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Robert L. Leahy
Director

How to Free Yourself from Worry

Robert L. Leahy, PhD

Let's imagine that you are trying to teach someone who comes down from another planet to worry. You turn to him and say, "Here are the rules for worrying":

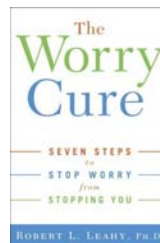
1. If something bad could happen—if you can simply imagine it—then it's your responsibility to worry about it
2. Don't accept any uncertainty—you need to know for sure
3. Treat all of your negative thoughts as if they are really true
4. Anything bad that could happen is a reflection of who you are as a person
5. Failure is unacceptable
6. Get rid of any negative feelings immediately
7. Treat everything like an emergency

Think about it. Now that you know the seven rules, you can worry every single day of your life about something that will probably never happen. You have the **ROYAL ROAD TO MISERY!** In fact, these seven rules are based on the latest research on the nature of worry.

But what can you do about it?

The first step to handle your worries is to ask, "What is the advantage in worrying?" Worriers think that worry will prepare them, motivate them, and keep them from ever being surprised. Worry is a *strategy*. For example, if you have a test coming up, you could try any

one of the following strategies: 1) You could get drunk; or 2) You could study. Which one is the best strategy? We ask worriers to distinguish between *productive worry* and *unproductive worry*. For example, if I am going to fly from New York City to Rome, then productive worry involves **ACTION THAT I CAN TAKE NOW**. I can purchase my airplane ticket and reserve a hotel room. Unproductive worry involves all the what-ifs that I cannot do anything about. These include, "What if my talk doesn't go well?" or "What if someone doesn't like me?"



The second step deals with *uncertainty*. Research shows that worriers cannot tolerate uncertainty. They treat any uncertainty as if it is a sure negative.

Ironically, 85% of the things that worriers worry about turn out to have a positive outcome. And, even when the outcome is negative, 79% of the time worriers say, "I handled it better than I thought I would". We help worriers commit to *accepting uncertainty*. In fact, you already accept a lot of uncertainty in your life. Demanding certainty is hopeless, so we can look for the advantages of *having some uncertainty*. These include novelty, surprise, challenge, and change and growth. Otherwise, life is boring.

Along with accepting some reality and uncertainty, we know that worriers *avoid uncomfortable experiences*. So we ask worriers to list all the things that they are avoiding and begin doing these things. The goal is "constructive discomfort"

and "successful imperfection". You have to be uncomfortable to grow and change and success is purchased at the price of imperfection. Once you realize that you are already uncomfortable (because you are a worrier and probably a little depressed) you can at least use your discomfort to make progress.

The third step deals with how you evaluate your thinking. Worriers have "thought-reality fusion". They think that "If I think I might get rejected---then it will turn out true---unless I worry about it and do everything to be sure it doesn't happen." Worriers treat their thoughts like they are already *facts*. Typical thinking errors include, *Mind-reading* (He thinks I am a loser), *Jumping to conclusions* (I don't know something, therefore I will fail), *emotional reasoning* (I feel nervous, so things won't work out), *perfectionism* (I need to be perfect to be confident), and *discounting the positive* (The fact that I have done well in the past is no guarantee of anything). Worriers also have "sudden emergency" ideas---such as, "slippery slope" thinking (If this trend continues, it could just keep going downward fast) or "trap door" (I could make a mistake and my whole life could fall apart). Worriers can challenge and test out their thinking---- "What's the worst, best and most likely outcome?", "What are all the things that I could do to deal with a *real problem*?", "Is there any evidence that things could turn out OK?", and "Am I making the same wrong predictions that I always make?" To learn more about how to handle your worries, please see my book, *The Worry Cure: Seven Steps to Stop Worry from Stopping You*. You can also follow my blog "Anxiety Free" at <http://blogs.psychologytoday.com/blog/anxiety-free>

Get more ZZZ's: CBT for Insomnia

Annalise Caron, PhD

Insomnia

Insomnia (difficulty falling or staying asleep) is not just a night time problem. It's a 24 hour problem! When individuals do not sleep well at night, their day time functioning at work and in their relationships suffers. Daytime sleepiness is not only aversive, but can interfere with concentration, affect mood, and decrease energy and productivity.

Insomnia can be a stand-alone concern, or can arise in conjunction with anxiety, depression, or other comorbid medical conditions. Further, one's risk of experiencing anxiety and depression increases if they already have insomnia. In general, the risk of insomnia increases with age.

CBT Treatment of Insomnia

Cognitive behavioral therapy [CBT] has consistently been shown to be the best first-line treatment for insomnia. CBT improves sleep in more than 75% of insomnia patients and leads to a reduced need for sleeping pills. In addition, CBT has none of the side effects associated with taking sleep medications, and has better long-term outcomes in terms of maintaining good sleep after treatment ends. This is because CBT provides people with strategies they can use to help themselves if the insomnia symptoms were to return.

Patients often see initial results in just four sessions, although they may stay in treatment longer to reach their optimal sleep potential. Treatment is usually around five to eight sessions. For those on sleep medications, the process likely will take longer. Patients are often able to reduce, if not eliminate, the amount of sleep medication they take.

Components of CBT for Insomnia

The crux of cognitive behavioral therapy for insomnia involves specific behavioral changes which your therapist will guide you through to enhance the efficiency of your sleep. People with insomnia often unknowingly engage in behavior that: a) inhibits sleep, b) disrupts circadian rhythms, and c) decreases their overall sleep drive. The behavioral component of CBT addresses all three of these



concerns by teaching the patient a new set of "Sleep Rules" (e.g., no napping, use the bed only for sleep and sex, get out of bed if you are awake, limit caffeine and alcohol, keep the bedroom quiet, dark and cool, etc.) and offering clear guidelines to make sure that the time you are in bed, you are actually sleeping! Often there is a big disparity between people's actual sleep time

and the amount of time they spend in bed. The idea that laying in bed longer will help you get to sleep is false. Laying in bed awake for long periods actually makes insomnia worse! Your therapist will work with you to identify your specific sleep problem(s), develop a specific individualized sleep plan to address them, and help monitor your progress.

In addition, your therapist will teach you strategies to decrease cognitive arousal (e.g., taking worries to bed) and address dysfunctional thinking patterns (e.g., "I'll never get to sleep and I won't be able to function tomorrow") that may be keeping you awake. Further, you may be taught general stress reduction techniques and breathing exercises to calm anxieties and enhance restfulness.

Unfortunately, not all psychologists (not even all cognitive behavioral psychologists) are trained in the skills needed to effectively implement CBT for insomnia. Here at the American Institute for Cognitive Therapy, we have specialists who have been trained specifically in this robust insomnia treatment.

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

Mindfulness and Meditation Group Therapy
Jonathan Kaplan, PhD

Dialectical Behavior Group Therapy
Lisa Napolitano, PhD

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

Avoid Avoiding!

Shireen Rizvi, PhD

It's no secret that we all have things in our life that we don't like to do. Paying bills, changing the cat litter, bringing up a sensitive topic with a partner, making a cold call to a potential employer, going to a party where we don't know anyone are examples of such activities that often fall to the bottom of our want-to-do lists. Most of the time we can get ourselves to do these noxious tasks, especially when the consequences become more severe (e.g., a late fee charge for an unpaid bill) but sometimes, especially when we are feeling depressed or anxious, the pile of avoided tasks

can build up. Avoidance then becomes a habit and it creates a vicious cycle whereby we feel worse when we avoid and we avoid more when we feel worse.

However, it's important to recognize that avoidance serves a function. If it didn't, none of us would ever avoid anything. Avoidance often brings short term relief. If you don't open up your credit card bill this month and instead shove it in a drawer, you don't have to experience the rush of dread that accompanies the sight of the dollar amount. Similarly, by avoiding a party where you don't

Master Your To-Do List

David Fazzari, PhD

The first thing people usually say when I tell them I help patients with procrastination is, 'You treat that in therapy?' Absolutely! And the starting point for tackling procrastination is often developing an organizational plan. Here are nine steps to help you get organized.

1. **Create a to-do list.** Any time we want to make a change in our life we first need to define the problem. For the procrastinator, a usable to-do list is often the problem. Take all those post-it's and different scraps of paper with notes scribbled on them and put everything on a master list.
2. **Tame the to-do list.** A common issue with to-do lists is that they can become enormous, which in turn can make them seem overwhelming. Go through your list and break things down into 3 categories: Needs to happen today, this week, and eventually.
3. **Break it down.** If some of the items in your list seem overwhelming, identify the very first step, preferable something you can make some progress on in an hour or so.
4. **Action plan.** Ok, so now you have your prioritized to-do list. Now you need to put it into action. Get a planner, if you don't have one already, and always carry it with you. Take the most urgent items off your to-do list and block out a time to do them during the day. For example, 9-10am, review to-do list and action plan, return phone calls, 10-11am search job postings, etc.
5. **Review.** Look at your planner and to-do list at least once a day and make sure they are up to date and reflect your current priorities.
6. **Be realistic.** Many times procrastinators overfill their daily action plan. Then when they find themselves falling short and feeling disappointed. Instead, be realistic and conservative in your estimates for how long things will take. This will help make this process a mastery experience instead of feeling like a failure.
7. **Out of sight, out of mind.** We've all thought "I'll do it tomorrow" only to find out the following week that we forgot all about it. Write everything down you need to do and make sure you scan your calendar at the end of the day and transfer anything that didn't get done to a new time slot.
8. **Trouble shoot.** If you find you're having trouble sticking to your plan, spend some time trying to understand what got in the way of success. Were there too many things packed into one day? Does anxiety get in the way of taking the steps listed here (see Dr. Rizvi's article on avoidance to understand why this is so common)?
9. **Reward.** While getting things done will be rewarding in itself, don't forget to reward yourself for each step you take. When you finish something, reward yourself by taking a break, going to a favorite restaurant, or even just saying "Wow, I did a great job finishing that!"

know anyone, you don't have to experience any social anxiety, for example, worries that people won't like you or that you might do something embarrassing. Or by avoiding the work assignment due next week, you have time to do things that are more pleasurable. In psychological lingo, avoidance is negatively reinforced, meaning that it is likely to continue in similar situations in the future because it is associated with the short-term reduction of a negative feeling (usually anxiety).

Unfortunately, the short-term relief is also associated with long-term problems. The unpaid bill is not going to disappear on its own just because it's out of your line of vision (if only it did!). The avoidance of parties may contribute to feelings of loneliness or lack of meaningful relationships because you are not meeting new people. Not working on the assignment will not make the deadline go away. In fact, the more you avoid, the more likely you will start to think that you are incapable of doing certain things. And we all know what happens the more you think "I can't . . ."

So how do you reverse the habit of avoiding? It may be useful to first ask yourself what function avoidance serves for you. Once you have a better understanding of this, you have to start to avoid avoiding. Face those demons, and do whatever it is you don't want to do. Recognize that you don't have to like something in order to do it. Slowly, you'll find the obstacles in your path disappearing and you'll begin to feel better about yourself. While this might sound reminiscent of the Nike slogan "Just do it," there is a crucial difference. The slogan is oversimplifying of the complexity of human behavior - if you could "just do it", you probably would have already done it. However, sometimes we have a tendency to think too much before action which gives us plenty of opportunity to talk ourselves out of something. Does "I don't have to go to the gym today because I have a meeting later; tomorrow, I'm much more free, I can go then" sound familiar? When tomorrow comes, your active and smart brain can think up plenty of valid reasons for not going then either. But what if you just got into your gym clothes and walked out the door, without

thinking about it?

The trick is to start small. A habit isn't unlearned in one day. If you've been avoiding exercising, signing up for an extensive daily physical fitness program at a gym may not be the best initial strategy because it's not easily achieved and sets you up for failure. But getting out of your apartment and going for a 10 minute walk may be a good first step. (And distract yourself from unhelpful thoughts like "What's the point of a 10-minute walk?" when they occur. That's self-sabotage.) Then take credit for what you did. Reward yourself with self-encouragement and praise, a phone call to a friend, or a half hour TV program that you especially enjoy.

The best part is that it's easy to remember the two-word phrase: Avoid avoiding. If you practice, it's guaranteed that you'll increase your feelings of mastery and accomplishment which in turn will help you feel better about yourself overall.

Coping with Postpartum Depression

Antonia Pieracci, PhD

While the birth of a child is an exciting and wonderful event, many women feel other, negative emotions following childbirth including feeling sad, irritable, down, anxious and moody. These “baby blues” are extremely common. In fact, up to 80% of mothers experience these mood issues for up to two weeks. However, when the baby blues don’t go away and interfere with your life you must seek help. Postpartum depression affects 10-20% of women following childbirth. Although it can be difficult for moms to admit to their depression, it’s important to talk about and get help so that you and the baby both thrive after the birth.



Psychotherapy, light therapy (through daily use of a light box) and/or medication are all effective treatments for postpartum depression. Cognitive-behavioral therapy, a short-term psychotherapy, is proven to be effective for depression. In addition to these treatment options, here are some ways to boost your mood:

- **Get out of the house.** Brisk walking with your baby in a stroller or sling can trigger the release of mood-enhancing chemicals. Joining a mother’s group through your hospital or local YMCA can provide the opportunity to share your experiences. It’s important to be active and social despite your mood.
- **Enlist support from family members and close friends you trust.** Help could range from watching the baby to household chores. You can also hire a babysitter or housekeeper to help, even for just a few hours a week. Remind yourself that

mothers have to take care of themselves in order to be good mothers.

- **Make a childcare schedule.** If you have a spouse or family member who can help, then clearly map out who is with the baby at what times. Make self-care a priority by scheduling time where you’re not on duty and you can get a nap or have tea with a friend.
- **Set limits on visitors.** Your friends and family will all want to visit you after the baby is born and while it’s important to socialize, it can also be burdensome. Let visitors know in advance that it will be a short visit. Enlist your spouse in helping you get visitors out the door in a timely fashion.
- **Get help with breastfeeding.** There are great resources in every hospital and community. Lactation consultants are trained specialists who will come to your home to help with breastfeeding issues. However, if you use formula, then let go of the guilt. The differences in health and development between babies who are breastfed and those who are formula-fed are small. Nurturing your child is the most important thing you can do as a mom, whether it’s through the breast or the bottle.
- **Strive to be a “good enough mother” rather than a “perfect mother.”** Your love and care goes a long way in providing your newborn with the building blocks to healthy development. If you reserve a little energy for yourself (and maybe even for your spouse) it will benefit both you and the baby. Take care of yourself so you can not only nurture, but enjoy your new baby.

Changes: The Good, the Bad, and the Difficult

Laura Oliff, PhD

Psychologists often recommend that parents adjust their behavior to accommodate their child’s developmental level. However, what do you do when your child becomes a “young adult” and the rules no longer apply? Your child still needs you, but in a different way.

Parents must assume a new role in their child’s life, a role that encourages their child’s growing independence. Becoming a consultant or coach on adulthood involves shifting the focus from arranging the details for your child to consulting with them and allowing them to determine their own outcomes. Parents must allow their children to act on their own behalf so they can become more confident and competent in their handling of different life situations. Living apart from each other means your rela-

tionship will have to rely on good communication to keep it strong. Following a few guidelines could make this easier for both parents and their maturing children.

- Try not to give advice too quickly. Give your child a chance to tell you about the situation and express their own feelings about it.
- It’s more important to be a good listener for your child than to always have the “right” solution. Also, Listen without judgment or your child may not confide in you next time.
- Offer assistance if needed, but define exactly what it is that you are going to do on their behalf and get their permission or agreement.

For Licensed
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Professionals

AICT Offers:

Professional
Training
Program in CBT
-20 Weeks of
Training
or
-40 Weeks of
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Weekend
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Workshops,
Please Call
(212) 308-2440
Or visit
Our Website

- Remain positive with your child and do not share too much of your personal sadness. Find additional support from other parents, friends, or colleagues

Once your child leaves for college, you will have much more time than you may know what to do with. Reinvest your energy in some of the things you enjoyed before your child became the center of your life. Or explore new individual interests or activities you and your partner can engage in together.

Collaborative Problem Solving and the Power of Empathy

Courtney Rennie, PhD

By the time you've even considered bringing your child to a therapist, you are probably worn out from frequent battles with your child that may have severely depleted your reserves of compassion for them when they are "acting out", as well as your sense of efficacy as a parent. When parents begin to experience compassion "burn out" towards a child with challenging behaviors, a very important aspect of the child's behavioral difficulties tends to get overlooked: Why are they getting so upset in the first place? In the Collaborative Problem Solving approach to treatment, parents are coached how to elicit their child's concerns and empathize with their experiences during non-crisis moments when both parent and child are feeling relatively calm. The emotional information gathered during these conversations is then implemented proactively to plan solutions to frequently occurring or typical problematic situations.



There are three main steps to collaborative problem solving with your child:

Step 1: Be Empathic: Reflect, Reflect, and Reassure

Feeling heard and understood is a universally good feeling. It can be even more meaningful for a child who does not quite know how to label what they are feeling or are used to adults and peers being turned off by their ways of expressing distress and frustration.

Child: "I don't want to do my homework when I get home!"

Adult (reempathizing): "You don't want to do it when you get home. How come?"

Child: "Because I'm tired...I need a break."

Adult (reempathizing): "Let me make sure I've

got this right...you don't want to do your homework right after school because you're tired and you need a break. Yes?"

Child: "Right!"

Adult (reassurance): "Ugh! That must feel so hard every day after school to feel so tired and to need a break and not get one."

Step 2: Do Define the Problem, Don't Jump to Solutions and Conclusions

So often the "problem" becomes your child's method of expressing his/her frustration and the actual content of their dilemma gets overlooked. The experience of clarifying what your child's complaint is and communicating what your concern as the parent is helps your child with their problem solving and perspective taking skills.

Adult (defining the problem): "So you feel tired and need a break after school and I'm really concerned that if you don't do it right after school it won't get done."

Child: "Yeah."

Step 3: Invite Your Child to Brainstorm

When parents move in too quickly to solve conflicts or focus exclusively on disciplining their children when they are emotionally reactive, significant opportunities for their children's emotional and cognitive growth are missed. Involving your child in considering solutions that are both feasible and mutually satisfactory can really pay off in the long run in terms of improving your child's underlying problem solving abilities.

Adult: "Do you want to try to think how we can solve this homework problem?"

Child: "Yeah. I know! Maybe I could do homework after some ice cream."

Adult: "That's an idea. But you know what, I'm still concerned that if you eat ice cream every day before homework that you'll have a harder time concentrating. What if we looked at your after school schedule and made a plan for quiet time and then a specific time when you start your homework?"

Child: "Okay. What about if I get to play for an hour after school and then start my homework at 4:30PM?"

Adult: "Sounds like a good plan to me. Let's try it starting tomorrow and see how it goes."

For more information, see these resources:

The Explosive Child (2005) by Ross W. Greene, Ph.D. and www.thinkkids.org

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

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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 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.

Lisa A. Napolitano, Ph.D., Senior Supervising Clinician, (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. Tirsch, Ph.D., Director of Education. Dr. Tirsch serves as an Adjunct Associate 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 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, received her PhD in clinical psychology at Vanderbilt University. Dr. Caron completed a pre-doctoral internship at Columbia University Medical Center, and stayed on to become faculty of the New York State Psychiatric Institute at Columbia. Dr. Caron is trained in cognitive behavioral therapy with children, adolescents, and adults, and specializes in individual therapy for mood, anxiety, behavior disorders, as well as family interventions, parenting consultation, and parent training. Dr. Caron also has expertise in CBT for insomnia, and has experience working with families affected by medical conditions such as HIV and cancer. She has authored professional articles and book chapters on CBT and other empirically-supported psychotherapies for children, as well as studies examining the relationship between parenting and child problems.

Jonathan Kaplan, Ph.D., Director of the Stress Management Program, earned his doctoral degree in Clinical Psychology from UCLA. 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. Last year, he won an award from the American Psychological Association for his work in this area. He specializes in treating depression and anxiety and providing therapy to couples.

Antonia M. Pieracci, Ph.D., Senior Supervising Clinician, earned her graduate degree from Temple University. She completed her postdoctoral fellowship at The American Institute for Cognitive Therapy. Dr. Pieracci specializes in the treatment of mood disorder.

ders, anxiety and eating disorders. Her treatment incorporates cognitive, behavioral, mindfulness, and acceptance techniques. She also has expertise in pregnancy and postpartum issues. Dr. Pieracci has received training in Dialectical Behavior Therapy and Acceptance and Commitment Therapy. She is also an Adjunct Clinical Supervisor in the Ferkauf Graduate Program in Clinical Psychology.

Courtney Rennieke, Ph.D., Assistant Director of Child and Family Treatment (Ph.D., Columbia University) Dr. Rennieke has expertise working with children, adolescents, families, and adults with experience in treating depression, bipolar, anxiety, ADHD, and disruptive behavior disorders, as well as mental health issues secondary to bereavement, adoption, and medical conditions. Dr. Rennieke is trained in CBT, interpersonal psychotherapy, emotion-focused therapy, collaborative problem solving, and dyadic developmental therapy. Dr. Rennieke is an Adjunct Professor in the Ferkauf Graduate School for Psychology at Yeshiva University and has co-authored professional articles on trauma and resiliency, as well as on bipolar disorder and creativity.

Doris Chang, Ph.D., Clinician, received her doctoral degree in clinical psychology from UCLA 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.

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 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, Ph.D., Clinician, received his doctoral degree in Clinical Psychology at Teachers College, Columbia University. Mr. Fazzari 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 CBT for mood, anxiety, and personality disorders.

Samantha Monk, M.A., Clinician, received an M.A. in psychology from Hofstra University. Ms. Monk is currently pursuing a doctoral degree in clinical and school psychology at Hofstra University, where she has received training in CBT, mindfulness meditation, and acceptance and commitment therapy. Ms. Monk serves as a clinician at Hofstra University's Psychological Evaluation Research and Counseling Clinic, where she provides individual psychotherapy to adults, children and adolescents. Ms. Monk's clinical interests focus on the application of traditional cognitive-behavior therapy, acceptance and commitment therapy and dialectical behavior therapy in the treatment of depression and anxiety.

Meredith Perlman, M.A., Clinician, received her Masters in Psychology from Yeshiva University's Ferkauf Graduate School of Psychology, where she is currently in her fourth year of doctoral training. Previously, she treated patients within both the general and PACAP (Psychiatric Ambulatory Clinic for AIDS Patients) divisions of Montefiore Medical Center's Adult Outpatient Psychiatric Department. Meredith also worked in the Adolescent Unit of Albert Einstein College of Medicine, conducting assessments and therapy with teenagers carrying a range of diagnoses, including depression, anxiety, Asperger's Disorder, and ADHD. She is currently completing her dissertation, which concerns early learning experiences and emotion regulation skills among obese patients seeking bariatric surgery.

Rachel K. Gerstein, M.A., Clinician, graduated Cum Laude with a B.A. from the University of Pennsylvania. She earned her M.A. from Temple University, where she is currently working towards her Ph.D. in Clinical Psychology under the mentorship of Dr. Lauren Alloy. At Temple University, Rachel was awarded a University Fellowship for 2 years. Clinically, Rachel has experience in Cognitive-Behavioral Therapy, Acceptance and Commitment Therapy, and Dialectical-Behavioral Therapy. Rachel is currently working on her doctoral dissertation, entitled "The Long-Term Course of Bipolar Disorder: Applications of the Behavioral Approach System (BAS) and Cognitive Vulnerability-Stress Models."

Konstantin Lukin, M.A., Clinician, is currently in his fourth year of doctoral training. He has extensive training in the area of neuropsychological and personality assessment as well as cognitive behavioral treatments for variety of psychiatric disorders. Mr. Lukin has had experience with leading groups within the cognitive behavioral framework and extensive training in individual therapy with children and adolescents at Four Winds Hospital. Currently, Mr. Lukin was a research associate

at New York State Psychiatric Institute responsible for the overall conduct of treatment study. Presently, Mr. Lukin is a clinician at Bellevue Hospital focusing on disruptive disorders.

Helen Butleroff Leahy, RD, CDN, offers nutrition counseling specializing in weight management, eating disorders, Type II Diabetes, GERD, IBS and medical conditions requiring nutritional intervention. Ms. Butleroff Leahy is a Registered Dietitian by The Commission on Dietetic Registration and Certified Dietitian Nutritionist licensed by NYS. She is winner of the "Certificate of Achievement Award" and "Activ8 Kids Mini Grant" from the NYS Department of Health for her nutrition program targeting obesity in NYC public school children. Ms. Butleroff-Leahy gives nutrition presentations for the outpatient Psychiatric Clinic of New York Presbyterian-Cornell Hospital, for state legislators, United Nations Health forums, law firms and has been employed by GHI for TV segments on portion control, dehydration and healthy lifestyle choices. She also runs "The Nutrition & Fitness Education Initiative" that has now reached 2100 NYC school children.

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 also pursuing her Masters in Psychology at Hunter College.

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.

Roselyn Scavuzzo, B.A., Intake Coordinator, graduated Summa Cum Laude from Stony Brook University. At Stony Brook, she researched the effects of the Internet, technology and real-time communication on the tutoring of writing and other educational methods. For her honors senior thesis she developed a proposal for adolescent bereavement groups supplemented by online social networking. She is also founder of the Alternative Spring Break Outreach program which promotes critical thinking, social action and civic engagement by combining education and reflection with direct service opportunities for college stu-

CBT: It's far more than a "Quick Fix"

Dennis Tirch, PhD

Many patients come to AICT after reading about the impressive body of research supporting the effectiveness of cognitive-behavioral therapy (CBT). When first learning about CBT, a few aspects of the therapy tend to stand out. Patients often learn that this form of therapy is time-sensitive, that it focuses on the present, and that it uses specific techniques to help solve certain problems. As a result, some patients may arrive for therapy expecting a short-term approach that doesn't address their past. Some patients may even think that CBT doesn't examine the "deeper issues" involved in human psychology. These patients are often surprised to discover the depth and breadth of CBT perspectives. Far from only offering a "quick fix" for "superficial" problems, the evidence-based techniques found in CBT have been designed to address the whole person, across a wide range of dimensions.

CBT begins with an initial assessment that examines the patient's personal history, individual aims, and, of course, the current problems being faced. A cognitive-behavioral therapist will use this information to develop a unique conceptualization of how to best help their patient. Since CBT is solution focused, the patient and therapist work as a team to develop goals to pursue in therapy. The range of topics that can be addressed is remarkable. For example, some patients might use CBT to change deep beliefs that have troubled them since childhood, while others might work with a cognitive-behavioral therapist for personal coaching in developing effective organizational and decision-making strategies. Still others might come to CBT to learn to regulate their emotions, or to process the grief of a sudden break-up. Some patients may come to CBT for just a few sessions to address a phobia, while others may work with their cognitive-behavioral therapist over a longer period to master their "deeper" fears and conflicts, while pursuing their most valued goals.

A visit to the AICT website (<http://www.cognitivetherapynyc.com>) will reveal the wide range of topics that CBT can be used to address. Research has demonstrated that CBT can effectively treat significant psychological problems in a relatively short period of time. Nevertheless, cognitive-behavioral therapists treat people, not disorders. The therapists at AICT have been trained to take the whole person into account, and to integrate techniques from across many different disciplines within cognitive and behavioral therapies. Beyond a "quick fix" CBT may offer the patient a powerful way to understand and transform their state of mind in pursuit of a life well lived.

relating to each other; (2) clarifying their understanding of each other; and (3) communicating in ways that are healthy, respectful, productive, and underscore shared difficulties. Here are a few therapy interventions that have been shown to help couples like Pat and John:

Positive Activities

Research indicates that early divorce is predicted by specific, negative characteristics during arguments, while later divorce is predicted by the absence of positive emotions. In both situations, couples can benefit from doing more mutually satisfying activities together. Often however, it is necessary first to learn more about the meaning that each partner attaches to potential activity. Pat and John, for example, normally liked going to movies together, but Pat came to see these outings as a way for John to "escape" conversations. Pat felt disappointed whenever he suggested going to a movie. John, in turn, became confused and angry when he saw Pat getting sad about his idea of something to do for fun as a couple. Thus, it first was necessary to explore what "going to the movies" meant for each person before it became a jointly pleasurable experience.

Mutual understanding

Everyone has certain standards and expectancies for relationships as well as explanations about the other partner's behavior. While these thoughts ultimately shape how each person experiences the relationship, they're often incorrect or biased by selective attention. In therapy, Pat and John expressed and examined their assumptions about each other and the relationship. For example, during arguments, John believed that Pat purposefully was trying to attack him and wouldn't "cut him any slack." By examining his beliefs in conversation with Pat, he realized that Pat felt very scared and worried about losing him, which prompted the relentless efforts to engage him. He came to feel more sympathy for Pat's concerns as opposed to resentment.

Healthy communication

Sometimes, couples to learn how to make decisions and solve problems together. More often, couples need help in learning how to discuss perpetual, ongoing problems in constructive ways. Pat and John? They argued a lot about sex. John wanted more, while Pat felt "too pressured." As soon as they learned to recognize when their differences were becoming a problem, they avoided the usual arguments and developed an empathic connection that naturally led to sexual intimacy.

Couples Therapy: Overcoming Difficulties and Strengthening Relationships

Jonathan Kaplan, PhD

Soon after Pat started living with John, they started arguing about money, sex, and household responsibilities. Coming from a large family in which one had to compete for attention, Pat was accustomed to discussing problems openly and often got into loud arguments, which soon blew over. John loved Pat's expressiveness, in part because it was such a departure from his family's tendency to harbor simmering resentments. However, in their arguments, he typically was overwhelmed by Pat's assertive—and at times, aggressive—style. He withdrew from

such discussions, which only prompted Pat to get angrier and louder. While loving John's ability to "keep a cool head" in stressful situations, Pat considered him to be dismissive and unemotional when he did not try to work out problems together.

Pat and John are not unique. In any relation-



ship, conflict is inevitable. Fortunately, there are ways to help partners resolve conflicts and re-affirm their commitment to each other. Cognitive behavioral therapy provides specific strategies to help partners improve their relationship by (1) changing their ways of