater negative thoughts about others and the future, but not about themselves. They were also more likely to report dysfunctional attributional styles for negative events. When including depressive and manic symptoms in the analyses, both were significant covariates and accounted for the group differences in negative cognitions. Findings point to the importance of manic and depressive symptoms in the occurrence of maladaptive thinking patterns among pediatric patients with BD and highlight the unique cognitive styles specific to this group.

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Borges, J. L., Vagos, P., Dell'Aglio, D. D., & Rijo, D. (2020). Cross-cultural Validation of the Young Schema Questionnaire for Adolescents in Portuguese and Brazilian Samples. *International Journal of Cognitive Therapy*, *13*(3) 233-250. https://doi.org/10.1007/s41811-020-00067-6

Abstract

This study aimed to examine the psychometric properties and to investigate the cross-cultural equivalence of the Brief Form of the Young Schema Questionnaire for Adolescents (B-YSQ-A) in a sample of Portuguese (n = 453) and Brazilian (n = 560) adolescents. A total of 1013 adolescents aged 14–19 years old (M = 16.61, SD = 1.18)

completed the B-YSQ-A, the Depression, Anxiety, and Stress Scale for Adolescents (DASS) and the Mental Health Inventory-5 (MHI-5). The factor structure of the B-YSQ-A was investigated using confirmatory factor analysis (CFA); moreover, measurement invariance across culture and sex was tested. Internal consistency and construct validity of the scale were also analyzed. In line with Young's schema model, the CFA supported the existence of 18 early maladaptive schemas (EMSs) assessed via the B-YSQ-A, which achieved acceptable internal consistency values and validity evidence based on relations with other variables. Further evidence was found for the adequate model fitting across sex and culture. The B-YSQ-A seems a valid tool for assessing EMSs among adolescents across these Portuguese-speaking countries.

~

Ólafsson, R. P., Emmelkamp, P. M., Olason, D. P., & Kristjánsson, Á. (2020). Disgust and Contamination Concerns: the Mediating Role of Harm Avoidance and Incompleteness. *International Journal of Cognitive Therapy*, *13*(3) 251–270. https://doi.org/10.1007/s41811-020-00076-5

Abstract

Although the proneness to experience disgust shows a strong relationship with contamination and washing concerns in OCD, it still is not clear what mechanisms explain why disgust fuels contamination and washing rituals. We report two studies on university student samples (n = 233, n = 211) where the mediating role of beliefs related to overestimation of threat and harm and to not-just-right experiences and incompleteness is tested. The results showed that not-just-right experiences and levels of incompleteness partially mediated the total effect of disgust on contamination fear. Threat/responsibility beliefs and harm avoidance did not significantly mediate this relationship. The results suggest that sensitivity to sensory phenomena may partly explain why disgust leads to contamination and washing rituals and that the sensation part accompanying disgust experiences may play a role in contamination fear.

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Popov, S., Jakovljev, I., Radanovilc, J., & Biro, M. (2020). The Effect of Unconditional Self-Acceptance and Explicit Self-Esteem on Personal Explanatory Style. *International Journal of Cognitive Therapy, 13*(3), 271-286. https://doi.org/10.1007/s41811-020-00082-7

Abstract

The present study aimed to explore the relationship between unconditional self-acceptance (USA), explicit self-esteem (ESE), and explanatory style of success and failure in an experimental ego-provoking situation. We simulated a public speaking task with randomly assigned different feedbacks for participant's performance. The sample consisted of 188 university students. In the main analysis, we tested the hierarchical regression model with positive/negative feedback, USA, and ESE measures in the first, and interaction between USA, ESE, and feedback in the second step of analyses. USA is not a significant predictor of explanatory style, either individually or in interaction with feedback. ESE does not represent a significant predictor of explanatory style independently; however, it moderates the relationship between positive feedback and explanatory style, especially in the domain of personalization. Participants with higher ESE scores tend to show more internal attribution in the case of positive feedback.

~

A COLLECTION OF MEMORIES AND TRIBUTES: REMEMBERING ART FREEMAN

Editor's Note: Arthur "Art" Freeman recently passed away. He was a giant in the field and a prominent figure in our organizations. He served two non-consecutive terms as president of the International Association of Cognitive Psychotherapy. He also had a number of other important certifications and appointments, too many to list here. Though Art had been battling illness, his death felt sudden and sent a shockwave through the field. A number of his colleagues and past trainees started voicing memories and tributes to him. We sought to collect some of those here. The call for brief contributions was certainly limited in scope and duration. Undoubtedly, there are those who were deeply impacted in a positive way by Art and did not get a chance to contribute here. We would encourage you to share your stories too. There is a common values-clarification exercise where a clinician asks someone to think about how they would want to be remembered and eulogized. Even in death, Art teaches us a great lesson that what people really remember about us, is how we made them feel. Also, that the best way to teach is by example. You will read below about how Art's humanity, humor, and creativity made a profound global impact. He will be missed, but his impact will never be lost.

~

We shall all mourn the passing of Art Freeman. He was a true inspiration and was relatively unique in his spread of cognitive therapy throughout the world. What I most remember him for was in the earlier stages of his career, where he was an active member of the Albert Ellis group

in New York and moved to Philadelphia to assume the first role as Clinical Director of the Center of Cognitive Therapy. He then moved on and started a cognitive therapy course at Philadelphia Community College. After that program was up and running, he started an analogous program at the Philadelphia College of Osteopathic Medicine. Following the successful launch of that program, he moved elsewhere in United States. I do not recall the exact locations, but I know that he made a big hit wherever he went. Most importantly, he inspired a whole generation of cognitive therapists with his various writings. He will certainly be missed by all of us.

Aaron T Beck, M.D.
Originator of Cognitive Therapy

~

When I think of Art Freeman what comes to mind is his energy, his excitement over ideas, and his good humor. Art had a palpable energy when talking about his work. His eyes grew wide, he talked faster, and he almost seemed to bounce on his feet a little bit with excitement. You could not miss that he cared about his clients and this field. He was always looking to expand the role and influence of CBT -- especially internationally. He travelled widely and made a difference in far corners of the world. Good ambassadors have the kind of energy, intellect, and social skills that Art had, and he was one of the best ambassadors for the cognitive behavioral tradition who ever lived. He will be missed -- not just by all who knew him but by our field itself

Steven C. Hayes

~

I am saddened to hear of his death. I learned of his illness and incredible persistence and passion for life about a year or so ago from Mark Gilson, whom he'd visited in Atlanta while he was ill. He will be missed for sure by the many who knew him and who profited from having that opportunity to benefit from his exuberance, wisdom, friendship, and intelligence. Warmly, David

David D. Burns, M.D.

~

Art Freeman enjoyed life to the fullest and his optimistic positive outlook and particularly his extraordinary sense of humor made it a pleasure to know him and work with him. Among his many funny stories and anecdotes that he told to me or in my presence, his recounting of the sudden need to find a dentist in Romania and what he endured to get the help he urgently needed could have been a successful standup comic routine at the best comedy clubs in the world. And he had many anecdotes like that. With these traits, and wonderful technical and relational skills, he was a great clinician and relieved a lot of suffering over the course of his career. But, I think perhaps his greatest contribution was his talent in disseminating principles of cognitive therapy to the four corners of the earth and probably beyond, thoroughly entertaining and effectively teaching all who heard him speak. He enjoyed traveling, he enjoyed speaking, and he enjoyed meeting and interacting with people, and CBT and the world are better for it. He will be greatly missed.

David H. Barlow Ph.D, ABPP

~

Arthur Freeman was my mentor, colleague, and close friend. Over the course of the 35 years we worked together, taught together, and pulled each other's hair out at times over our many joint writing projects. We gave well received workshops together on every continent except Antarctica. Artie was an outstanding presenter who threaded that needle perfectly. Until he became ill, he was usually on top of his game. He had a knack for making people laugh and ended up endearing many of them to him eternally.

One of my most colorful memories is from decades ago while we were both teaching in Brazil. Our hosts threw a party for us and tried to teach us Brazilian dancing. At one point, Artie became so absorbed with the shuffle, that he lost his balance and stumbled off of the elevated dance platform only to have his fall broken by a large palm bush. The Brazilians got hysterical and started calling him, "O destruidor de palmeiras" (The palm tree crasher). We joked about that one for years.

A few weeks before his death, Art called me to thank me for being such a good friend. As our final conversation came to a close, I told him that I will miss him terribly and that I would hopefully see him again someday on the other side. Art's reply was classic; "Yeah, right! Send me an email".
Art Freeman, what a character!

Frank Dattilio

~

Memories of Art: Supervising my first couples' case, he joins the session and sings to the couple. Navigating the stresses of life at the Center, he makes us all laugh. Perhaps he is underappreciated in those early years. He is all-too-human, creative, authentic, never unkind. A sad loss.

Ruth Greenberg

~

I am heartbroken to hear about Art Freeman. He was a rare and special man. Art was my first supervisor and it was he who helped ignite my passion for CBT. He was brilliant and warm and throughout the years always had a smile on his face when our paths crossed. The world is a better place because of Art. His contributions cannot be overestimated. I will always have a special spot in my memory and my heart for him. His life was a blessing for all who knew him.

Dennis Greenberger, Ph.D.

~

Art was larger than life - we used to collaborate trying to create a race of super insurance agents who would not take "no" for an answer - we did week-long workshops for groups of 50 or so 1st year agents and divided each day so that one of us would do the morning segment and the other the afternoon switching off each day - I would come in and cite references and watch people fall asleep - Art would come in with a rubber nose and a "wacka-wacka" noisemaker and drop balloons from the ceiling with dollar bills inside and the agents ate it up - I came to dread following his act and was struck by how much the agents learned when he was on - last time I saw him was in Cluj a couple of years ago - I was very fond of him - he will be missed.

Steve Hollon

~

Very sad. Art was a leader in CBT, a superb clinician, and a wonderful human being with a great sense of humor. He even joked and made me laugh when he told me about his cancer. I will miss him greatly.

Stefan Hofmann

~

Every so often, a field has a person who comes along and is "larger than life." In the world of cognitive and behavioural therapies, one such person was certainly Art Freeman. I first met Art in the late 1970s, and even then it was clear that he would make a huge contribution with his remarkable combination of intelligence, wit, verbosity, clinical acumen, and compassion. He of course went on to make outstanding achievements in theory and practice, the organization and advancement of CBT, and in particular training and global dissemination. The field of CBT has lost one of its treasures and his loss is poignant and sad, indeed. My condolences go out to his family, and to all of us who knew him in the field of CBT.

Keith Dobson, Ph.D.

~

I too am so sorry to read of his passing. Along with so many others, I worked with Art over the years and learned much from him at conferences, workshops, and in his writings. In addition, on a more personal level, he followed me as president of AABT (as it was known then). I mention this because the person who follows you is the president-elect and she or he makes the introduction of you for your address at the annual conference. One of my most endearing moments in his introduction was that he and I shared an early psychoanalytic background together and he cleverly superimposed my photo into a photo of Freud's inner circle – there I was, which drew lots of attention at our behavioral conference! In addition, he introduced my wife, Mary, to the tune of "I got you babe." And, yes, we were products of the 60s and 70s.

Indeed, Art was a good person, and he will be sorely missed by all of us.

Thomas H. Ollendick, Ph.D.

~

Art was a unique individual and I always took away a laugh or a smile when we talked. My condolences to his family.

Linda Sobell

~

I am so sorry to hear that Art has died. I have very fond remembrances of him from around the country and around the world. He was always jovial and a pleasure to spend time with. He was an important influence in cognitive therapy and will be missed.

Patricia Resick, Ph.D.

~

Many years ago, when I was looking for further certification in CBT, I inquired about a program Art had begun. He called shortly thereafter and asked if I would be interested in writing a chapter for Cognitive Behavior Therapy in Clinical Social Work Practice. I jumped at the chance. I certainly didn't know him well, hardly at all, in fact. If this is the sort of opportunity to grow, he offered everyone around him, I certainly understand the warm regard expressed here by those who knew him well.

Vaughn Roche, LCSW

~

We too are very saddened to learn of Art's death. As others have said his work was prolific & his personality was warm and embracing. He reached out to us when we first started doing cognitive therapy with older adults – 30+ years ago – a population that most people weren't interested in working with. He encouraged us & and invited us to co-author publications with him to help get the word out, that older adults respond just as well to cognitive therapy as middle aged and younger persons. We will always remember the impact he had on our lives and our subsequent careers. He will live on in our memories. Our support goes out to his family and loved ones.

Dolores Gallagher-Thompson, PhD, ABPP

~

I had the deep honor and privilege of having worked closely with Art for many years. I must admit that these were some of the best years of my life. It was totally delightful and exciting to work side by side with him on a daily basis and to have had the opportunity to appreciate his pure brilliance close up. Every day at noon we went to lunch and Art would hold court with his faculty family. These were fun times with him. I knew him for over 40 years, having first first met him at UPenn. I remember the exact moment and recall being totally impressed by him. Our friendship began then. Years later, Art recruited me to PCOM and served as my boss, mentor, clinical supervisor, colleague, and close, trusted friend over the years. He was such a remarkable, supportive human being and I learned so much from him. Our faculty are equally devastated by his loss. I am glad that we honored Art by awarding him an honorary doctorate a few years back and I remember him beaming with pride on the stage of the Kimmel Center. He also visited PCOM about a year ago and was able to spend quality time reminiscing with our faculty and students. He called me a few weeks ago to say good-bye and I promised him that we would carry on his legacy. He liked that. We are committed to doing that very thing in his memory... I will never forget him.

Robert A. DiTomasso, Ph.D., ABPP

~

My relationship with Art goes back to early 1978. People have already referenced his sense of humor – he was hands-down one of the funniest people I've ever known. A few years ago, I came across an account he had written of his initial involvement and eventual hiring at the Center – it had me laughing out loud. Art's humor always had a very disarming self-deprecating element. He had an innate appreciation for the absurd in all of us, but as funny as he was, I never heard him use his humor in a cruel or demeaning way. Art was an extraordinarily resilient and productive individual. May he rest in peace.

Richard Bedrosian, Ph.D.

~

Art's death is a great loss for us all. Art made huge contributions to cognitive therapy and mentored many cognitive therapists. He leaves a legacy that will not be forgotten. I was fortunate to be supervised by Art when I was at the Center and that had a lifelong impact on me. His loss is tragic, and he will be missed.

John Riskind

~

It is very sad and shocking news that Dr. Art Freeman has died. One of the giants in the CBT society has gone. He visited the Mettaa Institute, South Korea by my invitation and did excellent workshop for Korean mental health professionals long time ago. I pray for the repose of the deceased and will remember him in my heart.

Younghee Choi

~

I am so sad to learn of Art's passing. I learned so much about cognitive therapy from Art in the old days at the Center for Cognitive Therapy and marveled at his skill and energy at disseminating the model around the world. As others have described, Art had a lively and memorable personality, and was such an engaging and caring friend.

Norm Epstein

~

It makes life worth living to know that ART lived; shared, appreciated, and witnessed by so many. I watched the interview Bob sent, one of so many. The immeasurably wonderful sense is that every person is valuable and deserves to be understood and nurtured. May we emulate Art's resilience and joy of life that is never unkind.

My very sincere sympathy to his family.

Debbie Sookman

~

So sad to learn of Art's passing. He was indeed a CBT lion and will be missed for many of his professional and personal gifts. May his memory be a blessing to his family and all of us. With deep condolences

Bob Friedberg

~

Art was a wonderful colleague. I do not recall a time when he was not ready with a quip or bon mot. I will be holding those I love a little closer today to honor his memory and thinking about how fortunate I am do do the work I love, as he did.

Donna Sudak

~

So sad to hear. I have many fond and warm memories of Art. For all of us here in Israel he has been and will continue to be a huge source of inspiration. This very warm, humorous clinician, researcher teacher and above all a 'mensch'.We will miss him very much.
שיהיה זכרו ברוך

Joop Meijers
May his memory be of blessing.
On behalf of many CBT therapists in Israel.

~

As visiting professor at the Center for Cognitive Psychotherapy and Education in Kungälv (Gothenburg) Sweden, Art Freeman visited the Center two or three times every year for 25 years (1985-2010). His lessons and role-plays were appreciated by both students and psychotherapists at the center as well as others from all-around Sweden. Art also inspired one of the first books in Swedish about cognitive psychotherapy. He contributed with a chapter: "How to Change a Behavior". (Palm A et al. Cognitive Approach. A Psychological Theory for Co-operation with the Patient, 1995).

Colleagues and students from the Center will forever remember him with love for his inspiration, enthusiasm, open-mindedness, and joyful demeanor

Astrid Palm Beskow, PhD, Jan Beskow, MD, and Anna Ehnvall, MD

~

I have the honor of listen and learn from him in many congresses. I will never forget the interview he gave me at a Congress here in Brazil.

A great loss of a great teacher, author, and person

Melanie Pereira https://www.youtube.com/watch?v=DUmUUzU-jMXA&feature=emb_title

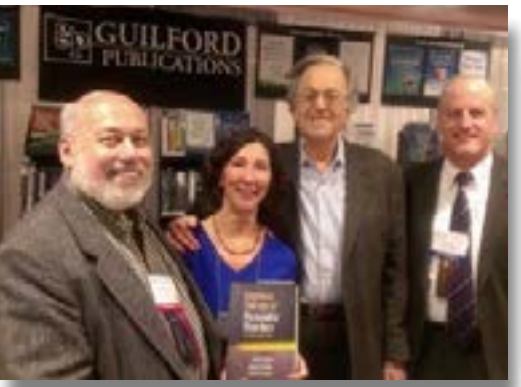
~

Art lived fully and truly touched the world. What an unmistakable presence he brought to any gathering, and warmth to every friendship and collaboration! I walk in deep sadness, mourning the loss of his presence in the world and remembering all that was ART. It is a comfort to be part of this chorus of care and recognition of his tremendous impact, as we have all lost a great friend. At least he is free from any more physical suffering now.

I met Art at APA in 1982, when he was presenting a paper on dream interpretation, part of a panel discussion of the relationship between CBT and psychodynamic psychotherapy. He encouraged me to come for training at the Center in Philadelphia, and provided steadfast support as I began to do training and supervision in CT. In those days, CT was a novel approach, and there was a good measure of skepticism to be addressed. Art's sense of humor was quite likely the secret weapon that disarmed the doubtful, and helped to build the critical early community, when CBT was considered radical and potentially dangerous. He taught through his example, and I learned so much from his demonstrations, anecdotes and discussions! Art always had a new idea for expanding CBT, leading to his next publication. He truly touched the world with his tireless efforts to educate, create new resources, and nurture the careers of colleagues. Art lived fully, bringing unmistakable presence to any gathering, and warmth to every friendship and collaboration. I am very grateful to have had the gift of nearly forty years of friendship and collaboration with him. We published 3 books together, co-wrote chapters, co-taught workshops, consulted on cases and shared many good times, great dinners and hearty laughs. It is a great comfort to hear the many stories of his impact, and the love and affection he inspired among so many people around the world.

The first photo is at the World Congress in Vancouver, 2001. The people in the 3rd (group) photo (L to R) are Art, me, Seymour Weingarten (owner of Guilford), and Jim Nageotte (editor) at ABCT, 2014. Art in the hat is New Year's Eve, 2005. The last photo is with Frank Datillio and Frank's wife at the 2001 World Congress. Sadly, we didn't carry around digital cameras in the early days, so no photos of the younger years.

Denise Davis



~

One dies only when his/her name is commemorated for the last time... There are things that death cannot take away from us and one of them is our genuine feelings towards our loved ones that never truly leave us. My grief cannot steal the beauty of our memories that I will save like a treasure my dear big brother, ART.

No doubt that you illuminated my path by being the master of Cognitive Therapy but most importantly you have always been a unique unforgettable big brother for me over decades.

My thoughts and prayers will always be with you.
I will always love and miss you.

Thanks Bob... "He lived a life that was worth suffering." I learned that he passed away early in the morning, but I could not write it to the listserv. My condolences to all but especially to those who were lucky to meet this giant.
Mehmet

Mehmet Sungur
Professor of Psychiatry, Istanbul Kent University, Istanbul

~

When I think of Art, my thoughts are full with pictures, colors and voices. Art was (it is so strange to write about him as was) a colorful person. I can see his smiling face, surrounded by people, hear his jokes, and feel his hugs. But I can also hear his lectures, a deep profound professional. I have known Art for more than 35 years. Art was happy to come to Israel and train us when the Israeli association was still young and looked for experts to come and help in training. He came and stay with us at home.

He attended my wedding in Copenhagen, when my late husband, Michael did not want to get married in a religious marriage in Israel, and Art joined us but then insisted on playing the role of a Rabi. He was my friend, my co-author, A colleague and A support system. Unfortunately - there are still some mission we haven't completed - two books we intended to write together, and I cannot see myself completing it without him.

Conferences in the future will not look the same without him, and I am sure that just like me, there will be many people to look around for his smiling face.

Art left good memories wherever he was, and I am sure he will be remembered around the world.

Tamar Ronen Rosenbaum

~

It is with a heavy heart and deep sadness that I and the members of our Russian Association for Cognitive Behavioral Therapy learned of the death of our dear friend, teacher and colleague Arthur Freeman. He was an amazing and wonderful person, a great therapist, scientist, writer, and teacher. We knew how much he loved life and admired his resilience. It was amazing how Arthur coped with the hardest blows of fate in recent years and emerged

victorious from the most difficult situations. But the most amazing things were his love, friendship, support for family, friends and colleagues, clarity of thought and humor even in the most difficult moments. After his visit to Russia, he called himself the "godfather" of our Association and helped us a lot in various issues. We were able to hold two of his face-to-face seminars in Saint Petersburg and Moscow in 2017, as well as two CBT courses from more than a dozen seminars under his aegis on-line, memorable for a lifetime. Each of his seminars and every meeting with him was a real festivity and a bright event. So much wisdom and knowledge he contained and shared so freely, so fascinating and elegant he explained the most complex things and so clearly conveyed them. I wanted to organize as many events as possible with the participation of Arthur, I wanted to see him as often as possible, and not only to learn from him, but first of all to be able to communicate and contact with him who has become very close to me. After Art's passing, we will have dozens of his excellent articles and books, manuals and videos, photos for memory, but nothing can replace his warmth and support. This is very difficult. He became an important and close person for many people in Russia, and for me a sensitive, understanding, supportive friend and a second father after my father's death. I mourn his passing, because I loved him and will always remember him. The bright memory of this man who loves life and people will remain in our hearts, and his name - in the history of cognitive behavioral therapy. Deep condolences to Rosie, Raymond DiGiuseppe, who was friends with Arthur Freeman for more than forty years, Robert Leahy, who has known Art since 1981, Mehmet Sungur and all other friends and colleagues. I fully agree with Donna Sudak that we need to convey to Rosie all the wonderful and warm words about Arthur in the letters here. I am ready to do this, that's why I decided to write this letter for all highly respected colleagues at the Academy of Cognitive Therapy.

With gratitude, Dmitrii

Dmitrii Kovpak, M.D., PhD

~

Ray Diguiseppe shared the following:

"Art Freeman was a very good friend and I shall miss him greatly. So how do we pay homage to a friend? How do we acknowledge his/her accomplishments?

It was important to Art that he had risen above his rebellious youth and completed his education and actually contributed academically. So, with the help of Kate Romero, we have compiled a list of Art's published works. Art was the ultimate disseminator of CBT. Is there an area of CBT that he did not write about? His writing was not his best strength, he was a great presenter. But I would not know where to start to compile his presentations.

~

Kevin T. Kuehlwein, PsyD, ACT

I will always be honored to have known and been affected by that towering figure in CBT, Art Freeman. He was in some ways like a Johnny Appleseed of CBT, traveling widely and disseminating the theory and practice of CBT to practitioners and theorists in many different countries, always with a sense of humor and creativity. In the early years, excitement and news of CBT spread far and quickly. People recognized the value of CBT and took upon themselves to self-educate. When someone is new to CBT there can be to an over-emphasis on techniques—missing the rich depth of CBT done well. When Art visited and gave lectures far and wide and peppered them with amusing examples people understood CBT at a much deeper level. He taught them, as he taught me, of the importance of the therapeutic relationship, how to work with deeper beliefs, how to use imagery, and how to work with personality disorders. More than that, he formed important friendships and alliances with all sorts of therapists in so many countries, providing them support for their learning and helping them to apply CBT with their populations and their unique needs. One of the most important lessons Art taught us was in his generosity of spirit. I also appreciated how he made it clear that CBT could be creative and also fun for you and the client, not some staid examination of

thoughts, beliefs, emotions, and behaviors.

Art was my CBT teacher in grad school, one of my funniest and most creative supervisors at Penn's Center for Cognitive Therapy, and he very kindly invited me to write my first professional published chapter. A fear years later my friend Hugh Rosen & I asked Art to write a chapter for our 1st book together: Cognitive Therapies in Action: Evolving Innovative Practice and he wrote a fine one. I later also ended up teaching his old CBT course in the Mental Health Nurse Practitioner program at Penn.

I don't recall lots of specific anecdotes about Art offhand, but I always remember him warmly from conferences with his broad smile, his impish eyes, his quick wit, and his keen observations about clinical matters. When you saw him in person, he really focused on you, always made you feel like you'd learned something and that you were glad to encounter him. He was simultaneously larger than life and yet easy to relate to. He is sorely missed and his impressive and varied contributions to the field will continue to live for generations to come.

~

By Martin E. Keller Ed.D. ABPP

I was a 22-year-old Counseling Psychology graduate student at Columbia University when my advisor called me into his office to tell me that he recommended me to teach at a small liberal arts undergraduate school in NYC. He asked me to contact the Chair of the Psychology Department, Arthur Freeman to schedule an interview. I met with Art for an interview. One day later, I received a call- "Hey Keller... you are hired. Here is the syllabus and the textbook. You start next week. If you have any questions, I'm here to help you."

Art became my mentor, teacher, friend and big brother for the next almost 50 years. Art supervised me at various clinical positions, hired me as psychologist for an adolescent division of a high school for special needs teens, and offered me adjunct faculty positions at a Clinical Psychology program housed in a medical school in Arizona. "Hey Keller- I have an idea for a book. Hey Keller, Let's do this project together, Hey Keller, what do you think of this piece I'm writing?"

Art edited my articles and reports, consulted with me on difficult cases, guided me in private practice, mentored me for board certification in Clinical Psychology and gave me advice and feedback on many professional and personal dilemmas.

Art and I supported each other through our numerous life transitions.
"Keller, I met this woman Rosie. She is my bashert. I'm in love."
Art and Rosie were so in love and I felt such joy for their special connection.

"Hey Keller, I have pancreatic cancer."
"Hey Keller, I picked out my cemetery plot."
Art and I talked until his recent death.
We were life-long buddies.
We cared deeply about each other.
We loved each other.
Hey Freeman! I miss you.
Your memory will be a blessing.
Thank you for our almost 50 -year journey of friendship.

~

Three-Legged Stool – Remembering Art Freeman

Nikolaos Kazantzis, Ph.D.
Psychologist and Researcher

It was September 2005, and there sat Art, larger than life, round turtle shell glasses, heavily patterned tie under a button-down collared shirt, smile beaming through his bright white beard. Flanked by Dr. Frank Dattilio and Dr. Bob Leahy, they sat among the remains of a massive luncheon on the day before the start of the European Association for Behavior and Cognitive Therapies conference in Thessaloniki, Greece. The venue restaurant was empty apart from this table, yet the trio's laughter, anecdotes, and friendly jousts filled the high ceilings and boomed against the marble floor. I had worked with Art on a special issue for In Session: Journal of Clinical Psychology and the first edition of Using Homework in Cognitive Behavior Therapy for Routledge, but this was our first in-person meeting.

Art pulled me to one side and started to draw on a paper napkin. He illustrated that the practice of Cognitive Behavior Therapy (CBT) was like a three-legged stool, it required as much emphasis on theoretical undergirding as its science and that an understanding of the theorized change mechanisms had been neglected in the definition of skillful practice. He lamented that we had become too concerned with the "brands" of therapy and what was emerging as "third wave" therapies were often specific techniques. He noted our cognitive and behavior therapies were united in facilitating flexibility in attention, prompting greater engagement with the environment including enhanced interpersonal functioning, and in promoting reappraisal of thought/ belief content. He explained to me that none of this was "new;" Dr. Aaron T. Beck's earliest writings on depression had incorporated both attentional processing and changing the content in beliefs, and that Dr. Beck's work through the 1980's had noted the role of acceptance. Art and I resolved there and then to collaborate on a book Cognitive

and Behavior Theories in Clinical Practice (for Guilford) to bring together proponents across the CBTs to describe how theories were central to advancing the science and skillful practice of their approaches. We were surprised that leading names in CBT, ACT, DBT, and other approaches contributed; our goal was simply to unite.

In 2020, it is pleasing to see that our science is now advancing understanding of how central processes that lead to psychopathology in turn become treatment processes. Our experimental and process research is increasing with sophistication; we are closer to defining meaningful treatment processes that exist in the tailoring of techniques within therapeutic relationships. I am grateful to Art for his mentoring in the decade that followed, and of course for stimulating these ideas back in 2005.

When Art spoke, people listened. He was among the first to complete post-doctoral internships with Dr. Aaron T. Beck, and like his contemporaries, he had the capacity to talk to large groups as individuals. He was a rare talent. Art stands tall among his peers as one of the greats. Art called it like he saw it, he often did not follow trends in thinking or said what was expected. He followed his own path. Art's humor was second to none; I will miss his good cheer and wit.

The field of CBT is richer for Art's contributions and we will miss his distinctive personality.

STANDING ON THE SHOULDERS OF GIANTS

CONTINUED FROM PG. 2

the University of California San Francisco. My exposure to the multiple-problem patients at San Francisco General Hospital, and to the intellectual opportunities and support I got from Ricardo and the trainees helped me develop my ideas about case formulation and led to my first book, Cognitive therapy in practice: A case formulation approach. Jeanne Miranda, one of the trainees, and I carried out several really interesting studies of Beck's cognitive theory that were published in the Journal of Abnormal Psychology and other places.

So I was having fun and being productive, but still struggling with the feeling that I was supposed to be an academic, and that those who trained me at Penn were disappointed in me. When I confided my concern to Connie Hammen (Connie was on the faculty at UCLA, the same sort of program as Penn), one evening at the ABCT, she told me, "I don't need my students to be academics. What's important to me is that they make a contribution." That concept gave me a platform to stand on that has been extremely helpful to me.

Soon after my first book came out, when talking about it to my friend Rick Heimberg at the ABCT, I used the phrase "small book." Rick said to me, "Jackie. Your book is important. DO NOT call it a "small book."" Rick has been an abiding support, as have so many others who have been on my team over many years, including Jerry Davison, Deb Hope, Sheila Woody, Bob Leahy, Steve Hayes, Steve Hollon, Marsha Linehan, Lynn McFarr, Kitty Moore, Michael Tompkins, Hanna Levenson, Christine Padesky, Kelly Koerner, Cannon Thomas, and so many others that I cannot mention them all. The Academy of Cognitive Therapy, the ABCT, and the Society for a Science of Clinical Psychology, have been important professional homes for me, as has my local Northern California Cognitive Behavioral Network. I joined the clinical faculty in the Department of Psychology at UC-Berkeley in 1999, and that academic home and colleagues there, especially Ann Kring, Allison Harvey, Bob Levenson, and Nancy Liu, have been invaluably helpful to me. I have had tons of fun there teaching a CBT course and providing clinical and occasional research supervision to many amazing UC Berkeley students who have collaborated with me on so many fun projects.

Conducting research as a clinician is not an easy professional path. The Behavioral Health Research Collective, a free-standing IRB that a group of us, led by Travis Osborne and including Jason Luoma, Trent Codd, and Linda Dimeff, created several years ago to support the research of our group of private practitioners, has been an important support of my work and my identity as a researcher in a private practice world.

I'm working now with my colleague Rebecca Courry to build, at the Oakland Cognitive Behavior Therapy Center, an infrastructure for our clinical practice that allows us to collect data that both guide the clinical work and support research. We're hoping to disseminate what we learn about building this infrastructure, to ease the way for other clinicians to conduct research in their clinical practice. Even my ability to help others in this way is a testament to the many people who have helped me along the way, and upon whose shoulders I stand.

CULTURAL COMPETENCY IN COGNITIVE THERAPY

CONTINUED FROM PG. 3

In a similar vein, clients who are members of oppressed minority groups, whether in their home or chosen countries, may have adopted a mistrustful stance that may appear irrational to an outsider. However, it is important to consider the possible adaptive function that such vigilance may serve, as well as the potential psychological and interpersonal costs to the individual. Some African American researchers for example, have suggested that some degree of mistrust towards the larger White society, termed "healthy cultural paranoia" is protective against racially-based assaults on the self esteem of Black Americans (Ridley, 1984). From this perspective, cultural paranoia may be conceptualized as a type of cultural coping response in African Americans. Under these circumstances, therapists are cautioned to acknowledge the social

(CONTINUED ON NEXT PAGE)

and contextual factors that may contribute to the development of clients' core beliefs, even if they do not mirror the therapists' own experiences and worldviews.

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INTERNALIZED RACISM IN AFRICAN AMERICAN CLIENTS

CONTINUED FROM PG. 4

in turn, act as an additional lens through which everyday situations are interpreted. Corresponding emotional, behavioral, and physiological reactions result in the reinforcement of dominant societal beliefs, which, as described above, is a definitional aspect of internalized racism (Bivens, 1995).

Case Conceptualization and Treatment Planning Considerations

When conceptualizing individual cases, consideration should be given to the unique sociocultural influences on cognition and behavior among African Americans. This includes consideration of attitudes, beliefs, norms, roles, and self-definitions within the African American community, as well as implicit messages and cultural scripts about African Americans received from society (Hall & Ibaraki, 2016). Rather than focusing largely on the role of individual childhood experiences in the development of the client's core beliefs and assumptions, clinicians practicing a culturally adapted form of CBT should also be intentional in exploring the influence of racial stereotypes and biases on the client's worldview and sense of self. This might include gathering information by: (a) looking for common themes, (b) direct questioning, (c) suggesting hypothesized rules, attitudes, or assumptions the client might ascribe to, and (d) using the downward arrow technique, wherein clinicians ask clients the meaning they would ascribe to themselves were an automatic thought true (Beck, 2011).

In terms of treatment planning, goals should continue to focus on helping clients increase awareness of, challenge, and modify their negative thoughts and beliefs. This goal is actually quite similar to broader empowerment goals, which focus on consciousness-raising and claiming one's voice and power in a system of oppression. Implementation of specific empowerment strategies during therapy may also be helpful and may include: (1) identifying the strengths and resources of clients, (2) identifying the social, political, economic, and cultural factors that affect clients (3) recognizing signs indicating an individual's behaviors and concerns reflect responses to systemic or internalized oppression, (4) helping the individual identify the external barriers that affect his or her development, (5) training clients in self-advocacy skills, (6) helping clients develop self-advocacy action plans, and (7) assisting clients in carrying out action plans (Lewis et al., 2009).

Conclusion

In the past, CBT has been criticized for its lack of applicability to multicultural populations. However, although limited, some research has demonstrated the efficacy of CBT with African American clients for a variety of disorders. To increase its applicability to African Americans, CBT should be adapted in consideration of this population's cultural and sociocultural identities. In future newsletters, I hope to demonstrate this adaptation through a case study in which case conceptualization and treatment planning are demonstrated.

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MY PERSONAL THOUGHTS, FEELINGS, STRUGGLES... CONTINUED FROM PG. 5

built upon racist presuppositions without addressing new ways of behavioral responding (2020). This may lead to a wide variety of ineffective actions (Kanter et al., 2020; Magee, 2019; Masuda, 2014; Saad, 2020). Saad (2020) discusses the potential for performing optical allyship that is "symbolic but not substantive," where the person with white privilege is positioned and remains the center of power as "a white savior" or a "benevolent and conscientious hero," and "perpetuates the ideologies that... actions taken must [still] benefit those with white privilege at the expense of, to the detriment of, and on the backs of BIPOC" (p. 160). A desire to divest from white supremacy requires willingness to step outside of the comforts of privilege, making contact with uncomfortable sensations and experiences that arise (Kanter et al., 2020; Masuda, 2014; Saad, 2020).

Mindfulness skills may be helpful in this process, cultivating the ability to observe the mental, emotional and physical experiences that arise in race-related contexts without judging them, and to develop curiosity about these experiences (Kanter et al., 2020; Magee, 2019; Masuda, 2014). Magee (2019) explores applications of mindfulness to the work of dismantling racism and the pursuit of racial justice. She invites us to sit with compassionate awareness of our own racial contexts and those of others, willingly making space to be with our observed experiences nondefensively and nonjudgmentally. We may begin to recognize the spaces in which we feel comfort or discomfort and question for whom those spaces were designed. "We may become more cognizant of the manifold obvious and not-so-obvious ways that race and racism are perpetuated, how any one of us may contribute to the maintenance of stereotypes... of constructing a story about another person or group that bears the imprint of racism" (Magee, 2019).

Comfort, control, and power are interrelated. It is often implied that, if we want to experience the stability and ease that may be afforded to us from "achieving" the innumerable things that we strive for as psychologists, like economic security, tenure or promotion, we must remain at least partially self-interested. However, self-interest may stand in opposition to the values that lead us toward racial justice, for "racist power creates racist policies out of raw self-interest... economic, political and cultural self-interest," where "racist policies necessitate racist ideas to justify them" (Kendi, 2019). We will certainly find it impossible to hold onto privilege when divesting from white supremacy, which requires awareness even of the power afforded to advanced degrees and titles such as "Doctor," and charges us with "transferring the benefits of privilege to those who lack it" (Saad, 2020).

Ultimately, we have an opportunity to explore our values and what our actions are in service of, our own security and comfort or the deconstruction of abuses of power and control. Identifying the values that you hold as a person and a clinician, and how these values operate when engaging with persons with marginalized identities, are a critical foundation to build upon. "Racial justice... is about taking actions against racism and in favor of liberation, inspired by love of all humanity, including actions at the personal, interpersonal, and collective levels... Racial justice cannot exist apart from the effort to alleviate the socially constructed, unevenly distributed suffering of all marginalized people... social justice cannot exist apart from racial justice" (Magee, 2019). Yet there is hope, for "if we bring to mind the harm that all of this does, we are on the road to personal transformation at a level that cannot but change the world" (Magee, 2019).

May we create a community of professionals who are dedicated to vulnerable, open, courageous words and actions. May we choose justice over the maintenance of power and control, even amid fear. May we be unrelenting in our centering of marginalized voices. May we be so loving that we refuse to be silent when we witness the

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oppression of any marginalized person. May we be so brave that we are willing to recognize the harm we cause, and face our own faults with honesty, humility and compassion. May we be audacious in our efforts to grow.

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BEYOND PRONOUNS
CONTINUED FROM PG. 6

position to offer absolution.

Incorporating Gender into Case Conceptualization. One of the hallmarks of cognitive behavioral therapy is an individualized assessment and formulation of a treatment plan based on case conceptualization founded in scientific principles. For example, we know from the scientific literature that fear of negative evaluation is the key feature of social anxiety but our individualized case formulation explains why our client fears work meetings but not dating. For TGD clients, it is essential to incorporate gender into their case formulation, including perhaps consideration of marginalization and discrimination they experience, perception of their gender by others, or their experience of their own gender over time. In the social anxiety example, gender could frame an automatic thought (AT) of "They think I'm not qualified to be a manager" in several ways. The AT may reflect the TGD client's perception of anti-TGD bias in their workplace. On the other hand, a transgender woman could be reacting to biases against women in leadership roles. A cisgender woman may be familiar with such gender bias but this may be a new experience for a transgender woman socialized into male privilege prior to gender affirmation. Or, the automatic thought might have nothing to do with gender and reflect a general dysfunctional belief of being found out as an imposter. I would argue that a complete case conceptualization for all clients should include gender as all clients have gender and it fundamentally shapes their experiences in life. (The importance of including other identities for all clients in case conceptualization is a topic for another column.)

Challenging Marginalization. Cognitive restructuring is a powerful tool to challenging clients' perceptions about themselves, the world, or the future that are leading to negative affect and/or dysfunctional behavior. Collaborative empiricism and the Socratic method ideally lead to cognitive restructuring that is a mutual endeavor. However, as therapists, we often see beliefs that are clearly dysfunctional based on our own experience in the world and use that experience to lead clients to challenge those beliefs. To the extent our experience in the world is shared by our client, this can be very helpful. However, for cisgender therapists, our understanding of what it means to be a gender minority is often limited. Even therapists who identify as TGD only have their own experience to draw from and it may not match their client. It is very important to avoid using cognitive restructuring to challenge a TGD client's lived experience. For example, a client who feels excluded at work after undergoing social gender affirmation may express a thought such as "They are avoiding me because they are uncomfortable with my gender transition." As a cognitive therapist, it may be tempting to label that thought as *mind reading* and query about evidence for it. A better approach is to accept this thought as their lived experience and query about the meaning. An underlying AT of "I understand it is weird to be transgender, I can't expect them to understand" is good material for cognitive restructuring. However "It is important to me to live as my authentic self even if there are some people who don't understand" suggests a healthy underlying thought and a more appropriate focus on improving the work atmosphere. Kevin Chapman has written eloquently about cognitive restructuring with racial and ethnic minorities and his advice applies well for TGD clients (see Resources).

Assessment Tools. Standardized assessment that helps inform case conceptualization and progress monitoring are key aspects of evidence-based practice. Before using any standardized assessments with TGD clients, the clinician should review the items for

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assumptions that respondents are cisgender. Standardized tests that have gendered norms may not be appropriate for TGD clients unless there is research indicating which norms to use. However, many standard questionnaires commonly used by CBT therapists for anxiety, depression, and stress are used regularly in research with TGD samples, offering indirect support for their appropriateness. In order to remedy the lack of options for progress monitoring specific to concerns around gender identity (outness, social support, body dysphoria, etc.), our research group developed the Trans Collaborations Clinical Check-In (TC3) (see resources). The TC3 is a good adjunct to symptom measures as it monitors important gender identity related experiences efficiently, especially if treatment is not focused on gender affirmation and such topics may not always be discussed in session.

Usual Practice is Not Always Best Practice. As clinicians, we often encourage our clients to interact with the world outside of session or we make referrals for additional services including to manage risk such as suicidality. In each of these situations, it is important to think about the context you are asking your TGD client to enter. For example, when we ask TGD clients who are engaging in therapeutic exposures as part of treatment for anxiety, we consider whether the exposure situations will put them at risk for marginalization, discrimination, or violence. In negotiating these conversations with clients, we carefully disentangle anxiety-related avoidance from risks associated with their TGD identity, prioritizing their own judgement about the risk. They often prefer to take someone along as a safety precaution. Another situation where practice as usual may need reconsideration is referrals to additional services. For example, a substance abuse treatment group where members decline to use correct names or pronouns or are overtly hostile is unlikely to be therapeutic. Suicidal ideation and attempts are very common among TGD communities and many clients have had terrible experiences in past hospitalizations such as a transgender woman being forced to share a room with a cisgender man and treated as male on the hospital unit. Such clients may be very fearful of being hospitalized again so developing a plan early on for what to do if they become a danger to themselves can help a therapist be prepared if the need arises. As clinicians look for the most TGD affirming options, a facility that requires some travel or a non-traditional option may be best practice.

CBT therapists have much to offer TGD clients who are seeking treatment for anxiety, depression, or other common presenting problems. However, therapists can create barriers to engagement and successful outcomes by inadvertently marginalizing TGD clients. An affirmative environment requires self-education, an audit of paperwork and policies, and the desire to trust and understand your TGD clients' lived experience.

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BOOK REVIEW: SOCRATIC QUESTIONING CONTINUED FROM PG. 7

model involves helping the patient and the therapist arrive at a nonjudgmental understanding of the patient's problematic beliefs, given their histories and their current contexts. The authors achieve this by effectively linking SQ/GD to the validation strategies that are central in DBT. The book shows how to incorporate DBT validation strategies in a way that fosters the treatment alliance and promotes emotionally evocative exploration, all without provoking shame and resistance.

There are two separate chapters that show how to incorporate SQ/GD into an ACT and a DBT model. These chapters each provide clear summary statements about ACT and DBT, including how and why they depart from traditional Beckian techniques. While acknowledging the ways that ACT and DBT deliberately depart from Beck's model, the authors of these chapters effectively demonstrate how ACT and DBT practitioners can benefit from including SQ/GD in their therapeutic repertoire. It is rare to see this integration attempted, let alone pulled off successfully. Waltman et al pull this off admirably.

In short, Socratic Questioning for Therapists and Counselors is a worthy addition to the CBT training library. It is a model of pragmatism, simplicity, heart, soul, and comprehensiveness. It belongs not just on the trainer's shelf, but in the library of all those who aspire to master the practice of modern Cognitive-Behavior Therapy.

https://www.routledge.com/Socratic-Questioning-for-Therapists-and-Counselors-Learn-How-to-Think-and/Waltman-III-McFarr-Moore/p/book/9780367335199

BOOK REVIEW: SOCRATIC QUESTIONING CONTINUED FROM PG. 6

one of the larger and more active Association of CBT in Europe.

2000: I organized and chaired, in Catania, the congress Cognitive Therapy Towards a New Millennium. It was one of the most interesting, and impressive international conference ever organized in the field of Cognitive Therapy. (Aaron Beck dixit, while awarding me, in Catania, during the Congress, for the great job I have done).

2005: Development and patenting for an original device named MindLAB Set for integrating Applied Neuroscience and Biofeedback into Cognitive Therapy.

2012: I published and presented, all around the world, a scientific proposal called Neuroscience-Based Cognitive Therapy that was further described in my book: Neuroscience-based Cognitive Therapy. New Methods for Assessment, Treatment and Self-regulation, which was published by Wiley in Oxford.

2016: I founded a School of Complex Cognitive Music Therapy, named Musica Ribelle ALETEIA.

2020: I developed a new cannabidiol-based herbal medicine, patented with the name NegEnt. Nowadays I am working on refining a new perspective and a new book as follows:

TULLIO SCRIMALI
COMPLEX THERAPY
A COMPLEXITY-BASED APPROACH TO PSYCHIATRY, PSYCHOTHERAPY AND PSYCHOSOMATICS
(IN PREPARATION, TO BE PUBLISHED ON 2021)

SCIENTIFIC FACTS AND METHODS
BECOMING A BEHAVIORAL THERAPIST (SCRIMALI, 1978)

When I was young, I was interested in Psychiatry and Psychotherapy but also in Neuroscience. At that time, I understood that Psychoanalysis was based on the cultural background of the Thermodynamic, flourished in the Nineteenth Century. This way, during Seventies, I became a behaviorally oriented therapist and I applied some behavioral techniques such as Biofeedback and Systematic Desensitization. I published the first European article on integrating Biofeedback into Systematic Desensitization.

The Basaglia Revolution (Foot, 2015)

While attending at the Medical School, University of Catania, I took part in the political movement named Psichiatria Democratica (Democratic Psychiatry, a left wind oriented Organization) headed by Franco Basaglia. The goal was to close any Asylum and starting to rehabilitate patients at their home or in some sheltered apartments!

In 1978 (at that time I was a young physician attending the Resident School of Psychiatry at the University of Milan) a new era of Psychiatry started in Italy and I was able to take part personally in this fantastic revolution. In 1978 (at that time I was a young physician attending the Resident School of Psychiatry at the University of Milan) a new era of Psychiatry started in Italy and I was able to take part personally in this fantastic revolution.

From Behavioral to Cognitive Therapy (Beck, 1978)

At the end of Seventies, a second scientific revolution arrived in my professional life that took me from behaviorism to cognitive psychology and psychotherapy. It was the revolution of Cognitive Therapy. After being interested in the scientific and clinical work of Aaron Beck, I became finally a Cognitive Therapist!

My Maestro in Standard Cognitive Therapy was Arthur Freeman. I met him in Canada, during the World Congress of CBT, in 1992 and we started to work together in America, Europe and Asia.

Michael Mahoney, who was active, in Italy, together with Vittorio Guidano, strongly influenced me, with his proposal of a constructivist approach to psychotherapy.

Italian Approach to Cognitive Therapy (Guidano, Liotti, 1983)

During the 1980s, Guidano and Liotti proposed an original, Italian approach to Cognitive Therapy. They were two Authors who worked in Rome at La Sapienza University with whom I strictly collaborated and that I consider my Italian Maestri. This original Italian approach to Cognitive Therapy was based on Constructivism and Attachment Theory. Guidano e Liotti collaborated with John Bowlby and they integrated attachment perspective into Cognitive Therapy.

Neuroscience-based Cognitive Therapy (Scrimali, 2012)

Neuroscience-based Cognitive Therapy that I developed is a new approach to Cognitive Therapy, which attracted some interest from all around the World! The corner stone of Neuroscience-based Cognitive Therapy has been the realization of a new and original device I patented and named MindLAB Set (www.psychotech.it).

Complexity and Complex Systems (Scrimali, 2001)

Thanks to the hard work I have done during Eighties, at the beginning of Nineties, I was able to propose a complex approach to Psychiatry and Psychotherapy. I also founded a new scientific journal, named *Complexity and Change*. The most important topic of a complex approach to Cognitive Therapy are:

- Attachment Theory

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- Constructivism and Motor Theories of Mind
- Complex Systems
- Complexity and Chaos Theories
- Biological and Psychological Evolutionism
- Ecology
- Social solidarism
- Ethical business or nonprofit activities
- Hospitality, Care and Integration for Refugees

The most important contribution I developed in the field of a complex approach to cognitive therapy is my book: *Entropy of Mind and Negative Entropy. A cognitive and complex approach to schizophrenia and its therapy*, Karnac Books, London, 2008).

NegEnt: a cannabidiol–base herbal medicine to be integrated with Complex Therapy (Scrimali, 2020)

This topic describes a research project that included the conception, development, testing and dissemination of a new drug, based on cannabidiol and called NegEnt (registered name and trademark). I developed in many years of lab and clinical research a new herbal medicine that can be used for significant progress on various treatments for different conditions in psychiatry, neurology, and medicine. It also presents completed work for new herbal medicines at affordable costs worldwide. NegEnt will be available soon on the international market.

Conclusion

I am sure that we shall overcome the Covid-19, the last challenge of complexity for humankind. In order to win this challenge we should start to respect more and more nature, our planet and humans. *You may say I am dreamer but I'm not the only one. I hope someday you will join us and the World will live as one!*

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SLEEPLESS IN THE DESERT
CONTINUED FROM PG. 11

the American Academy of Sleep Medicine (AASM) accredited Center for Sleep Disorders at Banner University Medical Center – Tucson (BUMC-T), a clinical 7-bed sleep laboratory where over 5,000 patients are seen annually, the Outpatient Psychiatry Clinic at UA College of Medicine, the Whole Health Clinic within the Department of Psychiatry, the Behavioral Health Clinic in the Department of Psychology, and the Early Psychosis Intervention Center (EPICenter).

During their BSM practicum training, students treat patients experiencing difficulty with sleep disorders, sleep state misperception, CPAP compliance (i.e., systematic desensitization), and phase advance or delay syndrome (i.e., chronotherapy). The majority of patients seen in the clinic are adults with comorbid insomnia, however students occasionally see pediatric cases with supervision. Students' responsibilities include completion of intake and therapy sessions with related progress notes, weekly review, recording of sleep log data, and ongoing communication with the primary sleep physician regarding patient progress and medication.

At external placement sites, students work with psychologists (primarily Dr. Grandner) and physicians for 10 hours per week over a 12-month period. The graduate program offers continual supervision and support for each student with annual progress meetings, weekly research meetings, and weekly meetings with the practicum supervisor. The postdoctoral training also provides at least weekly clinical and research supervision.

Students in the BSM Training Program are also involved with ongoing research, requiring the students to coordinate research, perform statistical analyses, and co-author manuscripts on various sleep-related studies. Research programs include the Insomnia and Sleep Health Research Laboratory, led by Dr. Taylor focusing on insomnia and comorbid conditions (e.g., circadian rhythm disorders, PTSD) and the Sleep & Health Research Program, led by Dr. Michael Grandner focusing on health outcomes of sleep

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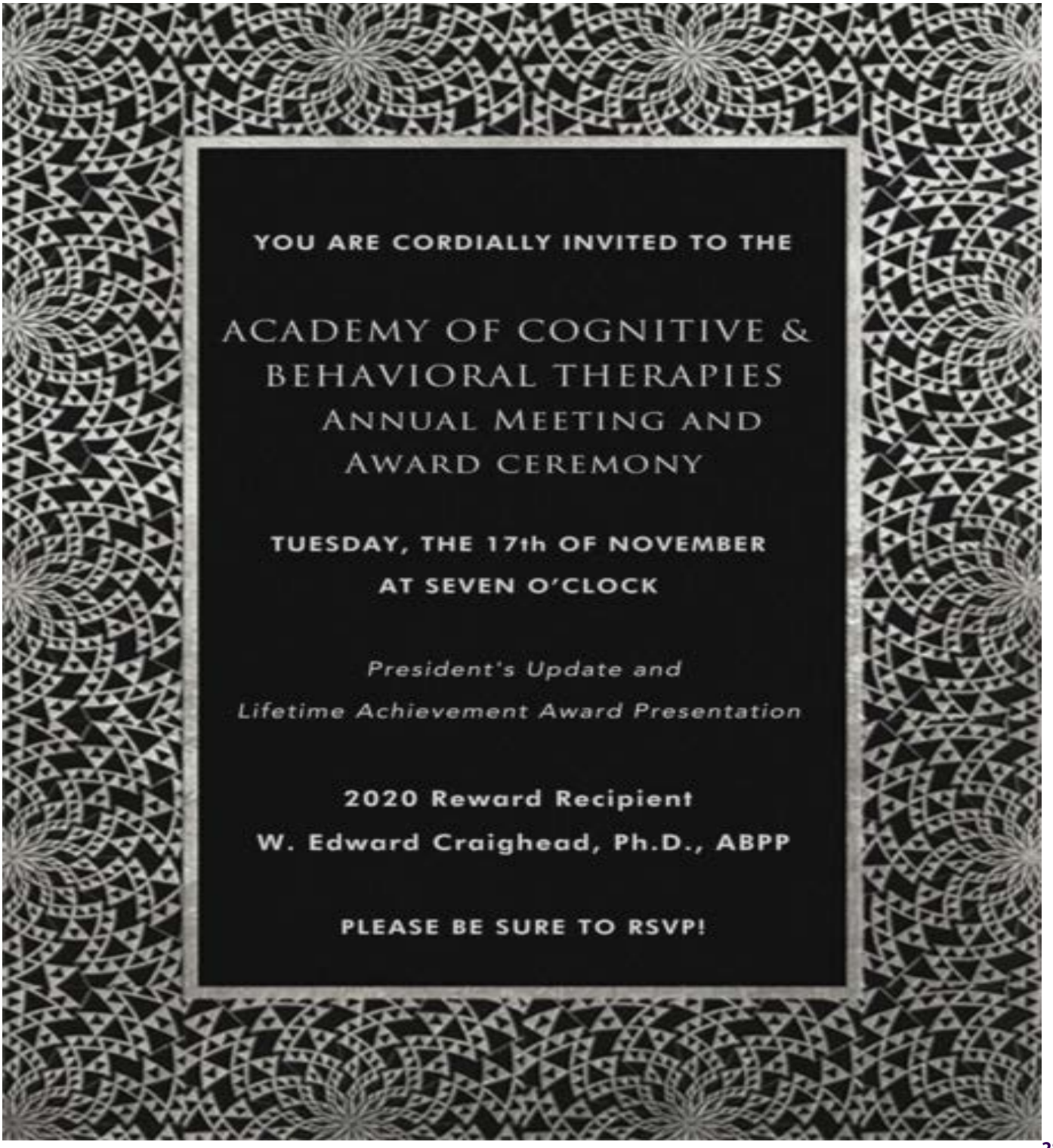
and sleep-related behaviors, determinants of sleep, and developing sleep interventions. Drs. Taylor and Grandner are also part of a larger team, including Sairam Parthasarathy, MD, Patricia Haynes, PhD, and Scott Killgore, PhD, who are the executive committee of the soon-to-be built Center for Sleep and Circadian Sciences (CSCS). The CSCS is an 8-bed, world-class interdisciplinary research center performing campus-wide sleep studies, including overnight polysomnography testing, long-term temporal isolation, physiological and respiratory experimental procedures, and neurocognitive testing.

The combined clinical and academic training in BSM provided by the combined UA and UAHS sites represents one the most comprehensive and prestigious training sites currently available in BSM. Graduates of either of these BSM programs will meet all qualifications for board certification and will be well established to become leaders in the field of BSM.



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