AMERICAN INSTITUTE FOR COGNITIVE THERAPY

136 E. 57TH STREET, SUITE 1101
NEW YORK, NY 10022

PHONE: (212) 308-2440

# Cognitive Therapy

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## Do We Live in The Age of Anxiety?

### Robert L. Leahy, PhD

In any given year, 16.4 % of Americans will have an anxiety disorder—a rate that is twice the number of people with depression. Forty million Americans are suffering from some kind of anxiety disorder and, over their lifetimes, 28.8% will have an anxiety disorder. Almost 50% of us will have a history of a psychiatric disorder during our lives. Anxiety is not good for your health. People with panic disorder are more likely to have mitral valve prolapse, hypertension, peptic ulcer, diabetes, angina or thyroid disease. In fact, men who have anxiety disorders are also at greater risk for cardiac disorders, hypertension, gastrointestinal disorders, respiratory illness, asthma, and back pain. Women with anxiety disorders are more likely to have a history of cardiac problems, hypertension, metabolic, gastrointestinal, dermatological, respiratory disorders and arthritis.

Anxiety begins early—and gets worse as children get older. The average age at which adults report they first had an anxiety disorder is eleven. About 16% of kids have an anxiety disorder. And when kids have anxiety problems it impacts on their future development. They have more difficulty in school, more days absent, more problems with their friends. And their anxiety is likely to result in a lifetime risk of anxiety--- eventually they become anxious adults.


Anxiety is costly. In 1990 the cost due to anxiety disorders was 46.6 billion dollars. About 32 % of the cost of treating all psychiatric problems is for the treatment of anxiety. People with anxiety disorders are less productive at work and are more likely to use medical services or visit emergency rooms. People with an anxiety disorder are three to five times more likely to visit a doctor. In fact, people with panic disorder are five times more likely to receive disability payments because they are unable to work. Anxious people are continually visiting their general practitioner complaining about vague physical problems. They are more likely to have gastroenterological problems (like irritable bowel syndrome), fatigue, aches and pains, asthma, and other medical problems.

*Continued on pg. 2*

## Stress and Stress Management: Top 10 Lies that We Tell Ourselves

### Jonathan Kaplan, PhD

**10. Stress is bad.** Sure, excessive levels of chronic stress has been linked to a myriad of physical, psychological, and behavioral problems, including hypertension, depression, and substance abuse. However, we also need stress in order to survive and perform well. Stress is what helps us go to work, pay bills, and get out of the way of that speeding taxi cab!

**9. My stress would disappear if I had more money.** Research has demonstrated consistently that money is not the key to happiness or stress-free living. Once we've met our basic needs, then having more money does little to improve our inner lives. Giving away money, on the other hand, does makes us feel better.

**8. I don't have time to relax.** Nonsense! As long as you're breathing, you can relax. The trick is finding ways to manage stress that fit effectively with your current lifestyle. Maybe you can't spend an hour daily in meditation, but you can certainly practice relaxation breathing or improve your diet, even when you're trying to meet a tight deadline!

*Continued on pg. 2*

***Continued… Top 10 Lies that We Tell Ourselves about Stress and Stress Management***

**7. I can't relax.** All of us are capable of relaxing, but our methods differ. Some people enjoy sitting in meditation or practicing mindfulness. Others need to be more active, and pursue relaxation through sports, volunteering, or other activities in line with their values.

**6. Stress doesn't bother me: I can take it!** Whether you believe you can manage excessive levels of stress well (or take some amount of masochistic pride in being overwhelmed) doesn't really matter. Physiologically, stress is taking a toll on your health, and gradually shortening your life expectancy. Plus, you might be taking things out on people around you. As you're stressed, you're more likely to be irritable and get into conflicts with friends, family, and colleagues.

**5. I know exactly what I need to do in order to feel better.** This might be the case. However, it's not sufficient. Recent evidence has shown that our brains get locked into perpetuating unhealthy and ineffective patterns when we're overstressed, despite our best intentions. Thus, we need to exert more effort and solicit more support if we're going to make any substantive changes.

**4. I need stress in order to do what I do.** This is a half-truth. As I mentioned earlier, we do need a certain level of stress in order to function well and be "at the top of our game." However, the issue is related more to performance, efficiency, and effectiveness, than stress per se. Finding ways to excel at what we do is essential; maintaining an excessive or high level of stress is not.

**3. I just need a vacation.** Once we get past the traveling itself, vacations can be quite enjoyable and pleasant. However--like all good things--they must come to an end. And, typically, we come back to a mountain of work and messages that have piled up in our absence. Say goodbye to all of that relaxation! What we need is not intermittent respites, but rather ongoing ways to maintain our health and well-being.

**2. All I need is a new job, girl/boyfriend, or apartment (or whatever), and I'll feel better.** We continually ignore the multiple factors that contribute to our stress. Changing any one thing is not likely to lead to any long-lasting improvement. Indeed, our fantasies about how much better things would be are not only false, but we also have to deal with our corresponding disappointment when our lives are not drastically better!

**1. I don't need therapy for stress management.** A lot of our stress is determined by negative thinking and unhealthy ways of interacting with the word (like poor time management). It's not as simple as starting to meditate (how's that coming by the way?). Typically, we need more explicit guidance in making progress in these areas, and therapy for stress management can help.

*Jonathan Kaplan, Ph.D.*
*Director of Stress Management Program*

***Continued… Do We Live in The Age of Anxiety?***

And it's getting worse. Rates of overall anxiety have dramatically increased during the last forty years. The most dramatic increase in rates of anxiety occurred between 1952 and 1967, but continued to rise for the 1970's and 1980's. In fact, the average child today has the same level of anxiety as the average psychiatric patient in the 1950's. Why such a major increase in anxiety over the last fifty years? Aren't people better off financially? Aren't houses bigger, vacations more luxurious, and don't people live longer? Why so much anxiety and worry? Much of this increase in anxiety is related to the decrease in "social connectedness". People feel that their connections with other people are less stable, predictable and controllable. There has been an increase in divorce, fewer people are getting married, there's a decrease in participation in community activities and organizations, and job security is less of a sure thing. People don't feel they can count on their pensions when they get older---a more serious problem as more people look at their aging parents and grandparents and wonder how they will ever be able to get care for themselves when they get to their senior years. And people are living alone more ---with less support from family, friends and neighbors. In 1950 only 9.3% of households consisted of people living alone. The figure now is 26%. Living alone may give you greater autonomy, but it also leads to loneliness.

Psychologically, we have been changing as well. The increase in anxiety is linked to the belief that external events –rather than the self---control what happens to us. Rather than thinking, "I can make things happen", we are more likely to think today, "Things happen to me". Our sense that we are in charge has been replaced by a sense that the world controls us—and that we have less influence on what happens. We don't feel like we have as much control as our parents or grandparents felt they did. Things "happen to us"—we think. This makes us more anxious.

In addition, the demands of life have become more difficult for us. Even though we are financially much better off today than

# Treatment for Obsessive Thoughts

## Dennis Tirch, PhD

Obsessive-Compulsive Disorder (OCD) is a psychological condition that can be as confusing as it is distressing. Although it is technically an "anxiety disorder", the chief feature of OCD is a steady stream of bizarre or disturbing thoughts, that show up in the mind like a host of unwanted guests. Although the content of such thoughts varies across people and across time, the themes are routinely unnerving. Visions of contamination, fears of losing one's grip on one's mind, or an obsessive focus upon "sinful" thoughts are just a few of the curious themes that unfold in the mind during periods of struggle with OCD. Following the "intrusion" of these unwanted thoughts, people with OCD often neutralize their thinking by washing, checking, repeating, undoing, ordering, praying, seeking reassurance and other strategies. These thoughts can flow so steadily and relentlessly, that life can seem to be a constant struggle. But, it doesn't have to be that way.

If you have OCD you may have some of the following beliefs about your intrusive thoughts:

- They are personally relevant ("This says something about me")
- If I have these thoughts, they will lead me to act on them ("Thought-Action Fusion")
- They need to be eliminated or controlled
- I need to watch for these thoughts and catch them early
- I have a responsibility to neutralize these thoughts
- If I get reassurance, I can feel better
- I should feel ashamed or guilty because I have these thoughts

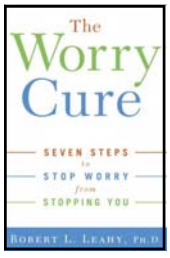
Evidence-based treatments, such as cognitive-behavioral therapy (CBT), have gradually unlocked many of the mysteries of OCD, through decades of clinical research and practice. CBT has proven itself to be the "gold-standard" among psychotherapeutic treatments for OCD in clinical trials.

A remarkably effective technique, known as Exposure and Response Prevention (ERP), is at the heart of CBT for OCD. ERP involves approaching, rather than avoiding, the objects, places, and ideas that trigger their anxiety. Instead of attempting to suppress or neutralize your anxious thinking, you learn to stay in the presence of the distress, with a full willingness to experience it without counterproductive defenses. This may sound challenging- and in some ways it can be. Nevertheless, ERP can reliably help you overcome your OCD symptoms—especially your fear of your own thoughts--and greatly improve the quality of your life.

At AICT, ERP is conducted in a collaborative and supportive way, with both the patient and therapist working together to craft a gradual, accessible path to mastery of distressing thoughts and compulsive behaviors. Patients often start with small steps, engaging in exposure to situations that they fear relatively little and, in time, face even those things that they fear most. Step-by-step, a patient with OCD will learn to observe their anxious thoughts, to notice troubling physical sensations and urges, and to tolerate difficult emotions, while acting productively in the real world. In this way, the patient comes to understand that the events that take place in their mind need not tyrannize them. Hours spent washing hands or searching the internet in the grip of compulsive behavior can be reclaimed, and spent in the pursuit of a life well lived. In addition to ERP, clinicians here at AICT employ a range of CBT techniques to help master obsessions and compulsions. Training in mindfulness meditation, self-compassion, and rationally responding to troublesome thoughts, are just a few of the techniques that you can learn to apply to your OCD. The promising news is that OCD can be treated effectively with new techniques that may often seem counter-intuitive.

*Dennis D. Tirch, Ph.D.*
*Director of the OCD Treatment Program*

our parents were, we believe that we need more than we have and we don't believe our future prospects are that good. The sense of "not living up to what we need" is reinforced by magazines that tell us how perfect we could look and how great our lives could be--- if only we got our act together. If we did the right thing and bought the right product—we might be happy. We didn't always have these expectations and troublesome "opportunities". In the 1950's you bought a pair of blue-jeans, but today you have a variety of choices, each of which makes you feel that the one you finally picked might not be the "best". As we have more and more choices, we become less and less satisfied—because we are continually wondering if we chose the right thing. Our standards of beauty, our expectations of success, our demands for continual and unrelenting happiness leave us dissatisfied in a world where we are getting fatter on junk food and labor-saving devices, and we purchase another self-help book promising a panacea of permanent happiness, weight-loss and fulfillment. We are victims of our own expectations.




Most people who have problems with anxiety get no help---and they are likely to continue having their problems for years. As the anxiety lasts longer and longer, it often leads to depression, alcohol abuse and reduced quality of life. However, there is good news-- there are effective treatments for anxiety. Most anxiety disorders can be treated effectively with our newer forms of cognitive-behavioral therapy. Thankfully, you don't have to feel hopeless about your anxiety. Newer forms of cognitive-behavioral therapy can empower you to cope more effectively, with less worry, more serenity and better tools to make your life what you want it to be.

*Robert L. Leahy*
*Director*
*Author: Anxiety-Free: Unravel Your Fears before they Unravel You and The Worry Cure: Seven Steps to Stop Worry from Stopping You*

# The Binge-Purge Cycle in Eating Disorders

Ilyse Dobrow DiMarco, PhD

Many individuals suffering from eating problems experience an unrelenting cycle of binge eating and purging. Dr. Christopher Fairburn at Oxford and others have worked to understand how and why the binge-purge cycle is maintained. They have found that most people with eating problems, regardless of what form these problems take, tend to display similar types of thinking about themselves. They place an excessive emphasis on the importance of their bodies, believing that the key to their self-worth lies in their ability to reach an ideal shape and weight. In order to achieve their ideal (and usually unattainable) shape and weight, they set exceedingly strict dietary rules for themselves. Unfortunately, it is impossible to adhere to such strict rules, which causes people to feel that they have "failed" in their efforts. In response to this, they might temporarily abandon their strict rules and binge-eat, experiencing a loss of control over what and how much they are eating. Binge eating often leads to extreme feelings of guilt and a renewed focus on shape and weight and strict dieting. Further, to compensate for their binge eating, individuals might purge, either by inducing vomiting or using laxatives or diuretics-- or even by engaging in excessive amounts of exercise. Individuals with eating disorders tend to think that purging is an effective way of compensating for binge eating, so they believe that it is OK for them to continue to binge eat in the future. And so the binge-purge cycle continues. In reality, however, purging is not very effective. Studies have shown that vomiting can only eliminate a maximum of 50% of the calories a person has consumed.

How can Cognitive Behavior Therapy (CBT) help break the cycle?

As you can see, the binge-purge cycle is about a lot more than just disordered eating. It is also about disordered thinking--namely, how one's beliefs about the importance of attaining an ideal shape and weight affect one's eating behaviors. In cognitive-behavioral therapy for eating disorders, both disordered eating behaviors and disordered thinking patterns are targeted.

Treatment strategies include:

- Education about eating disorders and how the binge-purge cycle is maintained
- Establishing a regular pattern of eating through regular self-monitoring of eating patterns
- Exploring the triggers for episodes of binge eating and finding alternative methods for coping with these triggers
- Discussing the origins of one's overemphasis on shape and weight and finding alternative ways to evaluate oneself
- Reintroducing "forbidden foods" into one's diet
- Addressing frequent checking of one's body shape or one's tendency to avoid looking at one's body
- Targeting interpersonal problems, low self-esteem, and/or perfectionism, if any of these factors appear to be maintaining eating disordered behaviors

There is now a large body of research indicating that CBT for eating disorders, including Anorexia Nervosa, Bulimia Nervosa, and Binge Eating Disorder, is very effective. In CBT, individuals with eating disorders work collaboratively with their therapists to develop a treatment plan that targets their specific eating problems. Treatment is designed to be relatively short-term, with a focus on the maintenance of eating problems, not the potential origins of these problems.

*Ilyse Dobrow DiMarco, Ph.D.*
*Associate Director of Eating Disorders Program*

# Parenting Your College-Age Students

Jonathan Kaplan, PhD

As parents, our work does not stop once our kids leave for school. Sure, we have some extra time to contemplate converting their bedroom into a study or sewing room. However, even though they might not be physically present, they continue to need our support--and I don't just mean financially!

A 2009 study by MTV and the Associated Press indicated that 85% of college students experience stress on a daily basis. The "Top 3" most stressful areas included school work (77%), grades (74%), and financial woes (67%). Given today's economy, it's not surprising that many students reported concern over finances. In fact, over 50% were worried that they would not find a job after graduation.

Regrettably, the combination of stress and a critical developmental period can lead many college students to develop a psychiatric disorder. In the MTV/AP survey, 10% of students reported symptoms of moderate to severe depression. In addition, epidemiological studies have shown that some forms of mental illness (including bipolar disorder, schizophrenia, and eating disorders) commonly first appear during the ages of 18 and 24.

Fortunately, the news is not all bad. The MTV/AP survey reported that 74% of students described themselves as "very" or "somewhat" happy, and--you'll be happy to hear this--82% believed that their college education was worth the time and money.

So, what can we do? We can't be there all the time, nor should we be. This is the time for our children to become adults in a relatively safe, protected environment, which means that they need to take responsibility for dealing with a lot of issues and difficulties. However, we can help them by offering advice and support, and become more involved

## Do's and Don'ts of Separation and Divorce

**Laura Oliff, PhD**

The divorce rate in the United States has increased to almost fifty percent of marriages. When couples separate, the process that ensues is difficult for everyone involved. Some basic principles are important to remember once you have arrived at this decision.

- Negotiate your own disagreements when possible rather than allowing a judge to decide for you. Schedule time-limited meetings, about a half hour to start, with one or two specific issues to discuss. Start with the easier topics and save the more contentious matters for later. Remember, this is not the time to complain or blame your partner. This is the time for compromise and to find a solution that benefits both individuals.
- If children are involved, both parents should be present when they are told about the separation. This process demonstrates that both parents will continue to love and care for them. Talking to all the children at the same time also helps the kids feel closer to each other as they express their own complex feelings and ask questions.
- Tell your children the truth about what led up to the separation. Lying or minimizing your conflicts can lead to confusion and distrust. Strive to be direct but not judgmental. For instance, stress that both parents have been disappointed or hurt in their own way and that both of you have experienced pain.
- If you are angry, acknowledge it without expressing rage or blame. If you blame the other parent, you put your kids in the position of choosing sides. Instead, assure them that they will continue to have the love of both of their parents.
- Emphasize that the children are not responsible for the problems their parents are having. Explain that you are divorcing each other and not the kids. Tell your children that you have made a careful decision to separate and that you are unlikely to change your minds. It may also be helpful to tell them about attempts you've made to reconcile your differences such as marital therapy.
- Encourage your kids to ask questions and express their feelings openly. They may not need answers as much as they need to know you're listening. Even as a single parent, you may want to consider monthly family meetings with your kids just to ask how they are doing and if you can do anything to make it easier for them.
- Do not become defensive when your children point out things you've done that have been problematic for them. If you respond in a hurt or angry way, your children will be less likely to confide in you in the future.

*Laura Oliff, Ph.D.*
*Associate Director of the Institute*
*Director of Couples Therapy Program*

should matters become too overwhelming for them.

Here are a few additional suggestions:

- Stay in touch with your son or daughter in their preferred mode of communication (e.g., e-mail, text, etc.). Avoid "friending" them on Facebook or MySpace however, unless you want be horrified.
- Be on the lookout for signs that indicate that your son or daughter might be developing a psychiatric disorder, like significantly low (or high) energy, sleep disruption, change in appetite, and a sudden increase/decrease in communication or spending.
- Review your own family mental health history. Our genetic make-up reflects our likelihood to develop psychiatric disorders. So, if you know that a particular problem runs in your family (like anxiety, depression, bipolar disorder, etc.), you can be more aware of its potential development in your children. Now might be the time to talk with them about this issue, too.
- Encourage your son or daughter to learn more about the university counseling center. In the MTV/AP poll, less than half of the students knew about the counseling center, and only 20% indicated that they would seek help there, if necessary. College counseling centers typically offer therapy and wellness-based programs, like meditation and stress management groups. Often, they provide emergency services and facilitate medically based leaves of absence too, when necessary.
- Contact the counseling center or residential life office yourself. If you're worried about your son or daughter, you can call these offices to learn more about the kinds of services offered. Sometimes, they can check-in with the student directly. Be judicious about asking for this however: how would you feel about getting a call from a psychotherapist "out of the blue"?
- Don't push counseling if your child is ambivalent. Generally speaking, young people today are more savvy than ever about mental health issues. (Check out the MTV sponsored website, www.halfofus.com, if you disagree.) So, they are more likely to seek counseling when they think it will help. Making them aware of resources and helping them consider various options is usually the best course of action, if they're unsure of talking with a counselor.

*Jonathan Kaplan, Ph.D.*
*Director of Stress Management Program*

# AICT STAFF

**Robert Leahy, PhD**
***Director***

**Laura Oliff, PhD**
***Associate Director***
***Director of Couples Therapy Program***

**Dennis D. Tirch, PhD**
***Associate Director***
***Director of OCD Treatment Program***

**Rene D. Zweig, PhD**
***Director of Eating Disorders and Weight Management Program***

**Ilyse Dobrow DiMarco, PhD**
***Associate Director of Eating Disorders and Weight Management Program***

**Jonathan Kaplan, PhD**
***Director of the Stress Management Program***

**Helen Butleroff-Leahy, RD, CDN**
***Nutritional Counselor***

**Clinicians:**
**Ilana Dworin, MA**
**Danielle A. Kaplan, PhD**
**Konstantin Lukin, MA**
**Mia Sage, MA**
**Agnes Selinger, MA**
**Karen Silver, MA**
**Jenny Taitz, PsyD**

**Staff:**
**Poonam S. Melwani, BA**
***Research/Editorial Assistant***

**Kelly J. Reilly, BS**
***Intake Coordinator/Research Assistant***

**For Complete and Detailed Staff Bios, please visit:**
***www.cognitivetherapynyc.com***

Robert L. Leahy
Director

**Robert L. Leahy, Ph.D., Institute Director** (Ph.D., Yale) has authored and edited seventeen books on cognitive therapy and psychological processes. He is the President of the Association for Behavioral and Cognitive Therapy (ABCT), Past-President of the International Association for Cognitive Psychotherapy, Past-President of the Academy of Cognitive Therapy and Clinical Professor of Psychology in Psychiatry at Weill-Cornell Medical School. He is the Associate Editor of the International Journal of Cognitive Therapy. His book, *The Worry Cure*, received critical praise from the New York Times and has been selected by Self Magazine as one of the top eight self-help books of all time. His new book, *Anxiety-Free: Unravel Your Fears Before They Unravel You*, was published in April 2009. He recently received the Aaron T. Beck Award for Outstanding Contributions in Cognitive-Behavioral Therapy. Dr. Leahy has been featured in the New York Times, Forbes, The Wall Street Journal, Fortune, Newsweek, Psychology Today, Washington Post, Redbook, Women's Health, Self Magazine, and he has appeared on national and local radio and on television (20/20, Good Morning America, and The Early Show). Read Dr. Leahy's Blog "Anxiety Files" at PsychologyToday.com.

**Laura Oliff, Ph.D., Associate Director of Institute, Director of Couples Therapy Program** (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.

**Dennis D. Tirch, Ph.D., Associate Director of Institute, Director of OCD Treatment Program,** Dr. Tirch serves as an Adjunct Associate Professor and Clinical Supervisor at the Ferkauf Graduate School of Psychology of Albert Einstein Medical School. He did his internship and post-doctoral fellowship 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. Dr. Tirch is currently co-authoring a book on emotion regulation, involving his research interest in the integration of CBT with various meditation techniques. Dr. Tirch is a Certified Cognitive Therapist and Fellow of the Academy of Cognitive Therapy.

**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. She supervises both psychology trainees and licensed professionals, and she is an Adjunct Supervisor in the Ferkauf Graduate Program in Clinical Psychology in New York City. Dr. Zweig is a Certified Cognitive Therapist through 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.

**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.

**Ilyse Dobrow DiMarco, Ph.D., Associate Director of Eating Disorders and Weight Management Program**, Clinician, (B.A., Yale University, Ph.D. Rutgers University) received her B.A. summa cum laude from Yale University and her Ph.D. in clinical psychology from Rutgers University. She completed a pre-doctoral internship at Montefiore Medical Center and continued to work there post-internship as an Attending Psychologist. Dr. Dobrow DiMarco has received extensive training in cognitive behavioral therapy for adults and specializes in the treatment of anxiety disorders and eating disorders. She also has experience treating mood disorders and relationship difficulties. She is trained in both Dialectical Behavior Therapy and Motivational Interviewing. Dr. Dobrow DiMarco has authored chapters and articles in the field of eating disorders and presented her work at numerous national conferences. Most recently, Dr. Dobrow DiMarco published her dissertation study, which found that adding a motivational intervention to a standard behavioral obesity treatment program

enhanced treatment outcomes. Dr. Dobrow DiMarco created the treatment manual for the motivational intervention and supervised therapists working on the study. Dr. Dobrow DiMarco currently supervises psychology trainees.

**Jenny L. Taitz, Psy.D., Post-Doctoral Fellow**, graduated Magna Cum Laude from New York University and earned her doctorate in clinical psychology at Ferkauf Graduate School of Psychology. Dr. Taitz is a post-doctoral fellow at the American Institute for Cognitive Therapy. She completed a pre-doctoral fellowship at Yale University School of Medicine where she specialized in Dialectical Behavior Therapy (DBT) for co-morbid substance use and personality disorders and Behavioral Health. As an intensively trained DBT clinician, Dr. Taitz incorporates mindfulness, acceptance, and motivational enhancement with traditional cognitive behavioral therapy. In addition to treating a diverse range of problems such as depression, generalized anxiety disorder, panic disorder, specific phobias, social phobia and borderline personality disorder, she also provides psychotherapy to patients with medical problems. Her research has focused on the efficacy of a self-administered mindfulness intervention and mechanisms of change in mindfulness treatments. Dr. Taitz is a psychologist in training at AICT.

**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. Concurrently, 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.

**Mia Sage, M.A., Extern,** is currently pursuing her doctorate in Clinical Psychology at Columbia University where she previously received her M.A. in Psychology in Education. Mia has been trained in cognitive-behavioral therapy (CBT), psychodynamic therapy, mindfulness meditation, and acceptance-based therapies. She is a clinician at Columbia's Dean Hope Center for Educational and Psychological Services, where she provides both neuropsychological assessments and individual therapy to adults. Mia has held research positions at Weill Medical College of Cornell University, Mclean Hospital of Harvard Medical School and the New York State Psychiatric Institute, which included extensive training in psychodiagnostic assessment and group CBT. She has experience in treating mood, general anxiety, social anxiety, panic, posttraumatic stress, sleep and personality disorders. Mia's clinical interests focus on the integration of CBT with mindfulness-based approaches.

**Agnes Selinger M.A., Extern,** is currently a 5th year doctoral student at Hofstra University's combined Clinical and School Psychology program. Agnes has also received a Master's degree at New York University in Clinical Psychology. Agnes is primarily trained in cognitive-behavioral therapy and is familiar with Dialectical Behavior Therapy and Acceptance and Commitment Therapy. She is a clinician at the Bio-Behavioral Institute in Great Neck, NY providing individual and intensive treatment to individuals with obsessive-compulsive disorder and body dysmorphic disorder. She has experience leading a variety of groups from anger management to mindfulness for the chronically mentally ill at Pilgrim Psychiatric Hospital. Agnes has held a research assistant position at the NYU Child Study Center working on developing and assessing the efficacy of a preventive parenting program for children at-risk, assessing the efficacy o f a cognitive behavior group therapy for socially anxious adolescents and developing a parenting program for parents with asthmatic and socially anxious children. Presently, Agnes's research focuses on the specific and core beliefs of individuals with body dysmorphic disorder.

**Karen Silver, M.A., Extern,** graduated from Columbia University with a B.A. in Psychology and Sociology. She received her M.A. in Psychology from Ferkauf Graduate School of Yeshiva University, where she is currently in her fourth year of doctoral training. Karen has previously held extern positions at two inpatient facilities, Creedmoor Psychiatric Center and Bellevue Hospital Center, and at a substance abuse treatment center, Bridge Back to Life. Karen has received intensive training in Cognitive-Behavioral Therapy under the direction of Dr. Lata K. McGinn, and she provided individual therapy for patients within the CBT division of the Parnes Clinic at Yeshiva University. She has experience working with patients with a wide range of disorders including depression, general anxiety, social anxiety, and obsessive-compulsive disorder. Karen's current dissertation research focuses on environmental antecedents to cognitive vulnerability to depression.

**Ilana Dworin,M.A., Extern,** is currently in her fourth year of doctoral training at Yeshiva University's Ferkauf Graduate School of Psychology, where she also received her M.A. in Psychology. Prior to that, Ilana graduated with a B.A. in Psychology from the University of Michigan. At Ferkauf, Ilana has received intensive training in Cognitive Behavioral Therapy while conducting individual therapy at the Parnes Clinic. She has also been trained in conducting cognitive and personality assessments, psychodynamic therapy, group therapy, dialectical behavior therapy and substance abuse treatment. Ilana has experience in the treatment of depression and anxiety disorders, including generalized anxiety and social anxiety, psychotic disorders and bipolar disorder, substance abuse disorders and developmental disabilities. She has previously held research positions at Northwestern University, as well as prior externships at a school through the National Jewish Council for Disabilities working with adolescents with Asperger's disorder and other developmental disabilities, and St. Luke's Hospital's Continuing Day Treatment Program. Her research interests focus on peer influences on the development of depression during adolescence.

**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 Intiative" 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.

# Creating A Conversation Roadmap

## Jenny Taitz, PsyD

You will not get to Boston if you have driving directions to Buffalo. Similarly, in discussions with people in your life, it can be effective to have a sense of your general goal. Psychologists at the American Institute for Cognitive Therapy can help you cope with anxiety and frustration that arise from feeling either unable to assert yourself or badly about yourself following a conversation with a significant other. Many people ruminate about upcoming discussions and we all struggle with putting our foot in our mouth at times. Is there a conversation with a significant person in your life that seems overwhelming to you? Perhaps it would be beneficial to take a step back and pay attention to what you are looking to accomplish. Dr. Marsha Linehan, a psychologist who developed Dialectical Behavior Therapy (DBT), delineates skills to increase interpersonal effectiveness. The first step is to consider your priorities in a discussion. Generally, there are three common goals that capture potential directions to pursue in an interpersonal situation.

**Objective**
If your priority is objective, you want something. If you are at a restaurant and your goal is to get your favorite sandwich for lunch, pursuing your objective may entail asking and specifying exactly what you want and don't want in your sandwich.

**Relationship**
Another potential priority is the relationship. In many scenarios, our main concern may be acting in a way that keeps another person liking and respecting you so that you maintain relationships that matter. If you are ordering a sandwich from the local deli you frequent daily, and you'd like to continue being customer of the week, you need to attend to the relationship. How do I want the waiter to feel about me? Perhaps your tone is cheerful and you place your order in an easy manner.

**Self Respect**
In relating to others, your goal may be to maintain your self respect by behaving in a way that is consistent with your values. You may want to speak to someone in a kind, compassionate way, keeping in mind they are similarly struggling and doing the best they can. In the same scenario, if your objective is maintaining your self respect you may want to speak in a way that makes you feel good about after the interaction. You may ask how someone is doing and express genuine interest if one of your values is loving kindness.

You may have several objectives. It may be helpful to begin to be mindful and deliberate before that talk with your partner, to rank order your objectives, and ask, "What is my first goal? What comes next?". Although there may not be a big discussion you need to prepare for, it may be helpful to consider your goals in mundane interactions and think productively about what you would like to accomplish rather than worrying unproductively about potentially not getting what you hope for.

*Jenny Taitz, Psy.D.*

# Trapped by Bad Decisions: The Sunk Cost Effect

## Robert L. Leahy, PhD

Does this sound familiar? You bought a suit or dress, paid good money, you take it home, look at it and hang it in the closet. Years go by, you take it out and look at it and say, "It's not me—I'll wear something else". You can't seem to throw it out although you really know you won't wear it again. You say, "I can't throw it out. It's hardly been used. I paid good money for it". Or you find yourself stuck in a dead-end relationship and you know that it makes sense to get out. But you stay in because you think, "I've put so much time in this. I can't just walk away. It would mean I wasted all that time." So, you stay for another year and you feel even more stuck. You fear leaving because you think, "It'll feel so bad to be alone", "This will prove I can't make good decisions", and "Everyone will say, 'It's about time'". You find yourself justifying what you know is an irrational decision—because it's more important for you to be right than to make your life better. You are stuck in the sunk cost of your prior decision. You are now throwing good money after bad. You are making decisions looking backward to past investments and not making decisions based on future utility.

How can we liberate ourselves from the sunk cost trap? The first step is labeling your trap as a "sunk cost"—the jacket in the closet. Second, think about your decision in a "new point in time"--- "If you had never gotten into this behavior, would you make a decision to get into it now?" Third, focus on future "utility" (what you can get, what opportunities you will lose) rather than on past costs. For example, if you stay in a dead-end job or relationship, ask yourself what opportunities for new relationships and jobs you will lose. This is "opportunity cost". It's important to separate out the past cost from future utility. After a while it makes sense to junk that old car. Fourth, think about your past costs as "money down the drain". It's not important to "get your money's worth"—it's more important to reduce future costs and increase future benefits. Fifth, borrow someone else's head. What would a stranger think you should do? If you know that strangers are more rational about your life than you are, then you are stuck in a sunk cost. Sink it.

We often get trapped by our need to justify the decisions that have continued our misery—looking backward to the past for justification, rather than committing to actions for future utility. Focusing on valued goals rather than valuing our past can help liberate us from commitments whose payoffs have turned into deficits. Our "rationality" may be less logical than we think and more determined by rationalizing the past rather than pursuing a better future.

*Robert L.. Leahy*
*Director*