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ACT PRESIDENT'S COLUMN

LATA K. MCGINN, PHD

The way mental illnesses have been depicted in popular culture – particularly in movies and television shows – has been typically unhelpful. Mental illness is either glamorized or people who suffer from mental illness (and those who treat it) are portrayed as crazy, weak, violent, or strange. Additionally, when it comes to treatment, most television shows and movies fail to describe evidence-based mental health practices and instead focus on fairly outdated and stereotyped descriptions of treatment. The portrayal of mental illness and treatments in most television shows and movies has the potential to perpetuate the stigma associated with mental illness, to create hopelessness in people who suffer from it, and to discourage them from seeking help. An abundance of studies show that mental illnesses can be effectively treated with cognitive behavior therapies.

Having characters on television who struggle with mental illness has the potential to be helpful, especially for younger audiences. However, it is equally important that mental illnesses, the people who suffer from them, and those who treat them are portrayed more realistically in order to achieve any positive impact on audiences. For example, the first season of the television show *13 Reasons Why*, which came out in March of 2017, gave viewers a harmful message and missed the opportunity to educate our youth about mental illness, how to spot the signs of someone in trouble, and how to seek help. The show is about a high school girl named Hannah Baker, who has committed suicide and left behind thirteen cassette tapes addressed to the people who she believes contributed to the ending of her own life. The first season's glamorization of suicide as a form of revenge as well as its depiction of Hannah not receiving appropriate help even after she reaches out to professionals are just a few of the reasons why *13 Reasons Why* missed the mark. Particularly egregious was the fact that the show glamorized Hannah, and implied that she was somehow memorialized and made "popular" after the fact – effectively making the claim that she "lived on" despite having committed suicide.

Research tells us that the best way to depict suicide is to highlight that suicide is a dysfunctional or maladaptive coping strategy used by some individuals to try and get relief from experiencing high levels of negative emotions or to cope with negative events in their lives. It is imperative that forms of popular entertainment focus on why suicide is not a helpful, glamorous, or romantic solution to life's problems and that suicide is not an appropriate or effective way to punish people who have wronged you in some way. When someone dies in

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IACP PRESIDENT'S COLUMN
MEHMET SUNGUR, MD

First of all, I would like to give my best wishes to all of the distinguished members of the IACP and ACT. It has been almost a year since I began to serve as the president of the International Association of Cognitive Therapy. I would like to express my gratitude to all of our board members of IACP for their support and contributions to disseminate the science and practice of CBT through its peer reviewed journal and through lectures and workshops made in various parts of the world. Recently, I have run two days workshop in Latvia and one of our past presidents, Keith Dobson, and myself conducted workshops in St. Petersburg promoting both IACP and ACT. I am sure that our distinguished board members have conducted similar workshops in different parts of the world doing similar work. We have a new webpage which is almost completed and we are hoping to hear members' opinions and contributions to make it even better. We are also hoping that we will soon have further information for the upcoming ICCP congress in Rome in the year 2020.

When our new editor, Jamie Schumpf who has done great job until now reminded me to write a column for the newsletter, I thought this might be a good opportunity to express my views and humble opinions about disseminating good practice of CBT in this issue. No doubt it is open to criticisms and contributions. I have to thank to many giants in the field for giving me perspective in writing this short communication. There are many references which I made use of when preparing this column.

Efforts and contributions of many scientist practitioners have evolved CBT to become the most efficacious psychotherapeutic approach with the strongest current evidence. However, there are further challenges to be considered for the future of CBT. Definitions and treatment approaches in the past were based on expert opinions that were not supported by sufficient clinical research data. Unfortunately even the latest edition of DSM(V), that is supposed to be most reliable in terms of diagnostic criteria contains considerable amount of expert opinions that are not evidence based. Although experience is a major asset that deserves to be highly appreciated and embraced, experience being used as a substitute for research evidence may not always be acceptable for progress of science. Initially, Behaviour Therapy (BT) became a major therapeutic school by basing the clinical practice on learning principles, pragmatism and outcome data in place of hypothetized and unmeasurable unconscious conflicts. However as BT proved to be more and more effective it became a victim of success. Management decisions started to be taken merely by results (outcome) rather than a coherent theoretical model. A dispute among behaviour therapists arose about the significance of theory in their work. Connections between theoretical models and their practical consequences became a challenge. The question became "Does outcome research give reliable information about the value of the underlying theory?".

Cognitive revolution resulted in merging of BT with CT (CBT). Identification of cognitive spesifity made CT a perfect patner to BT, widening its explanatory range by bringing futher content to understanding the phenomenology (filling in the the missing pieces of the puzzle). Sharing the conceptualization with the clients and disconfirmation of beliefs via behavioral experiments led to 'shared understanding' and thereby improved collaboration.

However CBT today is losing its specificity. CBT is now recognized not only as a specific therapy but also as an umbrella term that includes many different empirically supported approaches including those defined as "third wave of CBT". Therefore new paradigms such as focusing **not only on the cognition** but the **response to the cognition**, **aiming to change the way** individuals **respond** and **experience** (control) thinking, **psychological flexibility**, **paying attention to the present moment** with a **nonjudgemental** attitude, and compassion (inner **warmth** towards self and others) came on board.

Therefore maybe it is now more accurate to view CBT as a maturing discipline that is not a single approach but a broad set of psychotherapies that continually evolve and change as more knowledge is accumulated. A new question raised asking "Will future of CBT be based on processes, emotions, transdiagnostic issues?" or does the question "which approach, for whom, under what circumstances and at what cost?" will still stand?

> *As evidence for efficacy and effectiveness of CBT became evident further alarms came about its provision: "Making effective therapies more accesible and available". When problems were identified as suitable for CBT, CBT was not readily available, which took us to disseminating evidence based therapies, by different delivery methods, ranging from internet based to face to face treatments. One of the major steps to improve dissemination was the adoption of CBT by governmental organizations. IAPT initiative in UK has been a major development in creating a model for delivery. Other organizations or associations such as EABCT, ABCT, IACP, AACBT, ACT and many others emerged for dissemination of CBT.*

As CBT became more available and accessible another alarm emerged. When CBT is available, is it really CBT? **Relying only on dissemination** may result in **discrediting** of the approach due to lack of "**competent adherence**". Dissemination is a necessary but not a sufficient construct. Maybe time has come to emphasize the significance of "**dissemination of good-ethical practice**" which requires defining the optimum pre-requisites that constitute an acceptable practice of CBT.

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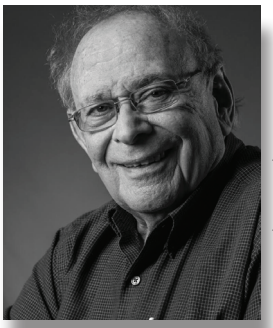
STANDING ON THE SHOULDERS OF GIANTS
MARVIN R. GOLDFRIED



Marvin R. Goldfried, Ph.D. is Distinguished Professor of Psychology at Stony Brook University, where he was involved in developing its graduate program in clinical psychology. In addition to teaching, clinical supervision, and research, he maintains a practice of psychotherapy in New York City. He is a diplomate in clinical psychology, Fellow in the APA, and recipient of several Awards from the APA and other professional organizations, and most recently received the APA/American Psychological Foundation Lifetime Achievement Award for the Application of Psychology. He is Past-President of the clinical division of the APA (Division 12), Past-President of the psychotherapy division of the APA (Division 29), Past-President of the Society for Psychotherapy Research, founder of the journal In Session: Psychotherapy in Practice, editorial board member of professional journals, and author, co-author or editor of several books, including Rorschach Handbook of Clinical and Research Applications (with Stricker and Weiner), Clinical Behavior Therapy (with Davison), Converging Themes in Psychotherapy, Handbook of Psychotherapy Integration (with Norcross), From Cognitive-Behavior Therapy to Psychotherapy Integration, How Therapists Change, and Transforming negative reactions to clients (with Wolf and Muran). Dr. Goldfried is cofounder of the Society for the Exploration of Psychotherapy Integration (SEPI), founder of AFFIRM: Psychologists Affirming Their Lesbian, Gay, Bisexual, and Transgender Family, and founder of the Two-Way Bridge Between Research and Practice.

I was born in Brooklyn to immigrant parents who had fled Poland prior to World War II. Growing up in an immigrant family, I was the first one in my family to attend college, and was fortunate enough to have available Brooklyn College, which offered free tuition at the time. Much to the surprise—an eventual delight—of my parents, I also decided to go to graduate school in clinical psychology.

As a counterpoint to the several cold and snowy winters at the University of Buffalo, where I received my PhD in 1961, I spent a glorious summer in the late 1950s on internship at Palo Alto VA hospital in California. It was a very special time and place. I vividly recall one end of the first-floor corridor of the psychology office building, where Krasner, Ullman, and Weiss were developing a new approach to therapy—behavior therapy—and the other end where Bateson, Haley, and Weakland were working a new form of family therapy. Only later did I come to realize how special it was to have observed how professional innovations actually occurred.

I happen to obtain my degree in January, which was when John F. Kennedy was being inaugurated as president. I vividly remember listening to his inaugural address, where he indicated that the torch was being passed to a new generation. Being young and idealistic, I took it personally, and was greatly inspired by his comment that any person could make a difference, and that every person should try.

Having receiving my degree, I spent three years at the University of Rochester. It was initially a very intimidating time for me, in that I was the youngest one in the graduate seminar that I was asked to teach. Fortunately, that no longer happens.

While at Rochester, I heard about a new clinical program that was being formed on Long Island; it was part of the New York State system in a place called Stony Brook. I joined the faculty there in 1964, where several of us in the clinical area were in our 20s and 30s. Not terribly experienced but very idealistic, we wanted to set up a clinical program that could bring to life the ideal of the scientist-practitioner model. Fortunately, we were able to make this happen, even to the point of setting up a program that allowed clinical faculty members to carry out therapy supervision as part of their teaching load—a practice that continues to this day.

The 1960s and 1970s were very exciting times. A new approach to therapy was developing, based on the unique idea whereby basic research findings would inform what goes on in clinical situations. (translational research is clearly nothing new). As many of the faculty were actually involved in clinical work as well as teaching and research, it eventually became clear that something was missing from behavior therapy. Our clients had this very annoying tendency to think, and the available behavioral interventions were not designed to deal with that. Being influenced by such people as Bandera, Mischel, Lazarus, Ellis, and Beck, many of us at Stony Brook championed the cause of introducing cognition into behavior therapy. Indeed, we set up a panel at the 1968 APA conference that dealt precisely with that subject.

In the early 1970s, Jerry Davison and I decided that we would write a book that described what really went on in the clinical practice of behavior therapy. When it was published in 1976, the term "cognitive behavior therapy" had not yet come into use, but we nonetheless made a case for the need to focus on cognitive variables when conducting behavior therapy.

A few years later, when on sabbatical in San Francisco, I began to develop the idea that a way of finding similarities across different therapy orientations was not through either theory or practice, but rather through principles of change that may exist across different orientations. My original training had been psychodynamic in nature—there was no behavior therapy at the time—and it eventually became evident that even though the theoretical jargon might be very different, there often existed commonalities between these two orientations. These ideas were eventually published in 1980 in an American Psychologist article.

COGNITIVE BEHAVIORAL THERAPY FOR CHRONIC GI DISORDERS

MELISSA G. HUNT, PH.D.

Melissa G. Hunt, Ph.D. is a licensed clinical psychologist and serves as the Associate Director of Clinical Training in the Department of Psychology at the University of Pennsylvania. She is a Fellow and Diplomate of the Academy of Cognitive Therapy (academyofct.org), and is proud to have served as the Chair of the Academic Training Committee for ABCT and as a frequent program committee member for both the Association of Behavioral and Cognitive Therapies (ABCT.org) and the Anxiety and Depression Association of America (ADAA.org).

Her primary research interests are in the domains of behavioral health and stress management, with a particular emphasis on individuals with chronic GI disorders. As a clinical scientist, her emphasis is on translating basic psychological science into treatments that are effective, acceptable, and accessible to patient populations. In particular, she focuses on identifying the underlying patient factors that lead to reduced quality of life, impairment and distress, particularly factors that exacerbate chronic health problems and make them harder to cope with, and then creating, testing and disseminating self-help treatments.

In addition to her work at Penn, she also has an active private practice in clinical psychology in which she utilizes cognitive-behavioral therapy, augmented by schema therapy, imaginal rescripting, mindfulness and yoga in the treatment of mood, anxiety, obsessive-compulsive, trauma, and chronic health disorders.

Patients suffering from chronic GI disorders including Irritable Bowel Syndrome (IBS) and Inflammatory Bowel Diseases (IBDs - Crohn's disease and ulcerative colitis) can benefit from psychosocial interventions (including cognitive behavioral therapy, gut focused hypnotherapy and mindfulness-based interventions) that target pain, symptom management, and coping (Ballou & Keefer, 2017). Distress and disability in GI patients are highly associated with anxiety, depression, catastrophizing, fear of food and maladaptive avoidance. As such, CBT is particularly well positioned to address many of the factors that contribute to poor health related quality of life (HRQL) in these patients.

IBS is characterized by recurrent abdominal pain (at least four times per month), relieved by defecation, and accompanied by abnormalities in the frequency and/or form of bowel movements (i.e. constipation, diarrhea or an alternating mix of the two) (Drossman, 2016). In practice, individuals with IBS often experience urgency and develop a number of maladaptive coping strategies, most of which are designed to help them avoid visceral sensations and the possibility of needing to get to a bathroom and not making it "in time." IBS patients often develop catastrophic cognitions about pain, about the possibility of incontinence and about the potential repercussions, both socially and occupationally, of needing the bathroom both frequently and urgently. Many IBS patients also develop avoidance behaviors which can meet diagnostic criteria for agoraphobia. Avoidance can include many feared foods and situations in which getting to a bathroom quickly and unobtrusively might be difficult. In many ways, IBS falls at the intersection of panic disorder with agoraphobia and social anxiety disorder, along with significant health anxiety. Indeed, as many as 65% of IBS patients suffer from psychiatric comorbidities, mostly anxiety and mood disorders (Stanculete & Dumitrascu, 2016).

The etiology of IBS is important to explain to patients, in part to get their "buy in" for the usefulness of psychological interventions. IBS patients understandably resent the suggestion that their problems are "all in their head." The key point is that visceral hypersensitivity (abnormal endogenous pain modulation) is centrally mediated and is the result of miscommunication between the enteric (gut) nervous system, the microbiome and the brain. In sum, patients with IBS feel normal gut sensations that most people would be unaware of, and experience many of those sensations as more painful than healthy controls. Similar to anxiety sensitivity in panic patients, visceral hypersensitivity leads to a vicious cycle of vigilance, stress, increasing pain, and increasing vigilance.

Fortunately, CBT is very well adapted to tackle both GI specific anxiety, catastrophic cognitions and maladaptive avoidance behavior, and can actually reduce visceral hypersensitivity. Indeed, CBT is the intervention with the most empirical support in the treatment of IBS (Kinsinger, 2017). With a little knowledge, most CBT practitioners can address the concerns of IBS patients. First, one should start with a good assessment, including coordination of care with medical providers. In most cases, diagnostic tests will all have been negative, but you should be sure that celiac disease and inflammatory bowel diseases have been ruled out. Extensive, invasive testing, including colonoscopy and endoscopy is not recommended by current medical guidelines, unless the patient has "alarm" symptoms (such as blood in the stool, inflammatory markers in the blood or stool, fever, nutrient deficiencies or unexplained weight loss) (Brandt, Chey, Foxx-Orenstein, et al., 2009). The next step is psychoeducation about how stress can result in HPA axis dysregulation that can directly affect the gut, leading to visceral hypersensitivity. This is important because it provides the rationale for relaxation training and stress management strategies. Next comes relaxation training, especially deep diaphragmatic breathing, which has been shown to optimize GI motility, as well as sympathovagal balance.

Once the patient understands the relationship between stress,

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IS THE THERAPEUTIC RELATIONSHIP THE HEART AND SOUL OF CHANGE IN COGNITIVE-BEHAVIORAL THERAPY?

NIKOLAOS KAZANTZIS, PH.D.

Nikolaos Kazantzis, Ph.D. is currently an Associate Professor within the School of Psychological Sciences at Monash University where he leads the Doctoral training program in Clinical Psychology and is Director of the Cognitive Behavior Therapy Research Unit. His research brings innovations in the assessment of in-session therapeutic processes from research trials to community practice contexts, including the linking of core dimensions of psychopathology with treatment and in-session processes. He is recipient of the Beck Scholar Award for Excellence in Contributions to Cognitive Therapy from the Beck Institute for Cognitive Behavior Therapy. His research program has supported significant funding (including NIMH grants), resulted in >120 peer-reviewed publications and >3,500 citations (Google Scholar) >2,500 (Web of Science). He has presented workshops in >20 countries and led the development of online training programs, particularly with the Australian Psychological Society's Institute, which have successfully trained > 6,000 psychologists and other health professionals.

When developing CBT, Aaron T. Beck cited the importance of both generic features of the therapeutic relationship, those that could be found in psychoanalysis and in Rogerian client-centered therapy, as well as those that are specific to the approach (A. T. Beck, Rush, Shaw, & Emery, 1979). Since then, significant research has been directed towards understanding the alliance in psychotherapy, which is important, and the research area continues to develop in sophistication (e.g., repairing alliance ruptures, and other processes that converge in predicting symptom change, including studies of the temporal order of change; Castonguay, 1993; Fluckiger, Del Re, Wampold, Symonds, & Horvath, 2012; Lorenzo-Luaces & DeRubeis, 2018). However, the science underpinning our practice is still evolving, and a clear empirical basis for CBT-specific elements of the therapeutic relationship is not yet fully developed (Kazantzis, Luong et al., in press; Zilcha-Mano, 2017).

There were three central constructs included in the Beckian foundational guides for CBT practice. First, the importance of collaboration, or active shared work was positioned as a defining feature of the relationship (Dattilio & Hanna, 2012). A collaborative approach not only communicates respect for the client's ideas, its requires us to solicit client input to guide the content and course of techniques, and seek periodic feedback throughout their use. Surprisingly, there are no published studies of collaboration in CBT, and the evidence for collaboration in psychotherapy more broadly requires further research (Tryon & Winograd, 2011). What is most concerning is that evidence for collaboration-outcome relations has been sourced from studies of homework adherence, which of course may reflect a range of relational processes other than collaboration (Callan et al., in press; Kazantzis, Cronin, Norton, Lai, & Hofmann, 2015).

Second, early writing on the practice of CBT and forming therapeutic relationships with clients emphasized "empiricism", succinctly described the process of helping the client to adopt the scientific method for their experience. While this might not appear as an element of the relationship on first glance, when we consider that it is collaboration in empiricism that was proposed, and this involves helping the client to develop meaningful tailored gauges for evaluating hypotheses (e.g., strength of belief, SUDS ratings to evaluate their predictions about the likely outcome of techniques) then perhaps the idea that these require an effective relationship is not too radical (Clark, 2013; Kazantzis, Beck, Dattilio, Dobson, & Rapee, 2013). Put differently, all our techniques can be "cognitive and behavioral experiments", and their design and evaluation always depend on a productive relationship.

Specific research evidence for empiricism as an element of the therapeutic interaction is still being developed and published—but it holds great promise as an untapped opportunity for enhancing the efficacy of CBT—both as an element embedded in techniques, and as an element that can be emphasized within the relationship (Tee & Kazantzis, 2011). We find it noteworthy that the original scale for evaluating therapist competence in CBT, the Cognitive Therapy Scale (CTS: Young & Beck, 1980), included an item on empiricism that was later revised as "guided discovery" (see recent review of the CTS properties in Kazantzis, Clayton et al., in press).

On Socratic (or Beckian) Questioning

Early works noted a third central construct of the therapeutic interaction – the goal of having clients ask themselves the same questions that therapists ask during sessions. While this "self-questioning", is to some extent an expression of the client's adoption of the scientific method for their experience (i.e., empiricism), it has been the focus of conceptual and beginning research as a distinct element (e.g., Braun, Strunk, Sasso, & Cooper, 2014; Kazantzis, Beck et al., in press).

Socratic dialogue is a relational process that uses sequential (a) exploratory; (b) perspective-shifting; and (c) synthesizing questions to achieve a cognitive change. The use of a downward arrow technique is a clear example of a specific questioning style designed to help a client gain access to an idea, or "discover" a new perspective. What its unique about the process of discovery is that it is both inherently relational and intervention focused. That is, it represents a questioning style designed to identify and encourage a different perspective (i.e., reappraise a specific content or process of cognition). It can be a relational process that is more or less collaborative, and also more or less empirical. Here, there is a

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IMAGERY-ENHANCED COGNITIVE BEHAVIOR THERAPY FOR SOCIAL ANXIETY DISORDER

PETER M MCEVOY

Peter McEvoy, Ph.D. is a Professor of Clinical Psychology at the School of Psychology, Curtin University, Australia, where he is a tenured teaching and research academic in the postgraduate psychology program. He is also a Senior Clinical Psychologist and Research Director at the Centre for Clinical Interventions (CCI), which is a community mental health clinic that specialises in individual and group cognitive behavior therapy for anxiety, affective, and eating disorders. In addition to psychotherapy, CCI provides free online treatment modules that are downloadable from its website (www.cci.health.wa.gov.au), trains health professionals in evidence-supported treatments for mental disorders, and conducts clinically applied research. CCI's website currently receives around 1 million downloads per week from clinicians and consumers worldwide. Dr McEvoy has published around 100 peer reviewed journal articles and book chapters on the assessment, maintenance, and treatment of emotional disorders, and he is an Associate Editor of the Journal of Anxiety Disorders and the Journal of Experimental Psychopathology.

The use of mental imagery in psychotherapy is not new (Beck, 1979; Edwards, 2007). Imagery-based techniques are commonly used in cognitive behavior therapy (CBT) to facilitate assessment and interventions (e.g., imaginal exposure, rescripting of past traumas), and emotion research strongly suggests that working within the imagery mode is more powerful than the verbal mode at evoking and modifying affect (Holmes & Mathews, 2010).

To capitalize on the benefits of imagery-based approaches, our new book, Imagery-Enhanced CBT for Social Anxiety Disorder (McEvoy, Saulsman, & Rapee, 2018), provides a detailed description of how we have comprehensively integrated imagery-based techniques throughout treatment to maximize affective engagement and change for our socially anxious clients.

Mental imagery is particularly important in the maintenance of social anxiety disorder. People with social anxiety commonly report vivid, multisensory memories of past social traumas that guide their expectations of social evaluation in the here-and-now. These images can serve as perceived prophecies about what will occur in current and future social situations. The images then drive problematic avoidance and safety-seeking behaviors, as well as unhelpful self-focused (e.g., somatic symptoms of social anxiety) and environment-focused attention (e.g., scanning for potential evaluation). People with social anxiety also hold distorted self-images from the observer's perspective, whereby the observability of their social anxiety symptoms and performance deficits are magnified. All of these processes serve to maintain perceptions of social threat and to strengthen core beliefs of the self as incompetent, inadequate, and inferior, and of others as hostile, judgmental, and rejecting.

We had been using the Macquarie University Group's CBT protocol for social anxiety (Rapee, Gaston, & Abbott, 2009) in our community mental health clinic for several years with good outcomes (McEvoy, Nathan, Rapee, & Campbell, 2012). However, we were highly motivated to identify clinical innovations that might lead to the next leap forward in outcomes for our clients.

Around this time we attended workshops on imagery-based approaches by Ann Hackmann, James Bennett-Levy, Emily Holmes, and the Oxford Guide to Imagery in Cognitive Therapy (Hackmann, Bennett-Levy, & Holmes, 2011) had just been published. The Macquarie Group's protocol targeted self-images with video-feedback, but otherwise predominantly described techniques within the verbal mode. We therefore decided to inject the protocol with imagery-based techniques to see whether outcomes could be improved.

Clients appeared to enjoy working within the imagery mode and clinicians were observing impressive quantitative and qualitative affective changes in their clients. Our early evaluations revealed higher levels of client engagement, very large effect sizes, and improved outcomes (McEvoy, Erceg-Hurn, Saulsman, & Thibodeau, 2015), so we wrote the book to share our program with other clinicians who may be interested to know how the treatment is delivered.

Some of the 'enhancements' to the program included replacing verbal-linguistic techniques (e.g., traditional approaches to restructure core beliefs) with imagery-based approaches (e.g., imagery rescripting of negative life events that were a potential source of core beliefs). Other techniques were modified to increase engagement in the imagery mode. For example, clients are encouraged to transform verbal thoughts into multi-sensory images to guide cognitive restructuring and behavioral experiments, rather than working with verbal thoughts alone. All new insights from these techniques are consolidated by incorporating learning into more helpful mental imagery. Every component of the 12-session program includes an imagery element. The book describes both traditional verbal approaches, as well as our imagery-enhancements.

The first section of the book (chapters 1 to 3) provides clinicians with background information about social anxiety disorder. The first chapter describes epidemiology and impacts of social anxiety disorder, causes, comorbidity, and how to establish differential diagnoses. The second chapter reviews key cognitive behavioral models and treatments, including the rationale for recruiting mental imagery in the pursuit of affective change. The third chapter provides an overview of the treatment, and suggested session guides

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TREATING THE CHRONIC PAIN TRIAD: PSYCHOLOGICAL TREATMENT THAT WORKS

ROBERT S. MEYERS, PSYD

Robert Meyers, Psy.D. is the founder and Director of New York Psychological Wellness, PC. and NYPW Continue Education Program located in Bayside, NY. His research, writing, teaching, and training of clinicians has focused on treating the Chronic Pain Triad – pain, sleep and emotional distress. He is a founding member of the Society of Behavioral Sleep Medicine. Dr. Meyers is also an attorney and professor for more than thirty years. He has two forensic psychology books anticipated for release in 2019.

Jane, an attractive, middle-aged, successful business woman, married with one teenage daughter, walked into the office. She wore a white, form-fitting, off the shoulder lantern sleeve flounce dress and made sure that she was noticed as she entered and exited the session room. She complained of constant neck and lower back pain and a growing dependence on "Oxy." Her medical records indicated that she was recommended for back surgery to alleviate some of the pain but the patient reported that her surgeon told her there was a better than 50% chance that the surgery would result in no change to her condition. She had seen many doctors, chiropractors, healers and others. I was her last resort. She reported chronic pain, sleep disturbance, symptoms of depression and difficulty getting through the day at home and work. During her first initial assessment session she was introduced to both a sleep and pain log.

For all the wonder and miracle of our human body, evolution has not seen fit to design these vessels of ours with the potency to withstand the rigors of daily living and the traumas of experience. With all the incredible things we have learned about our human systems, we know so little about how we work. We are complex and delicate and not easily repairable. And, as if that wasn't enough, our highly evolved and increasingly impatient brain is easily fooled into making our mechanical foibles worse.

So, when a patient tiredly recites every doctor, every medication, every surgery, every every that they have endured and arrives at our offices as the "last resort," we are challenged to secure their faith in their ability to 'heal thyself.' There is no 'magic pill' for the chronic pain sufferer. Cognitive behavioral therapy for pain (CBT-P), not unlike all other psychological therapies, requires 'buy-in' from the chronic pain sufferer that they have more control over their pain experience than any professional or capsule. That's right, the experience of pain. In many cases, chronic pain is not a simple matter and is largely based upon an individual's perception rather than a truly quantifiable element.

Simply put, pain is in the brain.

It is estimated that more than 100 million people across the United States suffer from chronic pain. Arthritis, osteoarthritis, in particular, is the number one cause of pain and affects 60% of the pain population—fifty percent of that population is over the age of 65. And, as our population ages, exceeding the design specifications of our human containers, the epidemic will continue to grow. More than 42,000 people died in 2016 from opioid overdose, forty percent of which were from legally obtained prescriptions.

What can a psychologist do in conjunction with a physician? A lot.

Psychological support and life changes can play an important role in reducing the chronic pain experience, improve sleep, reduce the need for opioid pain relievers and increase the quality of our patient's lives. Research and clinical experience suggests that chronic pain does not act alone on the individual sufferer. For many, the patient experiences the **Chronic Pain Triad** – pain, sleep loss and emotional distress, in the form of depression, anxiety, fear and/or anger, help to exacerbate and perpetuate the pain experience. Now, all of these do not have to appear in a patient's symptom profile—any one or a combination of these three basic elements may be present. Alleviating, or lessening these comorbid disorders will most likely lead to a reduction in the pain experience. And this can be done with a reduction in pain relievers or using none at all.

Using the biopsychosocial theory of pain, it is posited that each leg of the Triad has a unique effect upon the pain experience. When operating together the effects are magnified, thus causing a greater pain response. The research conclusively shows that lack of restorative sleep increases the amount of chronic pain experienced (Doufas, A.G., Panagiotou, O.A., & Ioannidis, J.A., 2012; Finan, P.H. & Smith, M. T., 2013; Gerhart, J.I. et al., 2017; Jungquist, C.R. et al., 2010; Martinez, M.P. et al., 2014; Pigeon, W.R. et al., 2012; Pigeon, W.R. et al., 2012; Tang, N.Y., Goodchild, C.E., Sanborn, A.N., Howard, J., & Salkovskis, P.M. 2012) Therefore, treating the sleep issue will reduce the levels of pain encountered and help return the patient to a productive lifestyle. Cognitive behavioral therapy for insomnia (CBT-I) is a proven treatment with high efficacy rates (Jacobs et al., 2004; Morin, et al., 1999; Sivertsen, B. et al., 2006; Wu et al., 2006). Most studies have indicated that CBT-I is more effective than sleep inducing medications and has a much longer lasting effect after the treatment has been discontinued.

Psychologically, the chronic pain experience leads to negative beliefs, emotional distress and avoidance behaviors. These in turn, work to increase the pain experience. The avoidance behaviors then create their own cycle in which the person engages in less activity.

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ENCOURAGING CLIENTS WHO ARE STRUGGLING WITH BEING SINGLE

JENNY TAITZ, PSY.D.

JENNIFER L. TAITZ, Psy.D., A.B.P.P., is a board-certified cognitive behavioral clinical psychologist and a Linehan certified dialectical behavioral therapist who specializes in offering people proven tools to enhance their life. Dr. Taitz is passionate about helping people move past habits that interfere with their capacity for joy. Her books, End Emotional Eating and How to be Single and Happy earned a Seal of Merit from the Association of Cognitive and Behavioral Therapies. Dr. Taitz has presented clinical applications on mindfulness and managing emotions at national and international conferences. She serves as a clinical instructor in the department of psychiatry at University of California, Los Angeles, and maintains a clinical practice, LA CBT DBT.

The most frequent question I hear when I share that I wrote a book called *How to be Single and Happy* is "Is it possible to be single and happy?" More recently, several people have suggested I consider writing a sequel, *How to be Married and Happy.*

Given the fact here are more than 110 million unmarried people in America, and 53 percent of all women over 18 are single, it's time to stop waiting for love to live better. In the decade that I've spent working as a psychologist, I'd estimate that roughly 50 percent of my clients tell me that their symptoms of depression and anxiety are due to their romantic disappointments. On a larger scale, in a 2012 Reuters global poll of more than twenty thousand adults, two thirds of those in relationships said that their partner was their greatest source of happiness and 45 percent of single respondents assumed that finding a partner would grant them bliss. But people's predictions about what will bring them joy are less accurate than you might think. According to Barbara Fredrickson, a leading positive psychology researcher at University of North Carolina, Chapel Hill, our persistence in glorifying coupling reflects a "worldwide collapse of imagination (Fredrickson, 2014)." Harvard psychology professor Daniel Gilbert, who has spent decades researching happiness and a concept called affective forecasting, which describes how our ability to predict our future feelings is inaccurate (Gilbert et al., 1998).

Yet expert wisdom hasn't entirely penetrated our psyches. A couple of years ago, a woman in her mid-30s who had come to my office, asked, "If we work together, do you think I'll be able to meet someone?" I told her that I could certainly help her live well and that we would track her symptoms and treatment progress with objective markers. But I couldn't promise an imminent wedding since I wasn't clairvoyant. "I only have a limited amount of money so I hope you understand that if the root issue is the fact I'm not meeting someone, a matchmaker seems like my solution." She didn't come back, but my prospective patient inspired me to research whether romantic love is required for happiness and how to most effectively couple up. To set the record straight, here are some facts to know about happiness and love:

You can be happy and single

In a study looking at over 24,000 adults over the span of 15 years, Richard Lucas, a professor at Michigan State University, and his colleagues noticed that on average, marriage increased happiness by one percent (Lucas, Georgellis, Clark, & Diener, 2003)! Regardless of what popular culture depicts, the ability to live in the moment, meaningful actions and sense of connection, is more linked to wellbeing than romantic situation (e.g., Lyubomirsky, Sheldon, & Schkade, 2005). In case your clients worry that feeling content uncoupled will prevent finding a relationship, people who marry and stay married tend to report feeling above-average life satisfaction before they wed (Johnson & Wu, 2002).

When people worry about ending up alone, they lose their mind

Ruminating or overthinking is one of the most predictive pathways to depression Further, when a person starts to worry about ending up alone, not only will he or she experience sadness, but he or she also won't be thinking clearly. In one study, social psychologist Roy Baumeister and his colleagues gave subjects a baseline IQ test, followed by a personality test, after which they informed the participants that based on their responses it seemed likely that they would end up alone (Baumeister, Twenge, & Nuss, 2002). After that harsh news, participants retook the same test and their performance suffered. In other words, it's essential to realize when one worries about the future in a pessimistic way, this sort of thinking is simply inaccurate and will only ensure feeling badly. Believing you will be lonely not only feel bad in this moment but actually predicts feeling lonely later in life (Pikhartova, Bowling, & Victor, 2016).

Love is a practice

We all need social connection. Many people assume that the key to reducing loneliness is increasing social plans. In analyzing seventy-seven studies on loneliness, the most effective strategy to feel more connected was to reduce maladaptive social condition, or thoughts that keep us painfully apart from others (Masi, Chen, Hawkley, & Cacioppo, 2011). Ideas like, "Friends don't matter as much as romantic partners," are painful mental traps that will diminish social support. In contrast, loving-kindness meditation, where you purposefully offer well-wishes to yourself and others, correlates with increased feelings of love, joy, and positive relations with others (Fredrickson, Cohn, Coffey, Pek, & Finkel, 2008).

Regardless of whether someone is partnered, clients can relish their lives by considering how life might feel different with a partner and

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RUMINATION-FOCUSED COGNITIVE BEHAVIORAL THERAPY FOR DEPRESSION

EDWARD R. WATKINS, PH.D.

Edward R. Watkins, Ph.D. is Director of the Sir Henry Wellcome Mood Disorders Centre and Professor of Experimental and Applied Clinical Psychology at the University of Exeter. He has treated depression and anxiety with CBT for over 25 years. His research investigates the interactions between cognition and emotion that underpin psychopathology—with a focus on rumination and worry—and translates this knowledge into improved CBT. He has published over 70 articles in leading psychology and psychiatry journals, and has held major funding from NARSAD, Medical Research Council-UK, the Wellcome Trust, and National Institute for Health Research. He has authored and edited books on the transdiagnostic approach (Cognitive Behavioural processes across the psychological disorders), depression (Depression, 3rd edition), cognition and emotion (Handbook of Cognition and Emotion) and the treatment of depression (Rumination-focused CBT for depression).

Any therapist treating depression will frequently encounter patients who are caught up in rumination, going over and over losses and difficulties in their minds and asking questions like, "Why do I feel so bad?" and "Why did this happen?" As well as typical of mood disorders, rumination is a maintaining mechanism that keeps patients stuck in their depression and anxiety and blocks therapy. When first working with patients with severe and chronic depression, I noticed that those who ruminated were trapped in their internal mental loops rather than paying attention to the world and that this made it hard for them to learn from mistakes, notice evidence that disconfirmed negative beliefs, or fully attend to what others were saying, including in CBT. Moreover, rumination interferes with activity scheduling: despite completing a previously enjoyable activity (e.g., a run), the patient misses out on any rewarding effect because of a running commentary of thoughts like "Why is this so much harder than it used to be?"

These clinical impressions are consistent with the wider empirical literature, which robustly implicates rumination in the onset and maintenance of depression through both large-scale prospective longitudinal studies and experimental studies (Nolen-Hoeksema, 2000; Nolen-Hoeksema et al., 2008; Spasojevic & Alloy, 2001; Watkins, 2008). Rumination is implicated in other disorders including anxiety, eating disorders and alcohol abuse, leading to proposals that it is a transdiagnostic mechanism contributing to the high levels of co-morbidity across mental illness (Nolen-Hoeksema & Watkins, 2011). Moreover, it is associated with slower treatment response and poorer rates of recovery to CBT (Ciesla & Roberts, 2002; Jones et al., 2008).

Therefore, for the last 20 odd years, I have focused on ways to treat rumination to improve the sustained efficacy of CBT. Building on both my clinical experience and observations, as well as lab research, we developed Rumination-focused CBT (RF-CBT).

An important early realisation was that rumination is a normal and universal process—everyone does it—it is natural to repeatedly dwell on major losses, setbacks and important unresolved goals. As such, preventing such thinking (e.g., by thought-stopping or distraction) will be unsuccessful and often counter-productive by invalidating a patient's values, priorities and circumstances. Instead, we normalise the need to dwell on personally important issues and shift the focus to whether this thinking is helpful or not. Our experimental research had indicated that there are distinct modes of processing during rumination with distinct consequences (Watkins, 2008): an abstract, decontextualized, and global style, asking "Why?", characteristic of depressive rumination, which causally contributes to its maladaptive consequences including poor problem-solving and increased emotional reactivity, relative to a concrete, specific, and contextualized style that asks "How?" and focuses on the sensory-perceptual details of events (Watkins et al., 2005, 2008). RF-CBT therefore uses imagery, behavioral experiments, and experiential approaches to shift a patient from the unhelpful abstract processing style to the helpful concrete style. We review in detail idiosyncratic examples of helpful versus unhelpful thinking so that patients can discriminate between rumination versus problem-solving and to coach them towards more helpful thinking. Patients use directed imagery to recreate previous mental states when a thinking style directly counter to rumination was active, including concrete thinking, memories of being completely absorbed in an activity (e.g., 'flow' experiences), and increased compassion to self or others.

Another key idea is that pathological rumination is a mental habit—an automatic cognitive response conditioned to triggering stimuli such as low mood (Watkins & Nolen-Hoeksema, 2014), which is set off by relatively trivial daily events, not just major concerns. RF-CBT therefore conceptualises rumination as a learned behaviour that acts as a form of avoidance and that is negatively reinforced. To change this habit, RF-CBT uses functional analysis as developed in Behavioral Activation to examine how, when, and where rumination does and does not occur, and its antecedents and consequences, to formulate its possible functions and to make plans that systematically reduce or replace it. Habitual rumination is explicitly targeted by identifying its antecedent cues, controlling exposure to these cues, and by practising alternative helpful responses to these cues.

An initial randomized controlled trial found that treatment-as-usual (TAU) (ongoing antidepressant medication and out-patient clinical management) plus individual RF-CBT significantly reduced rumination and depression relative to TAU alone (remission rates:

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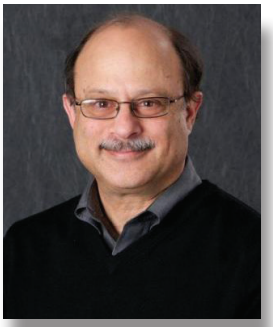
RE-VISIONING CBT FOR CANCER PATIENTS
SCOTT TEMPLE, PH.D. & EVA SCHOEN, PH.D.



Scott Temple, Ph.D., MHSA, is a Clinical Professor of Psychiatry & Internal Medicine at the University of Iowa, where he is a part of the palliative care team. He is a Founding Fellow in the Academy of Cognitive Therapy and is an ACT certified CBT trainer and consultant. He is the author of Brief Cognitive-Behavior Therapy for Cancer Patients: Re-Visioning the CBT Paradigm (2017) New York: Routledge/ Taylor Francis Publishers.

Eva Schœn, Ph.D. is a licensed psychologist and clinical assistant professor in the Department of Psychiatry at the University of Iowa Hospitals and Clinics. She is a diplomate of the Academy of Cognitive Therapy. In her current role as clinician at the UI Behavioral Health Clinic, she works primarily with patients recovering from trauma and with patients suffering from eating disorders. Dr. Schœn has conducted research in the areas of psycho-oncology, eating disorder recovery, college student mental health, and help-seeking processes. Clinically, Dr. Schœn utilizes cognitive-behavioral therapies (CBT, ACT, DBT, CPT) as well as EMDR. Dr. Schœn has a particular interest in the intersection between physical and psychological health.

One third of us will at some point in our lives be diagnosed with cancer. The rest of us will cope with the effects of that disease on our loved ones, our friends, and our colleagues. The chance to work with people facing grave medical crises, such as cancer, is an opportunity to serve others in their moments of greatest vulnerability and pain. Although most people with cancer manage the illness and its effects without the need for psychological services, perhaps 1/3 of those properly screened, merit a referral to a mental health professional. Depression and anxiety disorders occur at a higher rate in cancer patients than in the general population, and suicide risk is heightened in these patients (Temple, 2017). Several models of CBT for cancer patients have been developed, based primarily on Beckian and Problem-Solving approaches (Nezu et al, 1999; Moorey & Greer, 2012; Levin, White, & Kissane, 2013).

Just as the treatments for cancer have advanced (Mukerjee, 2010), so, too, has the field of CBT. This includes the 3rd Wave therapies (Hayes, 2004), which emphasize mindfulness, acceptance, and issues of values and meaning, in addition to the change technologies of CBT. Our challenge was to employ a primarily Beckian case conceptualization, yet be able to flexibly and in a disciplined manner, integrate Beckian and 3rd Wave interventions as indicated for each case. Frank Wills' work provided a case conceptualization model (Wills, 2013), chosen because of his efforts to expand the Beckian framework in the direction of integrating 3rd Wave therapies. While the model described in Temple (2017) has not been subjected to clinical trials, it broadly fits within the effort described by Hayes & Hofmann (2018) to create a more process-based CBT.

The model is built on eight key organizing principles, which are briefly described here:

1. Normalizing human suffering: CBT rose to its dominant position in the evidence-based world by virtue of RCTs for specific psychiatric disorders. However, many people who seek psychological help for adjustment to cancer have never suffered from, nor been treated for, a psychiatric disorder. We suggest that a purely medical paradigm is inappropriate for many of our patients, who are suffering from the inevitable pain that life imposes on us all. Normalizing psychological pain destigmatizes psychological treatment, and reflects newer trends in CBT, which help patients understand the evolutionary adaptive value of emotions, including sadness and fear (Hayes et al, 2012; Linehan; 2015; Gilbert, 2009).
2. A cancer diagnosis brings one face-to-face with the specter of death, and, in turn, with what matters most in life. Treatment using modern CBT can focus on rapidly accessing the patient's adaptive strengths, as well as orienting treatment towards the patient's most deeply held values. Modern CBT is replete with tools and techniques to help integrate value-driven behavior into daily life (Hayes, Strosahl, & Wilson, 2012; Linehan, 2015; Padesky & Mooney, 2012).
3. A focus on transdiagnostic processes in psychological disorders: The model draws on the work of Harvey, Watkins, Mansell, and Shafran (2009) in utilizing psychological, rather than medical frameworks for conceptualizing human suffering. For example, work with cancer patients is enhanced by a knowledge of how repetitive negative thinking (Watkins, 2018) cuts across diagnostic categories, and becomes a core process that contributes to suffering.
4. The disciplined use of the therapist's self in the treatment process: The model teaches how to combine Marsha Linehan's six levels of validation (Linehan, 1993; 1997) with Beck's use of Guided Discovery/Socratic Questioning (Beck & Rush, 1979; Padesky, 1993). Linehan's Radical Genuineness is especially salient in work with end-of-life issues, where the ability to be with the patient and family, as a compassionate and respectful companion may be our primary role.
5. Balancing mindfulness, acceptance, and change processes:

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Beck recognized the importance of acceptance in CBT, especially in his anxiety work (Beck & Emery, 1985). ACT and DBT elevate the importance of acceptance in therapy, and helping cancer patients radically accept their changed life status is often a prelude to employing any of the change processes available in CBT.

6. Balancing cognitive and experiential interventions in CBT: The model focuses on multiple modes of human information processing (Teasdale, 1999), and employs techniques from CBT, ACT, MBCT, and DBT that target these modes, cognitively, bodily, experientially.

7. An increased focus on self processes: A focus on self processes in American psychology dates to the work of William James (Richardson, 2006). Within the CBT tradition, Steve Hayes has reintroduced this focus to prominence (Hayes et al., 2012). The model we use with cancer patients involves employing mindfulness and experiential work to help patients access deeper states of knowing and wisdom, akin to Linehan's concept of Wise Mind (Linehan, 1993; 2015). This often accompanies and may precede values and problem solving work.

8. Employing a more contextual model of human suffering and change: There are many forms of contextualism, one of which shows up in ACT as functional contextualism (FC)(Hayes et al., 2012). We have employed a contextualism that shares properties with FC and general systems theory. In brief therapy, we utilize a contextual focus to help patients access the evolutionarily adaptive core of meaning, safety, and social connection (Temple, 2017).

Psychological treatment of cancer patients calls us to stand firmly and securely on the knowledge and skills taught to us by Beckian CBT, while integrating the mindfulness, acceptance, values and experiential work proposed by 3rd Wave therapies. This new model (Temple, 2017) proposes an organized and theoretically grounded way for clinicians to integrate core components of the aforementioned cognitive therapies for the benefit of a still psychologically underserved population.

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STRUGGLING WITH BEING SINGLE

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begin to purposefully live as closely to how they envision living then, right now.

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ACT PRESIDENT'S MESSAGE

CONTINUED FROM PG. 1

the community, it is important that survivors be allowed to grieve for the person who committed suicide. However, to avoid copycat suicides, it is important that individuals who commit suicide are not memorialized as romantic, glamorous figures who have now achieved celebrity status because they committed suicide.

It would be helpful for shows or movies about suicide to clarify that suicide is not a common response to adversity. Most people who experience negative events such as bullying, the death of a loved one, or any other form of adversity – do not commit suicide. It would also be beneficial for viewers to see that people with mental illnesses are not crazy or weak, and that a mental illness is no different from a physical illness: it is a health condition that requires treatment. It would also be useful for the television and movie industries to show that seeking help for mental illnesses is a good idea, that most people are responsive when sufferers reach out, and that mental health practitioners are sane professionals who are trained to treat people who suffer from mental illness. Finally, it would be wise to depict more accurate representations of treatments that have demonstrated success in treating mental illnesses. A responsible approach would also be to provide information at the end of the show or movie with resources on how to seek help. As the second season of 13 Reasons Why approaches, we can only hope that the producers have learned from the mistakes of the first season.

Sincerely,

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

IACP'S PRESIDENT MESSAGE

CONTINUED FROM PG. 2

The quality of CBT remains to be better analyzed and this analysis can be meaningful only when **client perceptions** of what was done in treatment **match** with **well-defined procedures** of what should have been done **in treatment sessions** and **in between sessions**. Many further questions need to be answered better for the future. Some of the questions are;

- What is the minimum prerequisites for an adequate CBT?
- With the aim of defining core competencies how could one define domains of competence?
- Who should be the judges for the assessment of adequate CBT including good adherence and competence?
- What should be the most appropriate ways of delivery?: for whom, under which circumstances?
- Does the efficacy obtained in randomized controlled trials (RCTs) remain effective during dissemination to routine clinical practice (RCP)?
- Do the available data show a clear transferability of efficacious CBT protocols?
- Is the reliability and validity for assessment tools well established for general and spesific competencies?
- CBT is evidence based, but is CBT training evidence based?
- What training or supervision methods are most effective to improve competency?

I believe theory and practice can be distilled in a coherent manner to identify the most effective ingredients to improve dissemination and efficiency by identifying common processes of change. We need to make a more precise description of what CBT is and how it works in order to agree on ways to judge how well it works and how to bridge dissemination with good practice. There is still much to be discussed about facilitation of disseminating good practice. We have to work harder as "a wave is alive only by its motion, when it comes to rest, it is not existent anymore."

distress and GI discomfort and is using deep breathing (and/or other strategies such as mindfulness and imagery), the therapist can move on to the basic CBT model, introducing the notion that beliefs (not situations) affect our emotions and physical reactions and that beliefs can be right or wrong. This is all standard CBT fare (thought records, benign alternatives, evaluating evidence) but will often focus on situations in which the person's gut is acting up. Behavioral experiments are an important part of this process. For example, send the patient to a movie theater or house of worship, have them sit in the very back, and count how many people actually get up at some point to leave and then come back. They will be surprised by how often this happens and how little most people react.

Finally, in vivo exposure therapy that reduces behavioral avoidance is a crucial part of every successful treatment for IBS. This may need to include avoided foods, food-related situations, abdominal sensations, and any situations the person avoids for fear of not being able to get to a bathroom "in time." Using standard in-vivo exposure strategies (e.g. constructing a fear hierarchy and working up it using graded exposure) works quite well. For example, if the person is afraid of long car trips, have them sit in the car in their driveway for 30 minutes. Then progress to driving around the block near their home 20 times. Then drive a mile away and drive back. At home, when they feel the urge to defecate, see if they can delay going to the bathroom for one minute, then try increasing the duration so the person learns that they can indeed "hold it" without experiencing incontinence.

Another important area to target is "subtle" avoidance. Many IBS patients take steps to avoid experiencing visceral sensations or having to defecate at all during certain periods. For example, they will "pre-load" by taking multiple doses of anti-diarrheal medications, or by the simple expedient of not eating all day until they are back home. Some patients carry quick acting, dissolvable anti-diarrheal medication with them the same way panic patients carry clonazepam wafers "just in case." Of course, both use of anti-diarrheals and fasting have adverse effects. Over use of anti-diarrheal medications can lead to constipation, straining, hemorrhoids, bloating and more gas pain, which may ironically require laxative medication to resolve, leading to a return of urgency. Fasting may seem sensible, but results in dizziness, nausea, headache, irritability, slowed reaction time, reduced concentration, memory impairment and learning deficits. While all of these subtle avoidance behaviors feel perfectly reasonable to IBS sufferers, they end up maintaining the cycle of visceral hypersensitivity, anxiety and catastrophizing, and thereby ironically tend to exacerbate symptoms and disability long term.

CBT has been tested in a number of RCTs, and typically results in substantial improvement in GI symptom severity and health related quality of life, gains which are typically maintained and consolidated over time (Laird, Tanner-Smith, Russell, et al., 2016). Several treatment manuals and self-help books are available that detail the CBT treatment approach. One (Cognitive-Behavioral Treatment of Irritable Bowel Syndrome: The Brain-Gut Connection; Toner, Segal, Emmott & Myron, 2000) is a manual written for clinicians. Another (Controlling IBS the Drug-Free Way: A 10-Step Plan for Symptom Relief; Lackner, 2007) was written for consumers. The third (Reclaim Your Life from IBS; Hunt, 2016) was also written for consumers, and is unique in that it was actually tested as a stand-alone, self-help therapy with no therapist guidance in an RCT (Hunt, Ertel, Coello & Rodriguez, 2014).

Unlike IBS, inflammatory bowel diseases lead to actual tissue damage and can have life threatening complications. They are auto-immune disorders that have a genetic basis and are probably related in part to disruptions in both the immune system and the microbiome. Nevertheless, psychological factors and life stress still have a bidirectional effect on disease outcome (Sajadinejad, Asgari, Molavi, et al., 2012). CBT can improve HRQL, catastrophizing, visceral sensitivity and the secondary depression and anxiety that often accompany IBDs (e.g. Hunt, Rodriguez & Marcelle, 2017; Mikocka-Walus, Bampton, Hetzel, et al., 2015). The key modifications of CBT for IBD versus CBT for IBS include recognition that pain may sometimes signal disease flares that require medical management, or even a life-threatening emergency like a small bowel obstruction. Moreover, individuals with IBDs experience urgency to defecate that is the result of inflammatory processes and tissue pathology, not centrally-mediated pain processing. Thus, CBT for IBD tends to focus more on problem solving, planning, decastrophizing the effects of their symptoms on their lives and social networks and reducing shame and secrecy. What might be viewed as maladaptive avoidance in an IBS patient (e.g. use of antidiarrheal medication, carrying wet wipes and a change of clothes, planning travel routes and activities with ready bathroom access) is appropriate, adaptive problem solving in an IBD patient in active flare. CBT for IBD is still in its early stages, but a self-help CBT workbook for IBD patients (Coping with Crohn's and Colitis) has been tested in an RCT and should be available commercially soon (Hunt, Loftus, Accardo, et al., 2018). Given how much we know GI patients can benefit from CBT to improve HRQL, it is my fervent hope that together we can improve patient access to these effective treatments.

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THERAPEUTIC RELATIONSHIP: THE HEART AND SOUL

CONTINUED FROM PG. 5

potential for therapists to rely on general principles of logic (e.g., cognitive errors in the processes of thinking) rather than the unique experiences of the client (Stuckey & Kazantzis, 2018).

So far, we have considered collaboration in empiricism, and noted that both can be embedded in Socratic dialogue for the purpose of reaching guided discovery. We have also attended to how these aspects of the therapeutic relationship can be delineated from generic elements of the therapeutic relationship.

The Relationship as a Change Agent

We can also use the specific relationship itself "as data" to bring about meaningful cognitive change, such as where a client has highly endorsed negative core beliefs about other people (and the world) to the extent that they experience long-standing and pervasive difficulties in forming and maintaining relationships (Kazantzis, Dattilio, & Dobson, 2017). For example, a client who was persistently suspicious, might benefit from monitoring the strength of belief in the idea that "others are out to get me" over the course of several therapy sessions in which their therapist places a particular emphasis on soliciting their input, emphasizing the client's own decisions about session discussion, selection of different techniques, and their extension in homework. Here, the particular emphasis in the therapist's collaboration can directly support cognitive change by using it as "data" that was produced by the therapeutic relationship (i.e., "my therapist is an example of a person genuinely trying to help me" and "maybe she's not the only person who might care about me").

Moment-to-Moment Case Conceptualization

It is useful to consider the time-varying nature of each of these elements. In particular, therapists can vary the extent to which they emphasize generic and CBT elements based on their evolving case conceptualization of the client (J. Beck, 2012; Newman, 2012).

A therapist's expressed empathy, for example, will depend on their own emotion awareness and capacity to experience emotion. However, the extent to which emotion focused empathy is emphasizes at a particular point in a session with a particular client, will depend in part on their values as a professional, and ideally, the case conceptualization (Kazantzis et al, 2017). To consider how the expressed empathy will be interpreted by the client at that point in the session and therapy is essential. For example, a client who is describing their most severe panic attack may benefit from a therapist who emphasizes a great deal of emotion-focused empathy for the fear and discomfort in the situation, while also normalizing and validating their experience. Through the therapist's actions, the client may think "ok—I am not being judged here" and "its so reassuring to know this is a common experience and we know how to treat it." In a later session, the same therapist may elect to do the converse, de-emphasize empathy in favor of a focus on seeking a high amount of client feedback about the level of fear induced in hyperventilation as interoceptive exposure. The therapist may

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also choose to express positive regard for the amount of effort the client was putting into in-session work. Thus, there is great practical utility in both distinguishing generic and CBT specific elements of the therapeutic interaction, and seeing each of these as able to be varied from moment-to-moment in a way that directly supports progress towards the clients therapy goals (Kazantzis, 2018).

Translating Science into Practice

As educators and supervisors, we at times can appear to be communicating conflicting guidance on the therapeutic relationship to our trainees. On the one hand we underscore that counseling skills are central to the delivery of any form of psychological intervention, yet on the other hand, these same factors are identified as "facilitators" and not directly responsible for producing clinically significant change in CBT. Although there is absence of evidence for the generic and CBT-specific elements of the relationship, this cannot be taken as evidence of absent process-outcome relations. Many of the elements discussed here do not have established measures. Perhaps if we can operationalize these aspects, and examine their relations with outcome alongside the alliance, we may be in a position to fully evaluate the centrality of the therapeutic relationship in CBT.

Other than the process-focused research mentioned above, there are other hints that the delivery of CBT is crucially important to its outcomes (Barlow et al., 2017; Hayes & Hofmann, 2017; Hofmann & Barlow, 2014; Petrik, Kazantzis, & Hofmann, 2013). There is also an opportunity to enhance our assessment of clinician skills needed to deliver the intersecting processes discussed here (Dobson & Kazantzis, 2003; Dobson & Singer, 2005).

We are, very likely, still on the first day, of the first year of an exciting journey to fully understanding the complex interplay of variables in the most human part of our work with our clients—the therapeutic relationship.

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IMAGERY-ENHANCED CBT FOR SOCIAL ANXIETY DISORDER CONTINUED FROM PG. 6

for individual and group treatment formats.

The second section (chapters 4 to 10) describes each element of the treatment, with extensive therapist notes, example dialogues, session plans, and client handouts and worksheets. Chapter 4 describes how to socialize clients to the treatment model, which is followed by chapters describing how to modify the six key maintaining factors of social anxiety disorder featured within the model, including negative thoughts and images (chapter 5), avoidance and safety behaviors (chapter 6), negative self-images (chapter 7), attention biases (chapter 8), and negative core beliefs (chapter 9). The final chapter discusses relapse prevention and the process of terminating therapy (chapter 10). All client handouts and worksheets needed throughout the treatment are provided as appendices and are available online. Sufficient detail is provided to allow clinicians to implement the full treatment and work within the imagery mode with fidelity. We have recently demonstrated that an independent clinic can achieve comparable outcomes from using the treatment to the treatment developers (McEvoy, Erceg-Hurn, Barbar, Dupasquier, & Moscovitch, 2018).

Imagery-enhanced cognitive behavior therapy for social anxiety disorder was developed with the aim of helping a higher proportion of our clients achieve remission, compared to protocols that predominantly focus on the verbal mode. Although more work is to be done, evidence to date suggests that we have achieved incremental improvements in outcomes, and that the effect sizes within a group format are comparable to individual CBT (McEvoy et al., 2015). Our hope is that this book provides clinicians with all the skills they need to improve their clients' well-being as effectively and efficiently as possible.

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TREATING THE CHRONIC PAIN TRIAD

CONTINUED FROM PG. 7

This leads to de-conditioning and a worsening physical condition which then promotes more isolation, negative beliefs and emotional distress. Emotional distress, in the form of depression, anxiety, fear and/or anger, activates the hypothalamus and the fight/flight response. The sympathetic nervous system stimulation activation is believed to increase the pain experience.

The isolative behaviors, such as not engaging in social activities like family events, enjoying interactions with children, grandchildren and friends, shopping and the like, further add to the emotional distress and to the pain maintaining cycles.

Each of these elements that contribute to the pain experience occurs in the brain. Psychotherapeutic treatments can improve the level of sleep, reduce negative thoughts and emotional distress and help the patient return to a better quality of life.

In addition to CBT, CBT-P and CBT-I, other treatments are utilized such as: biofeedback; relaxation training; encouraging healthy eating and weight control; hypnotherapy; behavioral activation and more.

After evaluating the assessment material it became obvious that, in addition to other issues, spikes in Jane's pain experience were connected to her negative interactions with her mother and daughter—her daughter was literally a pain in her neck and her mother a pain in her... Improving Jane's sleep quality, helping her cope with family issues, changing her daily habits to reduce the risk of flare-up, and creating time for exercise as prescribed by her physician and physical therapist helped this patient to reduce her pain experience and eliminate the need for opioid use.

If you would be interested in learning more about how to treat patients suffering with chronic pain, please attend one of my workshops in New York (one coming up on June 30 - RMeyers@DrRobertMeyers.com.) or at APA this summer in San Francisco.

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RUMINATION-FOCUSED CBT FOR DEPRESSION

CONTINUED FROM PG. 9

TAU 21%; TAU+RF-CBT 62%) in patients with medication-refractory residual depression, comparing favourably to adding standard CBT to TAU in the same population (Watkins et al., 2011), with this effect partially replicated independently (Teismann et al., 2014). In another trial, group RF-CBT reduced symptoms of depression significantly more than traditional group CBT post-treatment in Danish outpatients with major depression. We have also tested group and internet-delivered RF-CBT as a preventative intervention for depression and anxiety in 251 high-ruminating adolescents and young adults, relative to usual care (Topper et al., 2017). Both RF-CBT interventions halved one-year incidence rates of major depression and generalized anxiety disorder, relative to control.

These results provide encouraging convergent evidence that explicitly targeting rumination may enhance treatment outcomes and for the potential value of RF-CBT. Our next steps are to test the active ingredients of therapy, pursue a large-scale definitive trial, and to extend RF-CBT into younger adolescents. To further disseminate these evidence-based approaches, I recently published the full treatment manual with Guilford Press, I recently published a detailed treatment manual "Rumination-Focused Cognitive Behavioral Therapy for depression", and offer intensive training courses—for more information, please visit my website.

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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 September 15th, 2017. Submissions should be 350-900 words with no more than five references (using APA style and as an MS Word document). In addition, please include a brief (50-100 word) author bio and high quality photo/headshot with your submission!

Submissions and/or suggestions for how to improve the newsletter and/or topics that should be considered should be sent to: Jamie Schumpf, PsyD, Editor: jamie.schumpf@einstein.yu.edu.

I look forward to hearing from you all!