

COGNITIVE THERAPY

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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

In this issue:

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Making Sense of Your Feelings

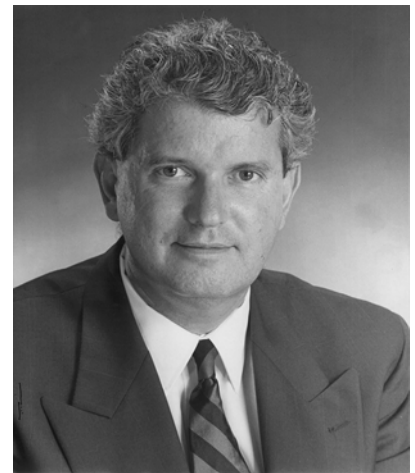
Robert L. Leahy, Ph.D.
Director of the Institute

All of us feel sad, angry, and anxious at times—but some people get derailed by these feelings. In the last few years I have been investigating how people differ in how they think about their emotions—and what they do once an emotion is activated. For example, imagine if someone feels sad—what do they think or do next? Our research shows that people who become clinically depressed have extremely negative views of their emotions. They are likely to feel guilty or ashamed about their feelings, they believe that their negative feelings will last indefinitely and overwhelm them, and that no one else has these kinds of feelings. Moreover, we find that clinically depressed people also believe that other people would not be supportive or validating—that they are all alone. And they believe that they should not have mixed feelings about someone.

An approach that we use at the Institute is to help people develop more positive views of painful emotions. What does this mean? Let's suppose that you have a friend who is going through a difficult time. She is sharing with you her sadness about the end of her relationship—but she now believes that her sadness is a sign of her weakness and that these feelings will last forever. Our *emotion-focused approach* would encourage her to share these feelings with sympathetic and loving friends, recognize that these feelings are a normal process of letting go of a relationship, and that these feelings—although painful—are not permanent. Moreover, we would help her recognize that having mixed feelings about a breakup is realistic—since relationships are complicated. We would also ask her how her sadness about a breakup points to her higher values—her desire

for intimacy and connection.

Our feelings are the central part of who we are. Attempting to eliminate feelings can become a self-denying or self-critical



process. Using an emotion-focused form of cognitive therapy can help you gain greater respect for your feelings—rather than fearing that they will overwhelm you and last forever. Making sense of feelings does not mean getting rid of feelings—it may mean using them to gain greater meaning and depth in your life.

Cognitive Behavioral Therapy and Coping with Divorce

Laura Oliff, Ph.D.
Director of Clinical Training

The divorce rate in the United States has increased to almost 50% of marriages. The separation and divorce process is difficult for everyone involved. Although having the freedom to change one's life can be exhilarating, the path toward a new beginning is fraught with emotional turmoil. Whether married three years or thirty, once a person begins the process of separation and divorce, they will experience extreme levels of stress as well as a profound period of mourning. Cog-

nitive behavioral therapy can help individuals lessen the emotional distress caused by divorce and help them adjust to being on their own.

Although much of the emotional pain of divorce is inevitable, it is often made worse by falling into cognitive and behavioral traps. Cognitive traps are habitual thoughts that increase your level of anxiety, depression, and anger. Certainly, any individual going through a divorce has real hurt, anger and fear. However, the way you think influences what you feel. *Blaming*, or ruminating about all the hurtful things your spouse has done or said to you, intensifies your feelings of anger until you are seething. *Catastrophizing*, predicting worst-case scenarios about financial ruin or imagining your children emotionally scarred for life, scares and stresses you unnecessarily. *Mind reading*, imagining that family and friends will be critical of you and see you as a pathetic loser, increases feelings of depression and self-blame. *Filtering* also influences depressive symptoms by focusing on the most negative aspects of a situation and discounting any potentially positive aspects.

Monitoring and challenging distorted cognitions such as these can lessen the intensity of the negative emotions you've been experiencing. For example, when you catch yourself thinking, "I can't stand the loneliness," replace this catastrophic thought with more realistic thinking such as, "I can adjust to this new life if I give myself some time and try some new things." Additionally, learning how to postpone or delay anxious thoughts can lessen the sense of being overwhelmed and allow you to be more in the present. Writing anxious thoughts out for a limited period of time every day can help you desensitize to recurrent worries and gain a better sense of control over them.

People respond in their own way to the stress of losing a marital partner. Behavioral traps are coping strategies that are carried to an extreme. For example, emotional exhaustion, and fear of social awkwardness or disapproval, may lead many people to *withdraw* from their social networks initially. However, if you

continue to avoid friends' calls and turn down invitations, you may find yourself isolated and more seriously depressed. Increased *dependency* on family and friends, even *clinging to an ex-spouse*, is a normal reaction to stress that gives one a sense of stability and continuity. If it continues for too long, it can prevent the individual from establishing new relationships. Similarly, *living for others*, even if it appears to benefit one's children in the short-term, is often a response to feelings of emptiness. You must remember to take care of yourself if you plan to be there for your loved ones in the long-term. Finally, *believing that you are incomplete without a partner* can make being alone a difficult and empty experience. Facing the reality that you are alone and challenging yourself to explore new interests and activities creates happiness in the present and hope for the future.

Post-Traumatic Stress Disorder

Dennis Tirch, Ph.D.

After the Vietnam War, and, more recently, the terrible events of 9-11, most Americans came to learn something about Post-Traumatic Stress Disorder (PTSD). When we experience traumatic events, which threaten the lives and safety of ourselves or those close to us, profound and disturbing emotional consequences often follow. For most of us, a process of natural healing occurs, which allows us to integrate memories of the experience, and move forward with our lives.

For some, however, a tragic event is too overwhelming to be integrated into experience. Due to genetic or learning factors the natural healing process is disrupted, leading to PTSD. People with PTSD may experience a number of highly distressing psychological symptoms for years after the traumatic event that include intrusive thoughts or sense memories of the experience, "flashbacks" during which a person may re-experience a terrible event, nightmares, and elevated fear and anxiety in situations that recall the event. As a result, people with PTSD

may come to avoid reminders of the event, withdraw from their lives, or may suffer disruption in their relationships.

While the disorder was once commonly referred to as "shell-shock" and was associated with war veterans, researchers have found that the disorder can manifest itself among people who have suffered a wide variety of difficult experiences, such as childhood abuse, automotive accidents, sexual assault, or crime victimization. Although this disorder was once considered notoriously difficult to treat, cognitive-behavioral therapy researchers such as Dr. Edna Foa, of the University of Pennsylvania, and Dr. David Clark, of the Institute of Psychiatry in London, have made progress in developing evidence-based psychotherapy methods to help people overcome PTSD. Other advanced developments in CBT, such as the integration of meditation techniques and a "mindfulness-based" approach, are also being used to supplement traditional therapy methods to treat people with PTSD.

PTSD is a paradoxical disorder. A person with PTSD is being affected by an event which is "in the past," yet their reactions reveal prominent fear, anxiety, and "feeling unsafe" in the present. PTSD may lead one to overestimate the danger in their present environment, and to fear what the future may bring. Cognitive therapy seeks to address these fears on several fronts. Patients are taught to challenge thoughts and beliefs which drive their overestimation of their danger in the present and future. For example, a patient who has come to believe, "I'm doomed, and bad things will always happen to me," may learn to elicit and systematically challenge such a belief, so that they may overcome their fear of everyday activities. Patients are led through a

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“reliving” of a traumatic event in their imagination, under the supervision of a therapist. Through such an exercise, a patient may come to accept and manage their anxiety in the telling of their story. Furthermore, such an exercise is designed to gradually allow a patient to integrate the experience into their memories, more fully emotionally process the event, and to reduce the frequency of intrusive thoughts about the event.

Meditation, relaxation, and mindfulness-based techniques can be used to help the patient in several ways. Patients are taught to cultivate control of their attention, adopt an accepting perspective, and to gently regulate their level of overall arousal. Here at the Institute, we are developing methods to train patients in meditation techniques using a continuum model of attention. Through this work, patients develop skills in “Zen-like” concentration meditation, muscle relaxation, emotion tolerance, and in “mindfulness,” which involves the ability to become aware of unhelpful patterns of thought, and to be able to intentionally “let them go.” PTSD may be viewed as a normal reaction to an extraordinary set of circumstances. Often, people with PTSD lose sight of this, evaluate themselves negatively, or may give up on life. The cognitive therapist helps restore the patient’s dignity and helps the patient reclaim his or her life following trauma.

Anger Management

Elissa Tolle Lefkowitz, Ph.D.

Anger can be useful, necessary and adaptive. It can serve to communicate with others, motivate our behavior and cue us in to potential dangers. However, if anger routinely limits our effectiveness in our workplace or leads to conflict in our interpersonal relationships, it can be maladaptive. Difficulties with anger management are frequently “under the radar” for patients, as they may not initially recognize it as problematic. This lack of awareness may be due to assumptions that underlie the anger, namely, that “it’s everyone else’s fault”. Presenting issues that tend to mask difficulties controlling anger include perfectionism, somatic complaints, relationship

or marital problems, substance abuse, avoidance or procrastination and problems maintaining friendships. As such, even if anger is not initially recognized as problematic, anger management may be set as an additional goal of treatment after a thorough evaluation. Cognitive therapy tackles the problem of maladaptive anger patterns using three basic components; 1) knowledge and understanding, 2) challenging and modifying cognitions, and 3) behavioral change. The goal of anger management is not suppression, but rather, appropriate expression.

Knowledge and understanding

A key component of anger management is to understand when and how you feel angry. Cognitive therapy can help you monitor your anger episodes—to track the frequency, intensity and duration of your emotions, as well as identify triggers which tend to arouse anger. Cognitive therapy also focuses on experiencing your anger in a safe environment in order to ascertain evidence of this emotion (i.e., clenched fists, shortness of breath, head pounding, gritting teeth), so you can recognize the early signs more easily in the future. Knowledge about uncontrolled anger includes an awareness of the negative effects on both mental and physical health.

Modifying thoughts and interpretations of events

Another component of anger management is to understand why you feel angry. Many times, it is due to our interpretation of an event – rather than the event itself. In other words, our “self-talk” may exacerbate angry emotions. Therapy can help you identify any distortions in your thinking, and assist you in making a more realistic assessment of the situation. For example, thinking “That guy is such a jerk for cutting me off!” would lead to more angry feelings than, “It’s possible he didn’t even see me, and realistically, I’m not going to get to my destination any more slowly because one car went ahead of me”.

Behavioral change

Anger management includes problem-solving techniques as well. If it is the case that your interpretation of an event is accurate, and this leads to angry feelings, therapy can help you control your emotions in a way that is more adaptive. Interventions that help prompt more productive expressions of anger include asking questions such as “What are the advantages and disadvantages of being angry right now?” Actual behavioral changes may include taking a “time out,” using relaxation techniques, engaging in assertive behavior, or walking away from the situation.

Attention Deficit Hyperactivity Disorder

Danielle Kaplan, Ph.D.

Attention Deficit Hyperactivity Disorder (ADHD) is one of the more commonly known and widely publicized disorders in school-aged children. In recent years, many adults pursuing treatment for ADHD for their children have also reported that they recognize signs of the disorder in themselves, starting in their own childhoods and continuing to the present. This report is consistent with our most current knowledge on the disorder. Recent studies suggest that the prevalence of ADHD in a community sample of 6 to 12 year olds may range from 4 to 12% of the general population. Many of these children will continue to show some symptoms of ADHD as adolescents and adults.

In young children, ADHD may manifest itself in several ways. Children with the diagnosis often have trouble sustaining attention and following through on assigned tasks. They may have difficulty following complex directions or waiting for the end of a set of instructions. Many children with ADHD appear disorganized; they often lose schoolbooks, gloves, and other items. In general, children with ADHD are easily distracted, although they can often sustain attention when faced with a new or interesting project.

A subset of children with ADHD also appear to be physically restless. They may fidget in their seats, get up from their desks and walk around without permission, or blurt out comments or questions out of turn. These children may act impulsively, and may engage in reckless activities without stopping to consider the consequences. As children with ADHD get older, their physical restlessness and hyperactivity may become less noticeable to others.

Perhaps because of the recent attention paid in the media to ADHD, parents and teachers may assume that any child who has difficulty concentrating or does not follow instructions has an ADHD diagnosis. It is important to recognize that many factors can contribute to attentional and academic problems in school-aged children. Anxiety, childhood depression, hearing problems, and many other problems may mimic the symptoms of ADHD. For this reason, it is important to have your child evaluated by a qualified mental health or medical professional before concluding that he or she has ADHD. A professional evaluation will allow you to discuss your specific concerns about your child, evaluate the pros and cons of medication, and explore factors that may be contributing to your child's particular difficulties.

There are many strategies that parents can implement at home to help their children. Because both children and adults with ADHD may have difficulty following complicated directions, it helps to break tasks into small, manageable components. A child with ADHD may have difficulty with the instructions, "Get your shoes on, call your brother, tell him to put his jacket on, and meet us downstairs in 5 minutes- and don't forget your backpack!" However, she has a much better chance of completing all these tasks successfully if they are mentioned one at a time. For tasks that repeat every day, many families find it helpful to post a schedule or checklist that the child can refer to himself.

Parents can also help their children organize their belongings into meaningful categories. It may help children, for ex-

ample, to keep their school clothes in one drawer and their play clothes in another. Similarly, adults may be helped by storing their cancelled checks by category instead of in a folder marked "Bills."

Cognitive-behavioral therapy can be helpful for children and families dealing with ADHD. In therapy, families can come to a better understanding of their child's strengths and weaknesses. A therapist can help families to develop organizational and communication strategies that are tailored to their child's needs. Cognitive behavioral therapists can work with children on improving their self-control skills and their ability to think before they act. For many families, partnering with a therapist can provide new ways to deal with the stresses of parenting a child with ADHD so they can more fully enjoy the unique and special child they have.

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 thirteen 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 overcompliance. Dr. Oliff has additional experience in child

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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.

Clinical Staff

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/acclimation issues. She has worked extensively with Latino

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Support FACT!

FACT is the **Foundation for the Advancement of Cognitive Therapy**, a non-profit organization, and supports training and research on the treatment and nature of depression and anxiety disorders. Millions of people suffer from depression and anxiety disorders—often disabling individuals and breaking apart families. 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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You can read more about FACT and make an online donation. Please consider supporting our efforts to train and educate more professionals in cognitive therapy.

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children and adults, and is bilingual in English and Spanish.

Elissa Tolle Lefkowitz, Ph.D., Elissa Tolle Lefkowitz, Ph.D. graduated from Columbia University, where she received an Ed.M. in Psychological Counseling and a Ph.D. in Counseling Psychology. She was awarded the Dean's Grant for Dissertation Research (2001) for her work on the influence of coping strategies and personality traits on adjustment to college, and was also the recipient of the Rose Biller Endowment Fund (1999). Her current interests include coping effectively with life transitions, the Impostor Phenomenon, and the integration of psychological theories and interventions for treatment of mood and anxiety disorders.

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 dialectical behavioral therapy of borderline personality disorder and compulsive self-injury. She is experienced in both the neuropsychological and psychological assessment of adults.

Carrie B. Spindel, M.A., is a graduate of Cornell University and is currently in the doctoral psychology program at Ferkauf Graduate School of Psychology at Yeshiva University. She has had clinical training at Bellevue and has been a primary clinician at the Ferkauf Graduate School as well as the Jacobi Center. She has presented her research work at the meetings of the American Psychological Association and has been a teaching assistant in cognitive-behavioral therapy.

Dennis D. Tirsch, 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

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with disabilities for two consecutive years. During his residency, Dr. Tirsch 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. Tirsch has focused on the assessment and treatment of depression, substance misuse disorders, neuropsychological deficits, and post-traumatic stress disorder.

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.

Rachel Moser, Intake Coordinator and Research Assistant, graduated Magna Cum Laude from the University of Pennsylvania with a B.A. in Psychology. While at Penn, she researched the psychological aftereffects of September 11th on Search and Rescue Canine Handlers. She received the Miles Murphy Award for outstanding psychology research and the Rose Award for exceptional research by an undergraduate. She recently presented two research papers at national meetings of the Anxiety Disorders Association of America.

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