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PENN PSYCHIATRY PERSPECTIVE

Perelman School of Medicine at the University of Pennsylvania | **Department of Psychiatry**

Ideas, Suggestions, and News!

We welcome your ideas, suggestions, and news about your activities for stories or announcements in Penn Psychiatry Perspective, the eNewsletter of the University of Pennsylvania Department of Psychiatry. Our goal is to offer useful and interesting news to readers and highlight our many outstanding faculty, programs, and services. Please submit your recommendations to psychweb@mail.med.upenn.edu.

Dwight L. Evans, MD
Ruth Meltzer Professor and Chair

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Ask the Expert

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In this "Ask the Expert" feature,* Cory F. Newman, PhD *answers questions about key elements of Cognitive-Behavioral Therapy (CBT) to help mental health professionals better understand this very effective evidence-based therapy and help them implement it with patients.

Dr. Newman will cover these and many related topics in a two-day PBH**Mind** Symposium to be held on April 5-6, 2013 – "Fundamentals of Cognitive-Behavioral Therapy for Depression, Anxiety, and Anger." Designed for psychologists, social workers, therapists, psychiatrists, and other mental healthcare practitioners, Dr. Newman's PBH**Mind** Symposium is appropriate for early-career clinicians and as well as those at any level of professional experience who wish to familiarize themselves with the essentials of CBT. For more information about this Symposium and details on location, times, and registration, please visit - http://www.pbhmind.com/cognitive-therapy-symposium-13. The last day to register is Friday, March 29th, 2013.

Dr. Newman is the Director of the Center for Cognitive Therapy and Professor of Psychology in Psychiatry at the Perelman School of Medicine at the University of Pennsylvania. He is a Diplomate of the American Board of Professional Psychology and a Founding Fellow of the Academy of Cognitive Therapy. Dr. Newman is a highly active therapist and clinical supervisor, and lecturer. He has served both as a protocol therapist and a protocol supervisor in a number of large-scale psychotherapy outcome studies, including the National Institute on Drug Abuse Multi-site Collaborative Study on Psychosocial Treatments for Cocaine Abuse, and the Penn-Vanderbilt-Rush Treatment-of-Depression Project, among others.

Dr. Newman is an international lecturer, having presented scores of CBT workshops and seminars across North America, as well as in South America, Europe, and Asia. He is the lead author on dozens of articles and chapters on CBT on a wide range of topics, including mood disorders and suicide, personality disorders, substance abuse, and the therapeutic relationship. He has authored or co-authored five books on CBT, including the recently released volume, *Core Competencies in Cognitive-Behavioral Therapy: Becoming a Highly Effective and Competent Cognitive-Behavioral Therapist.* Dr. Newman's honors include the Earl Bond award for outstanding mentoring and training of Psychiatry Residents and Fellows, the 5th annual Penn Psychotherapy Professorship Award for clinical expertise, and inclusion in *Philadelphia Magazine*'s "Best Therapists" lists.

Of Note

The Department of Psychiatry at Penn has been a leader in the development of psychotherapeutic approaches. **Dr. Aaron T. Beck** developed CBT and **Dr. Edna Foa** discovered prolonged exposure therapy, a form of CBT, to treat PTSD.

Ask the Expert - Q&A

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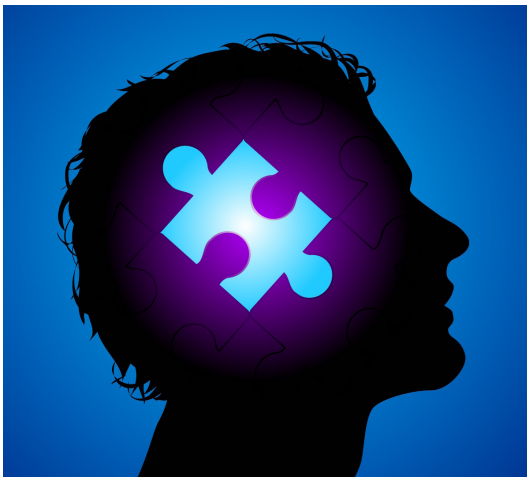
What are the factors that have enabled cognitive-behavioral therapy (CBT) to garner so much empirical support for its efficacy?

The basics of CBT are grounded in principles of learning (including social learning theory and human information processing) that have had a firm empirical basis for decades. Using these principles of learning, competent CBT clinicians *conceptualize* their patients' problems and strengths, understanding how past experience has taught them to enact a certain repertoire of behaviors, to think in certain ways, and to experience a range of emotions in given situations. Then, using positive social reinforcement and differential feedback, therapists teach their patients a broader repertoire of cognitive and behavioral skills, toward the goals of greater adaptive functioning and a higher psychological quality of life. This individualized approach to human functioning is combined with research on general areas of psychopathology (e.g., mood disorders, anxiety disorders, eating disorders, addictions, psychosis), such that CBT is adapted to meet the clinical needs of different *diagnostic groups* of patients, leading to the development of many CBT protocols that are tailor made for each clinical problem area. CBT comes from a strong empirical tradition, thus it is routinely subjected to empirical tests, leading to increasingly better understanding of patients and their therapeutic needs, and ongoing advancements in what CBT therapists need to provide to be most helpful. CBT is not static. It is continually developing as the field's knowledge base grows.



What are the key elements to a successful therapeutic relationship?

As with any form of talk therapy, establishing a positive, healthy therapeutic relationship in CBT starts with the therapist being a good, attentive listener who gives empathic feedback. The therapist treats the patient as an individual (not just as a diagnostic category), such as by taking the time to learn about the patient's personal history, and by showing an interest in understanding the patient's concerns, hopes, fears, and other aspects of his or her daily life and internal world. However, the real test of CBT therapists' skill in creating and maintaining a successful therapeutic relationship is in how they handle the rough patches in treatment, such as when therapist and patient disagree about the diagnosis or treatment plan, or have a misunderstanding, especially when the patient is particularly sensitive to feeling invalidated, controlled, or rejected. Here, highly effective CBT practitioners stay emotionally composed and try to work out their differences with their patients with an air of good will, and with the use of constructive problem-solving. The therapists also try to conceptualize what caused the strain or rupture in the therapeutic relationship, as this may provide important information about the patients' *schemas* (core beliefs), about how the patients process interpersonal information, and how well they connect with others. Effective CBT therapists value working to improve their own interpersonal skills, so that they minimize episodes of sounding unduly demanding, defensive, or critical, and maximize their ability to communicate a desire to collaborate constructively in treatment, even when (perhaps especially when) the therapist and patient are struggling for answers.

Please summarize some of the ways in which the methods of behavioral activation (BA) and rational responding (RR) help clinically depressed patients make significant improvements in their functioning and quality of life.

Arguably, *behavioral activation* and *rational responding* are the cornerstone categories of clinical techniques in CBT for depression. **Behavioral activation** is comprised of methods to help patients to increase their active involvement in life by doing things that give them more of a sense of purpose, accomplishment, and enjoyment. Many depressed patients are quite inactive, keeping to themselves, feeling lethargic, anhedonic and under-stimulated, and thus not getting much out of life, which maintains their sense of helplessness and hopelessness. CBT therapists encourage their patients to generate ideas for becoming more active, step by step, even if they don't "feel like it" at first, because "sometimes actions create a better mood." When these patients begin to schedule and take part in more activities (which can be as mundane and basic as just taking a shower, getting dressed, and getting outside for a bit), they begin to feel more of a sense of self-respect and empowerment, and they elicit more positive responses from their environment, which combat the sense of inertia and emptiness that otherwise reinforce the depression. **Rational responding** involves teaching patients to use their emotions as cues to identify what they are thinking that might be reinforcing their pessimism and low self-image. Rather than taking these thoughts at face value, CBT therapists note that these are the patients' *hypotheses* about themselves, their life, and their future, and that these hypotheses warrant being evaluated for their validity and/or utility. CBT practitioners

Ask the Expert - Q&A

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teach their patients to ask themselves a series of questions to stimulate a more flexible repertoire of thinking patterns (i.e., to become less black-and-white; more based on objective, concrete evidence; more oriented toward problem-solving rather than helplessness). Rational responding is not easy, and therefore requires quite a lot of practice, which makes it a common homework assignment, sometimes involving a structured, written format developed by Drs. Aaron T. Beck and Judith Beck called the *Automatic Thought Record*. Once the patients become familiar with this method, they typically show great improvements in their thinking style, thus enabling them to feel better and to make more constructive decisions.

Could you briefly describe the "Risk-Resources" model of clinical anxiety, and how CBT uses this?

In cognitive-behavioral terms, clinical anxiety is characterized by a cognitive style that magnifies or over-emphasizes a sense of risk, while simultaneously minimizing or overlooking personal resources, including coping skills. The result is an exaggerated sense of threat or looming crisis, along with a sense of helplessness in dealing with the threat. Behaviorally, the result is usually manifested by some sort of avoidance, in which the patient with clinical anxiety (e.g., generalized anxiety disorder, social anxiety disorder, panic disorder, agoraphobia, health anxiety) tries to avoid being in situations that he or she associates with feeling anxious (as well as avoiding certain thoughts, feelings, and memories, and perhaps excessively seeking reassurance). The result is an erosion of self-confidence, a poverty of problem-solving learning experiences, a build-up of neglected problems, and lost opportunities to habituate to the anxiety. CBT endeavors to help such patients to put their feared situations (or internal experiences) in a more objective perspective, and to gradually build a sense of self-efficacy through active exposures and coping.

How is CBT adapted to deal with patients who exhibit significant anger problems?

Anger that patients excessively experience and inappropriately express is particularly problematic in therapy, because (unlike dysphoria or anxiety) anger is an emotion that patients oftentimes do not wish to diminish or relinquish. The apparent "upside" of anger is that a person can feel in the right, deserving of compensation, and even empowered. Many patients with clinical levels of anger will believe that they have a right to their anger, and will view attempts by therapists to have them experience and/or express less anger as invalidating and unjust. Unfortunately, clinical levels of anger are typically counterproductive in the patients' lives, often causing physiological consequences, interpersonal rifts, problems in dealing with authority (e.g., parents, teachers, employers, police officers), and sometimes leading to dangerous situations and consequences (e.g., road rage, physical assault). Effective CBT therapists bear in mind that they have to help patients to come to see the reduction in their anger as being ultimately in their own best interest. They also explain that "anger management" is not simply about repressing anger or refraining from acting out, but rather it is about changing how they think about the situation so that they actually feel less angry. When patients express anger in the session, skilled CBT practitioners try to understand the thoughts that are behind the patient's anger, they try to express empathic understanding, and they refrain from engaging in power struggles. Additionally, therapists often find common ground with angry patients by trying to acknowledge the validity of what the patients are expressing, while respectfully pointing out that the angry patients' reactions may lack utility (i.e., "Yes, your feelings are understandable, but the way you are expressing them may not be working out so well for you and others").

What are some of the keys to moderating patients' fears about change and to help them become more receptive to treatment?

Empathic CBT therapists do not jump to the conclusion that patients who are reluctant to change are "not ready" for therapy or "don't really want to change," or that they would "rather suffer." Therapists understand that change is difficult, and often scary. Many patients, though unhappy when they enter treatment, fear that things will only get worse if they try to change their lives. The therapist's job is to show them that things can get better, though at first the process may seem unfamiliar and uncomfortable. Further, the therapist has to be a positive coach and supporter through this process, encouraging patients along the way. In order to promote the patients' sense of control over the process of therapy, CBT clinicians make sure to be very collaborative, and to give the patients as many choices as possible in how to proceed (such as in facing difficult tasks via small stages). Effective CBT practitioners are adept at ascertaining the patients' belief systems and life circumstances that may be serving as obstacles to change, and in helping the patients to modify their thinking styles and to apply problem-solving principles to their unfavorable situations. For example, a patient who believes that if he tries to face anxiety-arousing situations he will be humiliated would be helped to reframe this as a courageous step of which to be proud, no matter what the practical outcome. Another patient who faces family disapproval for being in therapy might be taught communication skills, such as defusing, reflecting, validating, and calm assertiveness, so as to strengthen her position in the face of the family's negative feedback, and to be confident in continuing with the work of therapy.

News and Announcements

Upcoming Events

Department of Psychiatry Grand Rounds – April 11 and April 25
Department of Psychiatry Grand Rounds are held from 12:00 noon to 1:00 pm on the designated dates in the locations indicated. The next two lectures are listed below. For more information about Grand Rounds and the 2012-13 schedule, please visit - http://www.med.upenn.edu/psych/rounds.html

April 11, 2013
Psychoanalytic Module - "Neuroimaging of Universal Mechanisms of Action in Psychotherapy"
Speaker: Andrew Gerber, MD, PhD, Assistant Professor of Clinical Psychiatry, Department of Child and Adolescent Psychiatry, Brain Imaging Lab, New York State Psychiatric Institute, Columbia University
Location: BRB II/III Auditorium

April 25, 2013
Psychoanalytic Module - "Case Conference - The Psychoanalytic Treatment of an Adolescent with Anorexia Nervosa"
Speaker: Newell Fischer, MD, Clinical Professor of Psychiatry, Perelman School of Medicine, University of Pennsylvania; Training and Supervising Psychoanalyst, Psychoanalytic Center of Philadelphia; Past President, The American Psychoanalytic Association
Location: TBD

PBHMind Symposia Series
The University of Pennsylvania's Department of Psychiatry and Penn Behavioral Health invite practitioners in the mental health and wellness arena to earn continuing education credits and Certificates of Advanced Training through PBHMind. Courses are designed to provide varying levels of knowledge for psychologists, social workers, therapists, and other practitioners in 11 different topic areas. Offerings include 1.5 day symposia, live webinar series, and small group consultation with experts. March symposia are listed below. Visit our website at www.pbhmind.com to learn more about our programs and to view our full course catalog.

April 5-6, 2013
Cognitive Therapy Symposium- "Fundamentals of Cognitive-Behavioral Therapy for Depression, Anxiety, and Anger"
Speaker: Cory F. Newman, PhD, ABPP
Location: 3400 Civic Center Blvd, Smilow Center for Translational Research
For additional information or to register, please visit: http://www.pbhmind.com/cognitive-therapy-symposium-13

April 26-27, 2013
Women's Behavioral Wellness Symposium - "Sex, Hormones and Mental Health: A Clinician's Primer To Reproductive Issues and Their Impact on Women's Wellbeing"
Speakers: C. Neill Epperson, MD, Deborah Kim, MD, Sarah Mathews, MD, Lindsay Sortor, PsyD, Delane Casiano, MD
Location: 3400 Civic Center Blvd, Smilow Center for Translational Research
For additional information or to register, please visit: http://www.pbhmind.com/womens-wellness-symposium-13

May 3-4, 2013
Stress and Anxiety Symposium - "Stress and Anxiety: Common Problems, Effective Interventions"
Speakers: Elizabeth A. Hembree, PhD, Edna Foa, PhD, Steven Berkowitz, MD, Ellen Berman, MD, Martin Franklin, PhD, David Yusko, PsyD, Michael J. Baime, MD
Location: 249 South 36th Street, Claudia Cohen Hall, Terrace Room
For additional information or to register, please visit: http://www.pbhmind.com/stress-symposium-13