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Cognitive Therapy

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INSIDE THIS ISSUE:

How to Handle Failure

Robert L. Leahy, PhD

Many of us worry in order to avoid any possibility of failure. We worry about "failing" at a relationship, a job, an exam—and even at having a conversation. We treat failure as if it would be an utter catastrophe, we think we would be unique in our failure, and that everyone would think that we are losers for failing.

But failure is an inevitable part of life. How can we avoid the inevitable?

We can't. However, we can avoid worrying about failure if we use some simple cognitive therapy tools. Many of these are described in my self-help book, *The Worry Cure: Seven Steps to Stop Worry from Stopping You*.

First, don't equate failing at a behavior with being a failure as a person. For example, if you don't do well on an exam, it doesn't mean that you are a total failure as a person. It means that you did not do well on one exam at one point in time. Second, you can examine if your standards were too high. Perhaps you consider anything less than absolutely excellent as total failure. Keep in mind that the average IQ is 100 and the average household income is $42,000, and that more than half of the marriages end in divorce. Consider comparing yourself to the full range of people in the world, rather than counting 100% as the only acceptable standard. Third, think about all the other behaviors---past, present and future—that you have succeeded at and will succeed at. One failure does not cancel out all the other successes. Your life is bigger than one behavior.

Fourth, ask yourself what you can still do even if you did fail at something. For example, John didn't feel he did well in giving a talk (he didn't "fail"—he just didn't live up to his standards). But he was able to realize that he could still do everything else that he always did even if this one talk didn't go well. Fifth, think about what you can learn from a failure. We know that kids who are resilient say to themselves, "I need to try harder. I can look at it a different way". In contrast, kids who feel helpless say, "I must be stupid. This is too hard. I may as well give up." Sixth, when you fail you may think that the entire world is watching. You feel ashamed. But it may be that no one noticed except you—and that no one really cares one way or another. They may be too busy with their own worries and getting on with their own lives.

Dr. Robert Leahy, Director of the American Institute for Cognitive Therapy

Seventh, perhaps you had the wrong goal---or it was the wrong situation. If a relationship ends it doesn't mean you failed, it may mean it was the wrong relationship. If you do really badly on something, perhaps it wasn't your "thing"---perhaps there are other goals that fit you better. The important thing to keep in mind is that what you "failed" at may not be essential—and, it might not even be a failure.

Robert L. Leahy

Director

Motivation to Move

Rene Zweig, PhD

The American Institute of Cognitive Therapy is pleased to offer various Group Therapy Programs:

Keep it Off! Weight Management Group Therapy Rene Zweig, PhD

Dialectical Behavior Group Therapy Lisa Napolitano, PhD

Social Anxiety Group David Castro-Blanco, PhD, ABPP

To Learn more about or sign up for any one of our groups, please call (212) 308-2440

It is common knowledge that physical exercise is important for maintaining cardiac health, strength, and body weight. Physically active people outlive those that are inactive, and they may have a better quality of life during those years. Lack of physical activity doubles a person's chance of developing heart disease and is considered as dangerous as smoking, high blood pressure, and high cholesterol. Exercise also reduces the risk of developing diabetes, osteoporosis, and possibly cancer.

The Dietary Guidelines for Americans recommend 60 minutes of physical activity daily for both adults and children. Yet over one-half of all Americans do not meet these recommendations. If you have been struggling to incorporate regular exercise into your daily routine, here are several additional reasons to do so:

1. Diet alone does not control body weight. Over 65% of U.S. adults are overweight or obese. If you exercise in addition to watching your diet, you are more likely to lose weight and keep it off.

2. Improve work performance. Regular exercisers report having more energy, improved stamina, more creativity, faster reaction times, less age-related mental decline, and better concentration. Research also suggests that you will more efficiently complete tasks after you exercise.

3. Reduce insomnia. Insomnia affects approximately 1/3 of American adults, and research has demonstrated that morning or afternoon exercise improves sleep quality and decreases insomnia. Just be sure not to exercise within 2-3 hours of bedtime.

4. Be more social. Exercise is not limited to solitary workouts on gym equipment. Many people find exercise more enjoyable when they workout with a friend, in a class, or with family members. So join a soccer league, take salsa dance classes, or take your son out for a bike ride. Research shows that more physically active individuals also feel more socially connected.

5. Improve self-confidence. There is a strong link between exercise and feelings of competence. Exercise is a "mastery" activity, something that may be tedious to do but results in a sense of accomplishment and improved mood. If you exercise regularly, you are likely to feel more poised and self-assured, to notice an improvement in your body image, and to experience a boost in your self-esteem.

6. Manage your mood and anxiety. Multiple research studies demonstrate that exercise is an effective treatment for mild to moderate depression. Exercise also lowers anxiety, reduces obsessive-compulsive symptoms, and improves stress coping skills.

7. Augment your cognitive-behavioral treatment. Not only does exercise positively affect many areas for which you might seek therapy, but getting physically active requires you to use many of the common cognitive-behavioral techniques. You will undoubtedly have days when you just don't feel up to exercising. These days will provide good practice at testing your negative predictions (e.g. "I will feel more tired if I go to my spin class"), challenging permissive thoughts (e.g. "It has been a stressful day, I deserve to relax on the couch tonight"), and watching for dichotomous thinking and discounting positives (e.g. 20 minutes of walking does not count"). Practicing these CBT techniques in one area of your life may help you better apply them to others.

8. There are few downsides. Exercise can be done almost anywhere, at any time, with no cost, has few side-effects, and you'll see results quickly. As always, check with a physician first. And be sure to keep exercise a moderate and positive, rather than punishing, activity.

Rene Zweig

Director of Eating Disorders and Weight Management Program

MANAGE YOUR ANGER

Jonathan Kaplan, PhD

Based on the research, here are some tips to help manage your anger better:

- Develop a better awareness of your anger cues. As anger builds, we experience changes in our bodies, thoughts, behaviors, and emotions. Each one of us has a different set of warning signs that accompany rising anger. What are yours? Tightness in your chest? Ruminating about a prior disagreement? Clenching your fist?

- Develop strategies to pursue when you notice your signs of escalating anger. Perhaps you'll decide to leave the situation, take a timeout, or practice a relaxation exercise. You might also remind yourself that most people do not do things purposefully to antagonize you.

- Act assertively, not aggressively. Anger can damage our interpersonal relationships when it prompts us to act in ways that are insulting, threatening, or intimidating. It is important to learn that we can communicate our displeasure in a ways that are effective and easy to hear, which is more likely to lead to a constructive resolution. For example, instead of accusing your partner of not caring when he or she forgets to do the dishes, try saying, "Honey, I feel disappointed that you forgot to do the dishes, yet I know that sometimes I forget things, too. When do you think you can wash them?"

- Incorporate regular relaxation into your daily routine. Just like exercising, eating well, and getting sufficient sleep, it's necessary for us to relax. Napping and plopping in front of the T.V. don't count. In fact, we need to try purposefully to relax in order for it to be restorative and helpful. Consider adopting a regular practice of yoga, meditation, deep breathing, progressive muscle relaxation, or some other form of relaxation.

What the ^%#*@ is going on?: CBT for anger management

Jonathan Kaplan, PhD

You want to get pissed off? Take a few moments to recall when someone insulted you…or disrespected you…or did wrong by you. It won't take long before you find yourself feeling angry, tense, and contemplating what you should have said or done differently. For all of us, anger is familiar emotion. Typically, it signifies that something (or someone) is not going the way that we expect, desire, or deserve. Used constructively, such anger can help us change a bad situation. However, if we experience anger too much, too often, or for too long, it undermines our cardiovascular health and wreaks havoc with our personal and professional relationships. Fortunately, empirical research has repeatedly demonstrated that a form of psychotherapy, cognitive-behavioral therapy (CBT), is effective for anger management.

CBT involves some combination of changing how we think and what we do in anger-provoking situations. A typical 10 – 12 week course of therapy begins by building motivation for change and learning to recognize cues of our escalating anger. Seemingly sudden outbursts of aggression are preceded by a build-up of stress that we often don't notice. Rushing through our day, getting stuck in traffic, or jamming into a packed subway car all contribute to an escalated state of tension that makes us more likely to get angry. CBT helps us learn to identify even subtle cues of our escalating anger. It also helps us appreciate the long-term costs of our anger, even in the face of seemingly immediate pay-offs.

Like CBT treatments for other problems, cognitive techniques for anger management involve a variety of approaches, such as changing our internal dialogue, challenging our automatic assumptions, and reframing anger-inducing experiences. For example, we might be "on the lookout" for being disrespected or constantly going over a perceived insult. These thoughts only serve to perpetuate our unhealthy anger, and ultimately do very little to contribute to constructive problem-solving. Recently, cognitive techniques in therapy have included the use of mindfulness (i.e., becoming non-judgmentally aware of the present moment) and the cultivation of forgiveness.

Behaviorally, therapy helps people develop strategies to address escalating anger and solve interpersonal conflicts. Through the use of relaxation techniques, people learn to relieve stress and tension, thus helping to prevent angry outbursts. In addition, certain techniques, like deep breathing, can be used very effectively during times of anger in order to reduce our emotional distress. Also, through CBT, people learn to respond assertively, rather than aggressively. If you have difficulties managing anger, you might be more likely to shout, argue, criticize, seethe, or even act out physically when you have a problem with someone. These aggressive responses might prompt others to capitulate to our immediate demands, but they also weaken our connections with important people in our lives. CBT helps people develop the skills necessary to resolve conflicts in ways that are productive, respectful, and affirming.

Jon Kaplan

Director of the Stress Management Program

KIDS CORNER

The American Institute for Cognitive Therapy is pleased to announce expanded child and adolescent therapy services. Cognitive behavioral treatment is offered addressing the following problem areas faced by children and adolescents:

- Depression
- Anxiety and Fears (GAD, Social Phobia, Specific Phobia)
- Obsessive Compulsive Disorder
- Post Traumatic Stress Disorder
- Attention-Deficit/Hyperactivity Disorder
- Disruptive and Noncompliant Behavior
- Oppositional Defiant and Conduct Disorders
- Social Skills Training
- Enuresis
- Adjustment Difficulties (e.g., parental divorce)
- Stress Management

- Parent-Child Relational Concerns
- Parent Training
- Family Therapy

-Annalise Caron, PhD

Director of Child and Family Treatment

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Senior Staff Clinican, Spanish Speaking

David Castro-Blanco, PhD, ABPP
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Recognizing Anxiety and Depression in Children

Annalise Caron, PhD

Are you wondering if your child or teenager may have symptoms of anxiety or depression? Both of these mental health concerns are "tricky" for parents to identify because they are experienced internally by the child – internalizing disorders – and lack the outward signs in behavior that children with other concerns such as Attention-Deficit/ Hyperactivity Disorder or Oppositional Defiant Disorder exhibit.

Sadness and worry are normal emotions experienced by all of us in life. It is natural for children's moods to fluctuate over time – sometimes feeling happier and sometimes feeling more sad or scared. For example, the loss of a relative or friend moving away can cause sadness. Worries are common as well, such as anxiety about making new friends at the start of the school year or fears about performance on a school test. In these ways, sadness and worry can actually serve productive functions in our lives, e.g., sadness allowing us to grieve or come to terms with a let down in our lives, and anxiety serving to help motivate us to get things done like preparing for a test. However, when these feelings become more constant in a child's life or affect their ability to function comfortably in school or with peers, then parents will benefit from paying closer attention to their child's mood states.

So, how can you tell if your child is just "feeling blue" and having "normal worries," as opposed to being warning signs of a more serious problem? Kids have difficulty identifying their feelings and sometimes can't find the right words to describe what is going on. They may express their anxieties through physical symptoms such (e.g., stomachaches, headaches), avoiding social activities, or by refusing to go to school. Decreases in academic performance (e.g., declining grades), increasing irritability, changes in sleeping and eating patterns, or withdrawal from interest in activities with friends can be possible signs of depression. Another way is to look at your own behavior in response to your child. Have you found yourself trying to help your child by telling them to "stop worrying – there's nothing to worry about" or maybe feeling frustrated with your child's lack or motivation or apparent laziness? Have you given suggestions to your child about how to handle situations that seem difficult for them, and they don't comply? Do you feel like you can't "get through" to your child or that they will not "open up?" These are common experiences of parents of children with anxious and depressive symptoms. None of these symptoms individually indicate a diagnosis of depression or anxiety, but can be warning signs.

Cognitive-behavioral therapy has been shown to effectively treat anxiety and depression in children and adolescents. CBT teaches kids ways to positively cope with distressing thoughts, unlearn and face their fears, and take proactive steps to feel better. Children are taught ways to identify and measure their anxious and depressive symptoms, recognize the triggers, and learn coping strategies and behavioral techniques to reduce their distress. Often, parents are included in the therapy, to help them understand what is going on for the child, and teach them how to positively reinforce the child (e.g., provide cheerlead-

ing) in using their CBT techniques and coping strategies. Parents do not "cause" anxiety and depression in kids, but they can be an important part of the solution. Many children and parents find the CBT strategies not only useful, but also fun. If you think your child or adolescent may have anxiety or depression, or would like more information about our CBT services for children and adolescents, please call 212-308-2440.

Annalise Caron

Director of Child and Family Treatment

AICT is pleased to announce our new Dialectical Behavior Therapy Group for Adolescents.

Dialectical Behavior Therapy (DBT) combines cognitive behavioral techniques designed to change behavior with concepts from Eastern meditative practice designed to promote acceptance. This group is appropriate for adolescents, ages 13 to 19, who have difficulties handling emotions, mood swings, problems with impulse control, eating disorders, anger management problems, and self-destructive behavior. Please call (212) 308-2440 to set up a consultation with Lisa Napolitano.

Making Sense of the Chaos: Identifying Triggers for your "Challenging" Child

Courtney Rennicke, PhD

If you are the parent of a child who has behavioral difficulties, you have likely been told on many occasions to set up a sticker or star chart to reward your child for good behavior. Behavioral reward charts that reinforce your child's positive behaviors are an important and well-researched way of dealing with disciplinary problems. However, parents of children with behavioral difficulties sometimes find that while they work in the short-term, sticker charts often fail in the long run to make lasting change in their child's behavior. When these reward systems fail, parents tend to feel disempowered and helpless to address their children's troubling behavior and children, in return, feel more damaged and "bad".

When you take a moment to think about the assumptions behind how reward charts work, they are essentially that your child either does not know what is expected of him/her and/or that they receive more attention for "bad" behaviors and not enough attention for "good" behaviors. While both of these assumptions can be true, star charts tend to overlook the possibility that your child's challenging behavior might be due to an underlying difference in how their brains are wired. In short, many children who often get into trouble can quickly tell you what they were "supposed to do". They know that they are not supposed to hit their sister or talk out of turn, yet they continue to misbehave. Therefore, the frustrating question for parents remains, "Why does my child continue to act this way?"

One possible answer, according to Ross W. Greene, Ph.D., who developed a new treatment for behavioral problems in children called Collaborative Problem Solving (CPS), is that "children do well when they can." In short, that if your child is misbehaving it is not because they want to ruin your morning or embarrass you in the checkout line (although it can certainly feel that way!), it might be because they lack the skills to deal with the situation at hand effectively. Thus, a crucial component of the CPS approach is identifying the patterns in your child's behavioral difficulties in terms of which situations, times of day, and types of possible skills deficits tend to act as triggers for their tantrums and other challenging behaviors.

The five main areas targeted for assessment with some examples of the children's observed behavior are:

- Executive Functions (e.g., "Tom never seems to consider the consequences of his actions. He just seems to do whatever he wants to do without thinking. Act first, ask questions later, that's Tom.")
- Language Processing Skills (e.g., "After Sarah throws a tantrum, I'll try to ask her what was bothering her and she can almost never tell me what set her off. Its like she doesn't know what words to use to tell me what went wrong.")
- Emotion Regulation Skills (e.g., "When Michael gets angry, he doesn't get a little angry, he explodes. At that point, it is impossible to talk with him and I just have to wait for his storm to pass.")
- Cognitive Flexibility (e.g., "One morning we had run out of Anna's favorite cereal and she just fell apart. It's like she can't deal with any change in her routine.")
- Social Skills (e.g., "Once I saw that Chris was cheating on a board game by not allowing his friend to take a turn. He seemed completely happy and totally unaware of how angry and miserable his friend was.")

Parents who feel like they are walking on eggshells by the seemingly random and unpredictable nature of when their child will explode often feel some degree of relief to finally have labels for what they routinely struggle with. In addition to the educational materials listed below, getting a thorough evaluation by a psychologist can be a helpful first step in identifying underlying skills deficits, possible psychological disorders, and environmental issues that might be contributing to your child's behavioral difficulties.

Recommended Materials:

The Explosive Child (2005) by Ross W. Greene, Ph.D. [book].

Parenting the Explosive Child (2004) featuring Ross W. Greene, Ph.D. and J. Stuart Ablon, Ph.D. [DVD].

Center for Collaborative Problem Solving website: http://www.ccps.info

Courtney Rennicke

Assistant Director of Child and Family Treatment

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Robert L. Leahy, Ph.D., Institute Director (B.A., Ph.D., Yale) is the President of the International Association of Cognitive Psychotherapy, President of the Academy of Cognitive Therapy, and Associate Editor of *The Journal of Cognitive Psychotherapy*. He is the Founder and Director of the Institute and he is Clinical Professor of Psychology in Psychiatry at Weill-Cornell University Medical School. He is the editor and author of fifteen books, nine of which are Book Club Selections. 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. His book, *The Worry Cure: Seven Steps to Stop Worry from Stopping You,* was published in Fall 2005.

Laura Oliff, Ph.D., Director of Clinical Training (Ph.D., New School for Social Research) has over eighteen years of clinical experience with individuals (adults and children), couples and families focused on the treatment of depression, anxiety, eating disorders, marital conflict, and women's issues. Her research has focused on women's self-esteem, assertion, rejection-sensitivity and overcompliance. Dr. Oliff has additional experience in child and adolescent assessment, 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.

Danielle A. Kaplan, Ph.D., Senior Supervising Clinician, (University of North Carolina at Chapel Hill) is trained in both cognitive-behavioral and Dialectical Behavior Therapy. Dr. Kaplan has taught CBT at Northwestern University and the Ferkauf Graduate Program in Psychology at Yeshiva University, and has lectured in the US, Peru, and the Dominican Republic. She practices at AICT and is the director of Cognitive-Behavioral Therapy at Bellevue Hospital Center. Her clinical interests include anxiety, depression, domestic violence, couples therapy, and the applications of therapeutic techniques to diverse populations. She is bilingual in English and Spanish. Dr. Kaplan is a Medicare provider for the New York City region.

Lisa A. Napolitano, Ph.D., Senior Supervising Clinician, (A.B., Barnard; J.D. Yeshiva; Ph.D., Fordham;) is the Director of the Institute's Dialectical Behavior Therapy (DBT) program. Dr. Napolitano has extensive clinical experience with the treatment of depression and anxiety disorders, eating disorders, self-esteem problems, perfectionism, and relationship issues. Her primary clinical and research interests concern personality disorders and the relationship of personality to thinking styles. Her research has been presented at the annual meeting of the International Association for Cognitive Psychotherapy. Dr Napolitano is an Adjunct Professor in the Ferkauf Graduate Program in Psychology. She is currently co-authoring a book on emotion regulation.

Dennis D. Tirch, Ph.D., Director of Education. Dr. Tirch serves as an Adjunct Assistant Professor and Clinical Supervisor at the Ferkauf Graduate School of Psychology of Albert Einstein Medical School. His internship and post-doctoral fellowship took place at the Veterans Affairs Medical Center in Bedford, MA, where he served as the Assistant Director of the hospital's CBT Center. He has co-authored several articles and chapters on CBT and has specialized in the treatment and study of mood disorders, PTSD, panic disorder, mindfulness and acceptance based techniques, and addictive behaviors

Rene D. Zweig, Ph.D., Director of the Eating Disorders and Weight Management Program. Dr. Zweig received her B.A. from the University of Michigan, her Ph.D. from Rutgers University, and completed a pre-doctoral internship at the Yale University School of Medicine. Dr. Zweig specializes in treating depression**,** eating disorders**,** substance abuse**,** and smoking cessation. She developed the *Keep It Off*! weight management group. Dr. Zweig has received awards for her research at professional conferences and has given invited presentations at the Mt Sinai School of Medicine, Bellevue Hospital, Yale University, and Oxford University. She co-authored a chapter in Treating Substance Abuse: Theory and Technique, and she currently is co-authoring a book on eating disorders.

Annalise Caron, Ph.D., Director of Child and Family Treatment. Annalise Caron, Ph.D. received her B.A. from University of Virginia, and completed her M.S. and Ph.D. in clinical psychology at Vanderbilt University. Dr. Caron completed a pre-doctoral internship at Columbia University Medical Center, and stayed on as faculty of the New York State Psychiatric Institute. She continues to collaborate with Columbia faculty on community-based CBT studies. Dr. Caron is trained in CBT with children and adults, specializing in treatment of mood, anxiety, behavior disorders, and parent training. She has authored articles, book chapters, and presentations at national conferences on empirically-validated treatments for children and adults, as well as studies examining parenting and child development.

Jonathan Kaplan, Ph.D., Director of the Stress Management Program, earned his doctoral degree in Clinical Psychology from UCLA and he currently serves as Associate Director for Counseling at Pratt Institute. As an adjunct professor at the New School for Social Research, he has taught graduate seminars in evidence-based treatments and mindfulness in cognitive therapy. Over the years, Dr. Kaplan has developed an appreciation for the inter-relationship between the mind and body, which underscores his therapeutic interests in mindfulness, nutrition, and fitness. At colleges

across the U.S., he has conducted numerous mind-body workshops on meditation and relaxation. This year, he won an Early Career Award from the American Psychological Association for his work in this area.

Antonia M. Pieracci, Ph.D., Clinician, is a Summa Cum Laude graduate from the University of Pennsylvania and earned her graduate degree from Temple University where she was awarded a University Fellowship. She completed her postdoctoral fellowship at The American Institute for Cognitive Therapy. Dr. Pieracci has experience in treating depression, anxiety, eating disorders, bipolar disorder, personality disorders, marital conflict, substance abuse, and psychosis. Her work incorporates cognitive, behavioral, mindfulness, and acceptance techniques. She has received training in Dialectical Behavior Therapy . Dr. Pieracci has co-authored several articles on how parenting and abuse history contribute to adult depression.

Courtney Rennicke, Ph.D, Assistant Director of Child and Family Treatment received her Ph.D. in Clinical Psychology from Columbia University. Her dissertation focused on the search for meaning of the events of September 11th among people who were in or around The World Trade Center and its impact on their well-being. Dr. Rennicke completed her pre-doctoral internship at Columbia University Medical Center in the Department of Child and Adolescent Psychiatry. She has expertise working with children, adolescents, families, and adults with experience in treating depression, bipolar, anxiety, attention deficit hyperactivity, disruptive behavior and personality disorders, as well as mental health issues secondary to medical conditions. Dr. Rennicke is trained in cognitive behavioral therapy, interpersonal psychotherapy, and parent training. She has co-authored professional articles on trauma and resiliency, as well as on bipolar disorder and creativity.

Elizabeth Jeglic, Ph.D., Clinician, received her doctorate in clinical psychology from Binghamton University. Dr. Jeglic completed a postdoctoral fellowship at the University of Pennsylvania under the mentorship of Dr. A.T. Beck. Dr. Jeglic has published numerous scholarly articles and chapters on suicide and depression. Dr. Jeglic specializes in the treatment of depression, self esteem issues, suicidal behavior, self harm behaviors and anxiety disorders. She also has experience working with adolescent populations, chronic mental illness and offender populations.

Doris Chang, Ph.D., Clinician, received her doctoral degree in clinical psychology from the University of California, Los Angeles and completed postdoctoral training at the Department of Social Medicine, Harvard Medical School. She is currently Assistant Professor of Psychology at the New School for Social Research, where she teaches courses in ethnicity in clinical theory and practice, and psychological assessment. Dr. Chang specializes in working with adults and adolescents struggling with depression and anxiety, family violence, and issues related to acculturation and identity development. She has published over 20 articles and book chapters on cultural issues in diagnosis and treatment and domestic violence

David Castro-Blanco, Ph.D., Clinician. Dr. Castro-Blanco is Board Certified in Clinical Psychology by the American Board of Professional Psychology, and is a Fellow of the Academy of Clinical Psychology. He utilizes a cognitive-behavioral approach to treating children, adolescents and adults. As a full-time faculty member in the psychology department of Long Island University, where he directs the Anxiety, Mood and Personality Studies Lab, Dr. Castro-Blanco teaches, supervises and trains students in the doctoral program in clinical psychology. He conducts research on cognitive vulnerability to anxiety, and cognitive-behavioral treatment of anxiety and mood disorders. In addition, he conducts research focusing on the therapeutic relationship and improving treatment engagement with adolescent and adult clients.

Shireen Rizvi, Ph.D., Clinician, received her Ph.D. in clinical psychology from the University of Washington. She is currently Assistant Professor of Psychology at the New School for Social Research. In addition, Dr. Rizvi is a trainer in Dialectical Behavior Therapy (DBT) with Behavioral Tech, LLC and provides trainings and workshops nationally and internationally. Dr. Rizvi specializes in the treatment of emotion regulation problems, including borderline personality disorder, suicidal and self-harm behaviors, depression, anxiety, and trauma-related problems.

David Fazzari, M.S., Clinician, received received his B.A. with honors from Boston University and has received an M.S. and is completing a doctoral degree in Clinical Psychology at Teachers College, Columbia University. Mr. Fazzari has contributed to research at the University of California, Berkeley and is currently conducting research at Columbia University where he is investigating the effect of social support, disclosure, and relationship-attachment patterns on coping ability among World Trade Center survivors. During his training at Columbia, he was trained in both cognitive behavioral and psychodynamic approaches to individual psychotherapy. During his externship at the American Institute for Cognitive Therapy and his internship at Weill Cornell Medical Center, Payne Whitney Clinic he received advanced training in cognitive behavior therapy for mood, anxiety, and personality disorders.

Jenny Taitz, M.A., Clinician. Jenny Taitz, M.A., graduated Magna Cum Laude from New York University where she earned departmental Honor's in psychology. Ms. Taitz is currently pursuing a doctoral degree in Clinical Psychology at Yeshiva University's Ferkauf Graduate School of Psychology. Ms. Taitz served as a clinician at Bellevue Hospital treating inpatients. Ms. Taitz completed an externship at Metropolitan Correctional Center where she performed forensic evaluations. In addition, Ms. Taitz is training in neuropsychological assessment at Columbia Presbyterian. Currently, she is conducting research with Dr. Tirch on the efficacy of a mindfulness intervention. Ms. Taitz's clinical interests include anxiety, depression, self-esteem issues, eating disorders, substance abuse, and relationship enhancement

Poonam Melwani, B.A., Research Assistant graduated Cum Laude from Queens College with a B.A. in Psychology and Anthropology. At Queens College, she was a member of the Anthropology Society and conducted research on Hamadryas Baboons. Additionally, she was an avid participant in the field of psychology as a member of Psi Chi, an assistant to a developmental psychologist, and a volunteer at CHEST, Center for HIV Educational Studies and Training. Currently, she is a research assistant at AICT and is planning to attend graduate school in Psychology.

Kelly Reilly, Intake Coordinator, received her B.S. magna cum laude from New York University in May 2007, where she structured an interdisciplinary program that forged connections between Culture and Communication Studies, Psychology, and Politics. At NYU, she was afforded the opportunity to travel to Peru to research the mestizaje , or the influence of the mixing of races. Additionally, she wrote her honors thesis on the positive impact Buddhist practices (specifically mindfulness) can have on social interactions and processes. Kelly plans to attend graduate school in Clinical Psychology.

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CBT Comes to Beijing

Lisa Napolitano, PhD

What an honor it was to help bring cognitive therapy to China! For an intensive eight-day period this past August, I had the privilege of training twenty-two highly skilled practitioners in Beijing. Days began early and ended late, filled with thought-provoking exchanges on the finer points of cognitive practice. Evenings were for long dinners, one replete with my new colleagues' continued amusement at my use of chopsticks.

Extremely serious matters gave rise to this opportunity. Suicide is the fifth leading cause of death in China and the number one cause of death in youth aged between 15-34 years old. The estimated suicide rate in China between 1995 and 1999 was 23.8 deaths per 100,000 individuals, translating into over 287,000 deaths per year. The rural suicide rate is three times the urban rate.

As China tries to bridge its long-cherished culture with Western influence, the Chinese government is exploring all ways to help alleviate this tragic situation. Enter the Beijing Suicide Research and Prevention Center. In conjunction with the International Association of Cognitive Psychotherapy and the Chinese Society of Psychiatry, the Center has developed a project to train Chinese psychiatrists in cognitive behavioral therapy so that they can better deal with depressed and suicidal patients.

I participated in the second course of what is anticipated to be a five-year training program. Participants in the training had competed nationally for one of the twenty-two training spots. The goal of the training was to enable participants to return to their native towns, many located in rural areas, and further train and supervise staff as required.

The training was incredibly rewarding for both the participants and myself. Aside from lectures, sessions were filled with role plays and supervision of cases. I particularly enjoyed being challenged by the participants as they tried to clarify concepts that were to difficult to translate. For example, when I was discussing the therapist's validation of the patient's emotions, my use of the phrase "makes sense" caused an unexpected stir. In translation, this phrase seemed to imply a therapist judgment that the patient's emotional experience was logical or rational. Invalidation, as you might expect, was an equally problematic concept for translation.

As you can see from our final session photo, I now have a whole new group of friends and colleagues. Translation and cultural differences aside, we all forged quite a bond. I trust we will all make a difference to China and I personally can't wait to help out again soon.

Lisa Napolitano
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