American Institute for Cognitive Therapy

Fall 2004

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COGNITIVE THERAPY

Recent books by

Dr. Robert Leahy:

I am pleased to announce the publication of several of my new books on cognitive-behavioral therapy covering the treatment of depression, anxiety, bipolar disorder and the application of the cognitive therapy model to the psychology of economics. These books may be purchased through the publishers or through Amazon.com.

Roadblocks in Cognitive-Behavioral Therapy : Transforming Challenges into Opportunities for Change

Cognitive Therapy Techniques : A Practitioner's Guide

Psychological Treatment of Bipolar Disorder (ed. with Sheri Johnson)

Clinical Advances in Cognitive Psychotherapy: Theory and Application (ed. with E. Thomas Dowd)

Psychology and the Economic Mind: Cognitive Processes and Conceptualization

Contemporary Cognitive Therapy : Theory, Research, and Practice

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Communication for Couples

Danielle Kaplan, Ph.D.

Even the most loving couples may find themselves hitting a snag when it comes to discussing difficult issues. Problems in communication may cause couples to feel as if they are working against each other when they would prefer to be working together. Over time, this may lead couples to experience tension and distress in their relationship. Cognitive-behavioral therapists have developed a number of communication techniques that are helpful for discussing difficult issues safely and effectively.

1. Timing Is Everything: The best time to speak with your partner about serious issues is not when he or she has just walked in the door after a long day at work or is preoccupied with concerns of his or her own. Try to gauge your partner's receptivity to talking before you begin a difficult conversation. If the timing is off, ask your partner if you can set aside a specific time to speak within the next couple of days. A conversation is likely to go much better when both parties are ready to have it.

2. Speak for Yourself: Your partner will hear you better if he or she does not feel defensive about what you are trying to communicate. Sentences that being with "You never…" or "Why can't you…?" are likely to lead to your partner's feeling cornered. In contrast, "I statements", in which you speak from your own experience, are likely to be better received. Consider the difference between the following two statements:

"You always abandon me and leave me to fend for myself at parties."

"When we go to places where I don't know a lot of people, I feel nervous, and it helps me to have you nearby to check in with."

The more you can speak from your own experience, the more likely your partner is to hear you.

3. Think positive: Often, areas of dissatisfaction in a relationship reflect a desire for more positive interactions. Try to identify the wish behind your complaint, and express it to your partner. (e.g. "I love spending time with you and wish we had more of it to spend together.") Reinforce behavior that you would like to see again by expressing your appreciation for what your partner is trying to do. ("Thank you for setting aside time to talk with me about this; it really helped me feel connected to you.")

4. Play fair: Ironically, we often communicate better with friends or colleagues than we do with members of our own families. When discussing difficult issues with your partner, basic rules of communication apply. Don't make an agreement if you don't intend to follow through on it. Comment on the behavior, not on the person ("I was frustrated when you forgot to pick up the dry cleaning" rather than "You're irresponsible."). Avoid generalizations and character attacks- try to keep problem solving focused on the specific issue at hand, rather than on revisiting old hurts or addressing multiple issues at once.

Above all, remember that you and your partner are in this together. Effective communication around difficult issues makes it easier to get back to the things you love and enjoy about each other and your relationship.

(Continued on page 2)

In this issue:

- Communication for Couples
- Divorce and Conflict Resolution
- Eating Disorders
- "What Can I Do?"
- Do You Procrastinate?
- **The Foundation for the Advancement of Cognitive Therapy**
- AICT staff

Divorce and Conflict Resolution

Laura Oliff, Ph.D.
Director, Clinical Training

The period immediately following separation presents most couples with the challenge of negotiating conflicting needs and interests. Problem solving becomes more problematic as unresolved feelings of anger and hurt influence negotiations over property, custody and parenting issues. Post-separation conflict is unavoidable and inescapable. However, it can be healthy rather than destructive.

In healthy conflict, issues are explored openly and potential solutions are generated. In unhealthy conflict, issues are masked beneath anger and blame, often leaving resolution in the hands of the courts rather than the couple.

Conflict resolution requires three skills: The ability to express your needs, to listen, and to generate alternative solutions.

Stating the problem involves speaking directly to an ex-spouse without blaming, sarcasm, or put-downs. You attempt to explain the problem, how you feel about it, and what you want to do to resolve it. Stick to the facts and describe the situation as non-judgmentally as possible. For example, discussing a day care problem with an ex-spouse requires a factual statement about the cost of childcare rather than accusations about the lateness of past child support payments. Using non-blaming "I" statements to **state your feelings** about a problem situation helps you acknowledge and report what you feel rather than attack and hurt an ex-spouse. Notice the difference between telling an ex-spouse, "You're making me crazy" and "I feel confused and upset." **Stating your wants** is the appropriate place to propose your solution to the problem. It is best to be specific, asking for what you want in objective or behavioral terms. For example, it is more effective to ask your ex-spouse to pick up the children by six o'clock than to ask him or her to be *more considerate*.

Effective listening requires that you understand how your ex-spouse feels. One way to achieve this is through a process called "active listening" where you practice paraphrasing what the other person has said in your own words. Paraphrasing allows both parties to correct errors and misconceptions immediately, minimizing future arguments. Asking questions that help clarify anything you don't understand is also part of listening. The goal of active listening is to understand and reflect back what you've heard, not to argue against the other person's point of view.

The final step in conflict resolution involves **agreeing on the proposed solution** or **generating alternative solutions** to the problem situation. If you disagree with the proposed solution, now is the time to make a counterproposal and suggest some reasons why your solution may be preferable. Alternatively, you can sit down together and brainstorm as many alternative solutions as possible and then look for ways to combine or modify some of the ideas you've come up with. Narrow down the list by evaluating each alternative in terms of long and short-term consequences, financial and emotional costs, etc. Agree to try out one potential solution for a specified period of time and then meet again to reevaluate its effectiveness.

Remember that conflict resolution is a process of negotiation that requires practice. The goal is to make decisions and solve problems. You and your partner will be more successful if you can keep communication emotionally neutral and more business-like. Have a specific agenda, address one problem at a time, maintain direct and courteous communication, negotiate disagreements, make explicit agreements and put them in writing, and establish trust by following through on all agreements.

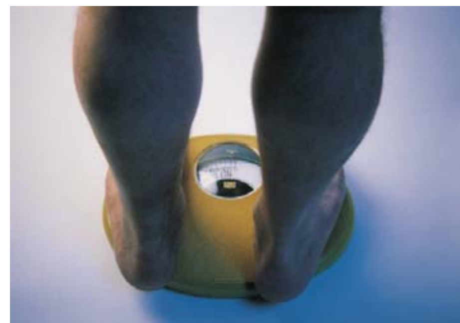
Eating Disorders

Rene D. Zweig, M.S.

There are three major categories of eating disorders, Anorexia Nervosa, Bulimia Nervosa, and Binge-Eating Disorder, all of which usually begin between early adolescence and early adulthood. Eating disorders are chronic without treatment. While Anorexia Nervosa is the most well-known of the eating disorders, likely because of its striking physical effects and high fatality rates, it is actually the least common eating disorder. Bulimia Nervosa (BN) and Binge-Eating Disorder (BED) are more prevalent, occurring in 2%-5% of the general population. BED is even more common among patients entering treatment for weight loss, estimated at 30%.

Individuals with BN and BED are preoccupied with shape and weight concerns, and they frequently binge, feeling a loss of control while consuming an objectively large quantity of food. Binges typically occur in secret and may include agitation, feelings of disgust, or a feeling of "being outside oneself". Binges most often consist of food that the patient considers "forbidden" under other circumstances. Individuals with BN engage in extreme behaviors to compensate for their binges: vomiting, taking laxatives, over-exercising, and/or fasting. While individuals with BED do not take such extreme compensatory measures, they frequently diet.

A variety of factors, many of which are not fully understood, are thought to cause eating disorders. Genetics, societal pressure for thinness and beauty, and life stress may all contribute to an eating disorder. It is clear that the extreme dieting associated with eating disorders begins as a way to gain control and improve self-confidence, but ultimately results in adoption of rigid rules and obsessive thoughts about food.



The cognitive-behavioral theory of BN and BED suggests that extreme concerns about body shape drive the patient to severely restrict her eating by making certain foods "forbidden" and/or by attempting to go as long as possible without eating. Strict dieting, in turn, leads to psychological deprivation and physiological hunger. Hunger and deprivation are natural bodily reactions to not ingesting enough macro-nutrients and, when combined with life stressors, negative emo-

tions, pleasure-seeking, and poor self-image, can trigger a binge. A binge leads to feelings of guilt, shame, self-loathing, and uncomfortable feelings of fullness. Individuals with BN will then typically vomit, take laxatives, or exercise excessively to alleviate the physical discomfort and guilt associated with bingeing. For both BN and BED patients, a binge is then followed by a vow to "be good", to not eat again for a long period of time to compensate for the binge (i.e. skip breakfast and lunch the day following an evening binge), and to again stay away from forbidden foods. Combined with feelings of shame and poor body image, the continuation of strict dieting propels the binge cycle.

Cognitive-behavioral therapy is considered the treatment of choice for BN and BED, and research has found it to be highly effective. Cognitive-behavioral therapy directly targets the binge cycle. The therapist and patient work together to change eating behaviors by slowly replacing binges with healthy meals, to discontinue purging, and to challenge rules that prevent natural and healthy eating patterns. Treatment also targets thoughts and feelings that can trigger binge-eating, including perfectionism and "all-or-nothing" thinking. Cognitive-behavioral treatment also focuses on improving body image. Many patients also choose to discuss weight loss as a part of their cognitive-behavioral treatment for an eating disorder.

Cognitive-behavioral treatment for BN and BED may initially be anxiety-provoking for patients, yet patients typically become more comfortable with the therapy once they observe how quickly it disrupts the binge cycle. Patients also typically benefit from improved body image and a reduction in other psychological symptoms.

If you would like further information about cognitive-behavioral treatment for an eating disorder, or if you would like to schedule an appointment for an eating disorder assessment, please call the American Institute for Cognitive Therapy at 212-308-2440.

"What Can I Do?"

Dennis Tirch, PhD.

When people are depressed they may describe a sense of being "stuck" in their current situation. Feelings of hopelessness and helplessness may flood them. From such a perspective, it can be difficult to see the path from despair to wellness. They may seek therapy or medication to pursue some sort of relief. Often, they arrive at their therapist's office with a central question, "What can I do?"

We can see some of the biggest differences between cognitive-behavioral therapy and some older forms of therapy in the responses to this question. Some traditional therapists might not really answer the "What can I do?" question. Rather, they may invite the patient to explore their feelings about the issue. Perhaps, they might even enjoin their patient to examine their personal history and family dynamics. By and large, most "traditional" therapists would assiduously avoid suggesting what to do, in order to remain "non-directive."

Cognitive-behavioral therapy assumes that problems are a part of life, and that problems demand solutions. As such, cognitive therapists are prepared to be collaborative, and, at times, directive, as they help their patients find out just what they can do to overcome their internal and external obstacles.

In cases of depression, the therapist and patient work together to develop a list of problems and goals for therapy. Specific interventions are developed to address these areas. For example, people who are depressed often lack experiences that are enjoyable or that build their self-confidence. As a result, a cognitive-behavioral therapist may work with a patient to schedule and evaluate a greater number of experiences of pleasure or mastery. Similarly, people who are depressed often need to develop greater assertiveness skills, in order to help them pursue their goals or improve their relationships. Often, cognitive-behavioral therapy for depression will involve assertiveness skills training, as well as other areas of social skills development.

Cognitive-behavioral research has established that people who are depressed have a higher frequency of negative thoughts, which can "pop into their heads" and provoke sadness and anxiety. When a person is able to reduce the frequency and intensity of these thoughts, their depression can often decrease in severity. Accordingly, cognitive therapists teach their patients to use specific techniques to identify and challenge such thoughts. Patients can learn to replace harsh self-criticism and hopeless forecasts for their future, with rational, balanced, and often positive beliefs about themselves and their world.

As cognitive-behavioral therapy develops, new evidence-based techniques are consistently being added to the therapists repertoire. Today, a patient in cognitive-behavioral therapy may employ a number of innovative solutions, ranging from the use of mindfulness based meditation to overcome depressive rumination to the use of emotion focused techniques to help better tolerate feelings of distress. Cognitive-behavioral therapists often work with patients who are also using medication to help them overcome depression. While cognitive therapy is about as effective as medication in the treatment of depression, it has been found to be more effective in preventing depressive relapse than medication alone. Many patients prefer the combination of the two treatments for this reason, and cognitive therapists are experienced and prepared for this.

It is natural to ask " What can I do?" when you are depressed. In cognitive-behavioral therapy, such a question will not be regarded as a rhetorical concern for intellectual psychotherapeutic exploration, but as a *crucial starting point*. This is where we can begin to develop solutions and to help our patients reclaim their quality of life and personal dignity. Rather than spend years exploring the past, cognitive-behavioral therapy aims to help people address their problems in the present, so that they might become more able and ready to enjoy their future.

Do You Procrastinate?

Lisa Napolitano, Ph.D.

Do items on your "to-do list" seem to linger indefinitely? Procrastination can limit productivity, compromise efficiency, and undercut the sense of accomplishment that you get from achieving your goals in a timely fashion. The difficulty in overcoming procrastination derives in part from its self-reinforcing nature--- for example, the avoidance of doing things that you dislike. By procrastinating, time is made available to pursue other more enjoyable activities.

In cognitive behavioral therapy, the erroneous beliefs that contribute to procrastination are identified and targeted for change. These often include the belief that *one must be motivated* before beginning a task. In actuality, the major motivation for completing many tasks is the *result of having started them*. The motivation comes *after* you begin the task. Procrastination may also be fueled by unrealistic expectations about the degree of ease with which tasks should be completed. Individuals with these expectations tend to postpone projects that are frustrating, rather than to persist in the face of difficulty.

A primary contributing factor to procrastination is *perfectionism*-- that is, inordinately high standards that for performance. For example, in response to the pressure to write a *perfect* essay, the task is avoided and nothing is written. By procrastinating, perfectionists often create circumstances of *time urgency* that enable them to overcome the strictures of their rigid performance standards. In cognitive behavioral therapy, the perfectionist learns more adaptive ways to overcome these performance-inhibiting standards.

Cognitive-behavioral therapy helps you:

- Weigh the advantages and disadvantages of procrastinating
- Identify and change your distorted thoughts
- Break down projects into simple steps
- Set realistic goals for performance and completion

AICT STAFF

Institute Director

Robert L. Leahy (B.A., Ph.D., Yale) is the President of the International Association of Cognitive Psychotherapy, Associate Editor of *The Journal of Cognitive Psychotherapy* and he serves on the Executive Committee of the International Association of Cognitive Psychotherapy and with the Executive Board of the Academy of Cognitive Therapy. He is the Founder and Director of the Institute. Currently, Dr. Leahy is Clinical Professor of Psychology in Psychiatry at Weill-Cornell University Medical School, the author of 130 articles and papers, and the editor and author of fourteen books. His research has been supported by the National Institute of Mental Health. He also serves on the Scientific Advisory Committee of the National Alliance of the Mentally Ill as well as the Advisory Committees of numerous national and international conferences on cognitive-behavioral therapy.

Dr. Leahy has been featured in The New York Times, The New York Times Sunday Magazine, Fortune, Newsweek, Individual Investor, the Washington Post and on numerous television and radio programs. He is currently focused on writing and research dealing with emotional processing, resistance to change, and decision-making processes.

Director of Clinical Training

Laura Oliff (Ph.D., New School for Social Research) has over eighteen years of clinical experience with individuals, couples and families focused on the treatment of depression, anxiety, eating disorders, marital conflict, and women's issues. She has also worked extensively with children and families. Her research has focused on women's self-esteem, assertion, rejection-sensitivity and over-compliance. Dr. Oliff has additional experience in child and adolescent assessment. She has conducted staff-training workshops on Attention-Deficit Hyperactivity Disorder and has appeared as a panelist on eating disorders and body image issues for Metro-Learning Center TV. She is a Founding Fellow of the Academy of Cognitive Therapy.

Clinicians

Danielle A. Kaplan (B.A., Cornell University, M.A., Ph.D., University of North Carolina), received her Ph.D. from the University of North Carolina at Chapel Hill, where she was a recipient of the Pogue University Fellowship and the Martin S. Wallach Award for the Outstanding Graduate in Clinical Psychology. Dr. Kaplan has substantial clinical experience with individuals, couples and families, focused on the treatment of depression, anxiety, women's self-esteem issues, relationship conflict, family violence and immigration/acculturation issues. She has worked extensively with Latino children and adults, and is bilingual in English and Spanish.

Lisa A. Napolitano, Ph.D., earned her doctorate in clinical psychology at Fordham University, and completed a pre-doctoral internship at the Manhattan Veterans Affairs Medical Center. Dr. Napolitano graduated with honors from Benjamin N. Cardozo School of Law. Prior to obtaining her doctorate, she practiced law in New York and Washington, DC. Dr. Napolitano's primary clinical interests include the cognitive-behavioral treatment of personality disorders, chronic depression, post-traumatic stress disorder, and in the dialectical behavioral therapy of borderline personality disorder and compulsive self-injury. She is experienced in both the neuropsychological and psychological assessment of adults.

Dennis D. Tirch, Ph.D., graduated Magna Cum Laude, and went on to earn a Ph.D. from Fairleigh Dickinson University. He received the Michael J. Fink scholarship for his work with persons with disabilities for two consecutive years. During his residency, Dr. Tirch served as the acting director of the hospital's Cognitive Behavioral Therapy (CBT) Center, and coordinated the delivery of outpatient CBT services. He has also co-authored two chapters in the New Directions in Cognitive Therapy series of books, edited by Dr. Robert L. Leahy. Throughout his clinical work, Dr. Tirch has focused on the assessment and treatment of depression, substance misuse disorders, neuropsychological deficits, and post-traumatic stress disorder.

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Rene D. Zweig, M.S. received her B.A. in psychology from the University of Michigan and is now a doctoral candidate in clinical psychology at Rutgers University. She completed a pre-doctoral internship at Yale University School of Medicine. Ms. Zweig has specialized training in cognitive-behavioral treatment for substance abuse, eating disorders, and depression. Her other clinical interests include anxiety disorders, gender-specific psychological treatments, body image, weight loss, emotional regulation, and leadership

(Continued on page 5)

Support FACT!

FACT is the **Foundation for the Advancement of Cognitive Therapy**, a non-profit organization that supports training and research on the treatment and nature of depression and anxiety disorders. We are working to train therapists and conduct research to develop more effective treatments for these devastating problems.

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The Foundation supports training of qualified therapists in cognitive therapy. We provide support to interns, post-doctoral Fellows, and workshops. In addition, we support ongoing research programs on depression, anxiety, emotional regulation, worry, decision-making and personality disorders.

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Please consider helping us with our research, training and education in cognitive therapy for depression and anxiety disorders. You can make a tax-deductible contribution to the Foundation going to our website: http://www.CognitiveTherapyNYC.com/

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(Continued from page 4)
development. She co-authored a chapter in Treating Substance Abuse: Theory and Technique (Second Edition), which was published in 2003. Ms. Zweig has presented and received awards for her research at the meetings of the Association for Advancement of Behavior Therapy and the Research Society on Alcoholism. She has also been awarded the Gamma Phi Beta Foundation academic fellowship (1999) and a pre-doctoral training grant from the National Institute on Alcohol Abuse and Alcoholism (1999-2003).

Shelby Harris is a graduate of Brown University and is currently in the doctoral program at the Ferkauf Graduate School of Psychology at Yeshiva University. She has had clinical training at Gracie Square Hospital and has been a primary clinician in the Cognitive Behavioral Therapy Program for Depression and Anxiety Disorders at Yeshiva University. She also acquired neuropsychological testing experience while at the NYU Comprehensive Epilepsy Center. She works as a clinical supervisor for Masters level students at the Ferkauf Graduate School of Psychology. Shelby is currently conducting research on the neuropsychological effects of insomnia in older adults. She has also contributed to research at Brown University, where she assisted in the development of treatment manuals for risk reduction among substance abusers.

David A. Fazzari received his B.A. with honors from Boston University and is now a Doctoral candidate in Clinical Psychology at Teachers College, Columbia University. Mr. Fazzari has contributed to research at the University of California, Berkeley on the perception of emotion and ethnicity and its manifestations in human physiology. He currently assists Dr. Leahy as Assistant to the President of the International Association.

Staff

Denise McMorrow graduated summa cum laude with a B.A. in Existential-Phenomenological Psychology, Studio Art, and Spanish from Duquesne University in Pittsburgh, and received an M.F.A. in sculpture from the Pratt Institute in Brooklyn, NY. Her interdisciplinary work integrating psychology and art has explored questions of individual and collective memory within the context of trauma and the continual revision of history, phenomenological approaches to the body, the poetic form and content of shifting ontological narratives, drawing as a form of meditation, and the creative process as a way of knowing. She is currently engaged in an ongoing oral history and photographic project with Hispanic women in West Harlem, is a volunteer with NY-based Free Arts, and is a contributing arts writer for the Brooklyn Rail and NYArts Magazine.

Rachel Moser Rachel Moser graduated Magna Cum Laude from the University of Pennsylvania with a B.A. in Psychology and a minor in Italian. While at Penn, she researched the psychological after-effects of September 11th on Search and Rescue Canine Handlers who were deployed after the terrorist attacks, and she studied an expressive writing intervention designed to help alleviate post-traumatic stress symptoms for the rescue-worker population. She received the Miles Murphy Award for outstanding psychology research and the Rose Award for exceptional research by an undergraduate. She has also worked for the Penn Resiliency Project developing a cognitive-behavioral based depression prevention program for adolescents. Ms. Moser and Dr. Robert Leahy have recently conducted a study on parental emotional socialization as it relates to meta-cognitive aspects of worry and the development of emotional schemas. She presented this research at the 2004 Anxiety Disorders Association of America conference.

For evaluation of anxiety, depression, phobias or couples problems, please contact our Intake Coordinator at (212) 308 2440

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