



Psychiatry

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POST GRADUATE EDUCATION**NEWSLETTER**

AUGUST 2001

UPCOMING COURSES

Upcoming continuing education courses in the year 2001, offered by the Department of Psychiatry at the Massachusetts General Hospital, are as follows:

Psychiatry: A Comprehensive Update and Board Preparation

Monday-Saturday, September 10-15, 2001
The Fairmont Copley Plaza Hotel, Boston

Psychopharmacology

Thursday-Saturday, October 4-6, 2001
Westin Hotel, Copley Place, Boston

FOR MORE INFORMATION

For information about this and other courses presented by the Department of Psychiatry at MGH, please visit our web site, call, write, or email our administrative staff, at:

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Cognitive and Behavioral Therapy: Integration and Innovation

June 7-9, 2001

COURSE DIRECTORS

JERROLD F. ROSENBAUM, M.D., MICHAEL W. OTTO, PH.D.,
LEE BAER, PH.D., AND JOHN B. HERMAN, M.D.

COURSE ADMINISTRATIVE STAFF

STEPHANIE LIPKA HACKETT, GAIL E. DICKSON, M.P.A.

Renowned for straightforward teaching of state-of-the-art psychiatry to practicing clinicians, the Massachusetts General Hospital Department of Psychiatry sends this e-newsletter to our friends and colleagues, nearby and around the world. It prints out nicely, or can be read "on-line."

For those who were unable to journey to this course in Boston, it is intended as an update and "taste." For those who were able to join us, we hope this newsletter will provide a useful summary. Please let us know what you think. If you are interested in being included in this mailing list, please respond to:

PsychiatryCOPE@partners.org

Here's to a long life of learning!

The Massachusetts General Hospital Department of Psychiatry brought you this state-of-the-art course on the theory and application of cognitive and behavioral therapy (CBT). Treatment of a variety of conditions (e.g., panic disorder, post-traumatic stress disorder, eating disorders, schizophrenia, obsessive-compulsive disorder, social phobia, chronic pain, and self-injurious behavior) were discussed; the application of practical strategies was highlighted. Recent research findings relevant to clinical practice were presented by MGH clinician-researchers as well as by distinguished guest CBT experts.

Each of the approximately 300 attendees of this three-day continuing education course (held at the Westin Hotel, Copley Place, 10 Huntington Avenue, Boston, MA, 02116) received a comprehensive syllabus, which contained an outline of each lecture, a printout of slides presented, and a reprint of key references. In addition, each speaker provided an extensive, up-to-date bibliog-



raphy. Continuing Medical Education (CME) certificates were provided for physicians, psychologists, social workers, and nurses for course attendees. A sample of selected (and annotated) references, which report on the results of clinical trials and review the literature in a field, is provided below.

Here are some facts from the MGH's Cognitive and Behavioral Therapy: Integration and Innovation Course:

PANIC DISORDER AND AGORAPHOBIA

David Barlow, Ph.D.

Dr. Barlow presented exciting, multi-media, data-driven, and systematic review of the nature of anxiety and panic from neurobiological, psychological, and social/interpersonal perspectives. He blended this with new methods of assessment and treatment. He demonstrated clearly, with the use of videotaped therapy sessions, the components of panic control therapy and described how one can adapt CBT to the treatment of patients with moderate to severe agoraphobia. Dr. Barlow also noted that:

- Panic attacks may be unexpected (uncued), situationally bound (cued), or situationally predisposed.
- Treatment of panic disorder and agoraphobia commonly involves psychoeducation, prevention of behavioral and cognitive avoidance, processing of negative affective cues (exposure), restructuring of emotional cognitions, and use of arousal reducing techniques.

POST TRAUMATIC STRESS DISORDER

Michael W. Otto, Ph.D.

Dr. Otto, a mentor to scores of clinician-researchers, demonstrated his command of the literature regarding post traumatic stress disorder. He eloquently described an approach to the management of those who have been plagued by a traumatic event. Highlights of his presentation included:

- Following a traumatic event learned cues (e.g., sights, sounds, smells, sensations, emotional states, and times of day) lead to conditioned emotional and cognitive responses (e.g., anxiety, fear, disgust, anger, dissociation, intrusive memories, and flashbacks).
- These responses contribute to a state of hypervigilance and chronic autonomic arousal, as well as to

avoidance of cues and conditioned emotional responses (which are manifest by emotional restriction, behavioral avoidance, cognitive avoidance, and to substance abuse).

- Diagnostic criteria for post-traumatic stress disorder (PTSD) include re-experiencing phenomena, persistent avoidance (or numbing), and increased arousal, each lasting more than one month.
- The prevalence of PTSD in the general population ranges from 1% to 9%; it is 15% for psychiatric inpatients, 36% for combat veterans in Vietnam, and 57% for rape victims.
- Treatment of PTSD involves reinterpretation of symptoms in a context of present safety, and differentiation of traumatic memories from current realities.
- Prior to exposure therapy the patient's ability to comfort himself/herself should be evaluated, and self-soothing strategies should be discussed.
- Cognitive distortions surrounding the traumatic memories should be identified.
- Helping the patient to "live in the present" is a key to successful treatment of PTSD.
- The use of stories and metaphors in CBT provides a method of enhancing information processing, and translation of affectively charged material into positive behavioral change.

EATING DISORDERS

G. Terence Wilson, Ph.D.

Dr. Wilson eloquently summarized a manual-based CBT approach for bulimia nervosa (BN), that is also applicable to the treatment of other eating disorders (such as anorexia nervosa [AN]). He illustrated the technique by focusing on dietary restraint and on dysfunctional concerns about body shape and weight. Methods of individualizing treatment within the framework of manual-based treatment were also discussed.

- CBT appears to be more effective than medications and psychotherapies for eating disorders.
- Manual-based CBT for eating disorders involves changing eating habits (i.e., reducing dietary restraint), developing skills for coping with high risk



situations for binge eating, and modifying dysfunctional body shape and weight concerns.

- Goals of CBT for eating disorders are to help the patient gain an understanding of the mechanisms that perpetuate the eating disorder and to appreciate the need for changes in behavior and cognitions.
- Dysfunctional dieting may include skipping meals, consuming insufficient food overall, and avoiding specific foods.
- Development of a regular pattern of eating involves focusing more on when eating occurs than on what is eaten.
- Inclusion of forbidden foods into meal patterns should be planned and deliberate; this empowers the patient, and reassures the patient that eating normally will not result in loss of control.
- Cognitive restructuring helps a patient draw reasoned conclusions that guide behavioral change.
- Once nutritionally sound and psychologically adaptive lifestyle changes have been made, patients need to accept whatever body shape and weight these changes produce.
- Negative affect is a common trigger of binge eating and purging which intensifies concerns about body image and undermines adherence to other components of manual-based CBT.

SCHIZOPHRENIA

Corinne Cather, Ph.D.

Dr. Cather systematically reviewed the complex issues involved in instituting CBT for the residual symptoms of schizophrenia spectrum disorders. In addition, she presented data from a series of randomized, controlled studies that suggest benefits of CBT. Predictors of response to CBT and suggested future directions were summarized.

- Historical factors that have discouraged the use of CBT for schizophrenia include a conceptualization of schizophrenia as too severe, of individuals with schizophrenia as passive recipients of treatment, of medication as wholly adequate treatment, and of the modification of delusions as potentially harmful.
- CBT for schizophrenia is encouraged by a growing appreciation of the influence of environment and behavior on residual symptoms and promising results of randomized controlled trials.
- Approximately 30%-50% of patients with schizophrenia has residual symptoms.
- CBT for schizophrenia is based on the premise that psychotic symptoms are maintained by dysfunctional patterns of thinking (e.g., appraisal) and behavior (e.g., avoidance, maladaptive coping).
- Among the treatment elements of CBT for schizophrenia are: creating a therapeutic alliance; psychoeducation; coping skills training; challenging beliefs; and carrying out behavioral experiments.
- CBT aims to foster a curious approach to symptoms and a “living with illness” attitude.
- Specific strategies for clinicians to respond to a patient’s paranoid beliefs about him/her were reviewed.
- Behavioral experiments such as tape recording voices and turning voices on/off can serve as evidence for auditory hallucinations as products of the patient’s own mind.
- Cognitive restructuring of delusional beliefs is guided by the evaluation of evidence and “What would be true if this were the case?”
- CBT must be tailored to compensate for the cognitive deficits present.
- When delivering information try to speak slowly and clearly, use repetition, present information in multiple forms, demonstrate homework in sessions, write down assignments, and identify cues to use outside of sessions.
- Assist the patient to identify pleasurable activities and functional goals.
- Elicit negative attitudes about treatment and the reasons for prior non-adherence with treatment.



CLINICAL PANEL DISCUSSION I

Michael Otto, Ph.D., Sabine Wilhelm, Ph.D.,
G. Terence Wilson, Ph.D., Corinne Cather, Ph.D.,
and David Barlow, Ph.D.

A nationally known panel of experts (including a course director for this course) eloquently fielded questions from the audience related to CBT.

CLINICAL APPLICATIONS IN CHILDHOOD DISORDERS

Bruce Masek, Ph.D.

Dr. Masek defined terms and described the guiding principles of CBT. He focused his efforts on the mediators of behavioral change, the goals of therapy, and the elements of treatment. Therapeutic techniques (including cognitive restructuring, self-control training, and relaxation training) were reviewed. Finally, applications of CBT in general medical practice were identified.

- Behavioral change in CBT is mediated by cognitive activity, by one's internal physiologic state, by overt behavior, by environmental cues, and by reinforcing consequences.
- Goals of CBT are time-limited and problem focused; they are meant to build or enhance coping skills and to maintain them following treatment.
- Elements of therapy involve restructuring cognitive deficiencies and distortions, altering physiologic arousal patterns, modifying the stimulus environment, and changing contingencies of reinforcement.
- Conditions for which CBT may be efficacious include asthma, cystic fibrosis, eczema, ulcerative colitis, irritable bowel syndrome, and sleep disorders.

CLINICAL APPLICATIONS FOR PERSONS WITH HIV

Steven Safren, Ph.D.

Dr. Safren provided concrete tools for clinicians, so that cognitive-behavioral interventions can be applied with patients afflicted with HIV infection. He ably described the demographics and stressors associated with HIV infection and its treatment. Common psychiatric difficulties associated with HIV infection were also reviewed. Practical examples in

problem solving were provided and applied to medication adherence, disclosure of HIV status, and health care planning.

- Given that highly active antiretroviral therapy (HAART) can reduce progression of HIV infection and reduce serum viral load, and that non-adherence leads to worse prognosis, adherence to therapy is crucial.
- Currently, only 40%-80% of patients adheres to HIV medication regimens.
- Depression is associated with impairment in problem solving.
- Problem solving requires selection of an action plan and breaking a seemingly overwhelming task into manageable steps (i.e., implementing the solution).
- A problem solving sheet, that allows for a listing (and rating) of all possible solutions to a problem (with the pros and cons of each solution) can be used to select an action plan.
- Key steps for HIV medication adherence include psychoeducation, arrival for appointments, communication with care providers, identification of side effects, appropriation of medications, creation of a schedule, storage of medications, initiation of cue control strategies, rehearsal and guided imagery, and a implementation of a strategy for dealing with errors in care.
- Tape recordings with instructions for progressive muscle relaxation can be created; these involve use of a slow, relaxing, somewhat monotonous voice.
- Progressive muscle relaxation involves tensing (for approximately 5 seconds), then relaxing (for at least 10 seconds) all muscle groups.
- Negative thinking patterns can be associated with the continuation of symptoms of depression, and can therefore impair successful problem solving.
- Cognitive restructuring can be facilitated by completion of a thought record; such a record tabulates the time and situation of thoughts, the nature of the automatic thoughts, your mood and its intensity, the cognitive distortions associated with each thought, and your rational response to the thought.
- The rational response can be used as a coping statement to help with situations that seem overwhelming or are associated with depressed mood.



CLINICAL MANAGEMENT OF SELF-INJURIOUS BEHAVIOR

Ryan Boxill, Ph.D., and Beth Gershuny, Ph.D.

Drs. Boxill and Gershuny provided a comprehensive overview of self-injurious behavior. They defined self-injurious behavior, described the demographics and prevalence of the syndrome, elaborated on the function of such behaviors, and provided a systematic approach to assessment and treatment. Case vignettes served to highlight the issues discussed.

- The prevalence of self-injurious behaviors in the general population is estimated at between 0.5% and 4%; in those with borderline personality disorder is is thought to approach 75%.
- Self-injurious behaviors may provide temporary emotional relief, regulate affects, affirm that one is still alive, communicate to others, and establish control.
- Dissociation may lead to and be associated with self-injurious behavior.
- A functional analysis of self-injurious behaviors is beneficial. It should provide the time of day of the injury; the nature of the injury; the precipitating events, emotions, thoughts, and bodily sensations; the consequences of the injury (e.g., emotions, thoughts, bodily sensations, and actions).
- The more one is able to identify the problematic behaviors, the events that prompt such behavior, and the circumstances that make one vulnerable to such behaviors, the better prepared one will be to prevent their occurrence.
- Assessment requires a description of the frequency, triggers, functions, and reinforcers of the self-injurious behavior, as well as a description of the type of self-injurious behavior, the current strengths and coping skills, and the reasons for seeking help.
- Treatment involves psychoeducation, a functional analysis of behaviors, a reduction in self-injurious reinforcement, management of anxiety, teaching of coping skills, cognitive restructuring, and development and maintenance of team or institutional support.

APPLICATION OF COGNITIVE THERAPY TO AXIS II PATIENTS

Stephen McDermott, M.D.

Dr. McDermott presented a comprehensive overview of Beck's cognitive therapy for patients with personality disorders; he moved nimbly from general theory to treatment strategies, and supported his presentation with printed materials and examples of worksheets.

- Cognitive therapy emphasizes the role of beliefs; it focuses on the past and the present.
- In cognitive therapy the past is explicitly examined in the context of a belief active in the present.
- In cognitive therapy beliefs suggest what is more relevant in a given situation; they form the basis for distortion in emotional thinking.
- Beliefs are the bridge between the past and the present and future.
- The degree of fit or relevance of the situation to the belief determines the belief system that has the most control of one's perceptions in a given situation.
- Beliefs lead to a self-reinforcing system.
- Cognitive therapy involves identification of core beliefs, conditional beliefs (or assumptions), overutilized and underutilized strategies, and competing adaptive beliefs.
- An understanding of how a maladaptive belief interferes with an individual's day-to-day life is key to behavioral change.
- Socratic questioning may help to develop evidence to support the old schema or belief system.
- Steps in the application of cognitive therapy include: Socratic questioning to develop evidence of a schema, to weaken the old schema, and to build a new schema; restructuring of old schema evidence; summarizing statements of belief change and alternative explanations.
- Remember that an idea is not necessarily a truth.
- Having identified a core negative belief. The therapist devises a more realistic and functional belief, and guides the patient to its use.



OBSESSIVE COMPULSIVE DISORDERS

Lee Baer, Ph.D.

Dr. Baer provided a comprehensive and practical overview of the diagnosis and treatment of obsessive compulsive disorder (OCD). He outlined the basic principles of exposure therapy, described the different types of symptoms found with OCD, and expounded upon newer cognitive therapy approaches. He concluded his presentation with a discussion of the impact of comorbid conditions on treatment of OCD and the impact of different OCD symptoms on outcome.

- Exposure therapy involves having the patient confront things they fear for an extended period.
- Response prevention relies on not giving in to urges to carry out compulsions (in an effort to reduce discomfort during or after exposure).
- Habituation conveys a state whereby after familiarity with a situation leads to our getting used to, or ignoring, that situation.
- Exposure and response prevention should last for 1-2 hours.
- A minimal trial of behavior therapy should include 20 hours of exposure and response prevention.
- Obsessions may involve thoughts of aggression, pathologic doubt, contamination, sex, hoarding, religion, symmetry, or somatic concerns.
- Compulsions may involve cleaning; checking; repeating rituals; counting; ordering; collecting; needing to tell, to ask, to confess; needing to tap, to rub, or to touch; or pulling hair.
- An individual often has more than one type of obsession.
- Uncomplicated cleaning, checking, or repeating rituals usually respond well and quickly to behavior treatment or selective serotonin reuptake inhibitors (SSRIs).
- Hoarding symptoms tend to respond less well and are more prone to relapse; they are often ego syntonic thoughts that bother others more than the person with the obsession.
- Cognitive errors are common in OCD sufferers (e.g., they attribute too much importance to having a par-

ticular thought, or that they need to have total certainty of a situation, or they need to do something perfectly to avoid criticism from others).

- We can, in general, control our behaviors more than our thoughts and feelings.
- A few conditions (body dysmorphic disorder, Asperger's syndrome, and schizophrenia) have a very strong impact on OCD treatment; presence of these conditions may prevent improvement on OCD symptoms.
- Other disorders (e.g., Tourette's disorder, eating disorders, alcohol abuse, panic disorder, PTSD, bipolar disorder, and generalized anxiety disorder) must be treated in parallel with OCD to improve efficacy of OCD treatment.
- Comorbid disorders (e.g., major depressive disorder, social phobia, dysthymia, and simple phobia) have little or no impact on OCD treatment.
- Contingency management means arranging conditions or contingencies so that certain behaviors will happen more often.

COGNITIVE RESTRUCTURING AND CORE-BELIEF WORK IN UNIPOLAR AND BIPOLAR DEPRESSION

Noreen Reilly-Harrington, Ph.D.

Dr. Reilly-Harrington introduced the strategies involved in CBT for both unipolar depression and bipolar disorder and emphasized cognitive restructuring and modification of core beliefs. She illustrated innovative techniques in the management of bipolar disorder and included strategies for management of mood elevation, medication compliance, and relapse prevention.

- CBT has been shown effective for unipolar depression (even in those whose course has been termed treatment-resistant).
- Adjunctive CBT can help supplement pharmacological treatment of bipolar disorder and aid in medication compliance.
- Patients with depression can be taught to monitor and challenge negatively biased thoughts and cognitive distortions (e.g., all-or-nothing thinking, overgeneralization, personalization, or mislabeling).



- Core beliefs involve central ideas about the self; they often involve themes of unlovability or helplessness.
- Daily mood monitoring allows for early intervention prior to severe episodes.
- Activity scheduling is used to regularize daily patterns of sleeping, waking, exercise, and social interaction.
- Problem solving skills are taught to manage life stressors and reduce a patient's vulnerability to triggering situations.
- Cognitive restructuring techniques often make use of a thought record.
 - Questions worth responding to are as follows:
 - What is the evidence that the automatic thought is true?
 - Is there an alternative explanation?
 - What is the worst that can happen?
 - What is the most realistic outcome?
 - If a friend were in this situation, what would I tell him or her?
- Cognitive restructuring may also be used to challenge the hyperpositive thoughts characteristic of hypomania.
- Utilizing a treatment contract, including the patient's support network, provides an opportunity for family education and an action plan to activate in case of future episodes.

SCHEMA-FOCUSED COGNITIVE THERAPY FOR BORDERLINE PERSONALITY DISORDER

Cory F. Newman, Ph.D., ABPP

Dr. Newman reviewed the diagnostic criteria for borderline personality disorder and demonstrated how key elements of the history can guide formulation and treatment. Techniques for managing the therapeutic relationship and dealing with crises and limit setting were discussed. Targets for standard interventions (e.g., excessive expectations of others, empathy training, self-correction skills, interpersonal limits, and extreme opinions of the self and others) were reviewed. In addition, the use of role-play was discussed. Schema-modification interventions include the use of imagery and reconstruction of past events.

- Diagnostic criteria of borderline personality disorder include affective instability, chronic feelings of emptiness, inappropriate or intense anger, fears of abandonment, and a wide range of self-harming behaviors.
- Maladaptive schemas related to this syndrome appear to include abandonment, mistrust and abuse, emotional deprivation, entitlement, dependency, and a sense of vulnerability to harm.
- Borderline personality disorder is often comorbid with substance abuse disorders.
- Therapy of the borderline patient is difficult; it requires work and is not supposed to be comfortable. Nevertheless, the therapist needs to provide a safe haven.
- One should neither avoid nor push uncomfortable issues in session.
- One should not make important clinical decisions as a result of feeling coerced or threatened by patients who are pushing limits.
- When borderline patients are untruthful one should use the patient's own words to illustrate inconsistencies and show empathy for the patient's hesitancy and ambivalence about being open.
- Problem solving skills should be taught, so that the patient does not feel hopeless and helpless, and so as to break vicious cycles of maladaptive functioning.
- Ground rules for therapy need to be explicitly stated early in treatment; the rules of engagement must be clear.
- Combat all-or-nothing thinking of the borderline patient. Look for the healthy middle ground.
- Help the borderline patient to articulate and modify extreme expectations of others; in addition, teach the concept of interpersonal reciprocity.
- Teach the borderline patient self-monitoring skills for the purpose of self-correction.
- Be a good role model for your patients; learn to tolerate imperfections in oneself and others. Keep emotions within normal limits and express hope for change.
- Teach patients how to resist acting impulsively on their emotions by thinking things through.



- Enhance the adherence to homework in therapy by explaining the rationale for the building of psychological skills and self-sufficiency.

CLINICAL PANEL DISCUSSION II

John B. Herman, M.D., Cory F. Newman, Ph.D., ABPP, Noreen Reilly-Harrington, Ph.D., and Lee Baer, Ph.D.

A nationally known panel of experts (including a course director for this course) eloquently fielded questions from the audience related to CBT.

OPPOSITIONAL DEFIANT DISORDER

Ross Greene, Ph.D.

Dr. Greene eloquently discussed concepts elaborated upon in his recent best selling book, The Explosive Child: Understanding and Parenting Easily Frustrated Chronically Inflexible Children (1998), and suggested methods of teaching and motivating compliant behavior. He noted that oppositional and explosive behavior may result from a variety of factors, including difficult temperament, ADHD, deficits in social skills, deficits in language processing, mood disorders, anxiety disorders, and nonverbal learning disability. Other features of oppositional disorder that were discussed included:

- Afflicted individuals seem not to learn from the consequences of their actions; therefore, telling individuals “don’t do it” may not be as effective as teaching individuals to recognize problematic situations and teaching them how to create flexible solutions to problems in evolution.
- Treatment should emphasize antecedents, the situational nature of explosive outbursts, involve a graduated training of lacking cognitive skills, and address potential neurobiochemical underpinnings of behavior.
- The collaborative problem solving (CPS) approach emphasizes assessing and understanding cognitive deficits that may contribute to the development of oppositional aggressive behaviors.

SOCIAL PHOBIA I AND II

Debra A. Hope, Ph.D.

Dr. Hope provided a comprehensive overview of social anxiety and social phobia and highlighted her presented by use of clinical vignettes and data from research protocols. In addition, she reviewed treatment options and focused on CBT for these diagnostic entities.

- Core features of these clinical syndromes include a hypervigilance for cues of social threat, a state of physiologic arousal, and behavioral avoidance.
- Commonly feared situations include acting or performing in front of an audience; working, eating, or writing while being observed by others; initiating or maintaining conversation; meeting strangers; expressing disagreement or approval; and talking on the telephone.
- The lifetime prevalence of social anxiety disorder is 13%; if public speaking fears that do not interfere with function are included, the prevalence rises to 27%.
- Social anxiety disorder is thought to be twice as common in women as men.
- Although half of those afflicted with this disorder have an onset of symptoms before the age of 12, treatment is typically first sought around age 30.
- A fear and avoidance hierarchy can be created and tabulated in chart form.
- A worksheet that lists feared situations, automatic thoughts, thinking errors, challenges, rational responses, and achievable behavioral goals is useful in CBT.
- Complications of social anxiety disorder include alcohol abuse, depression, increased health care utilization, and a heightened risk for suicide.
- Therapeutic interventions for this condition include applied relaxation, social skills training, exposure with and without cognitive restructuring, and pharmacological treatment. Exposure with and without cognitive restructuring and pharmacological treatments are considered the “first-line” interventions based on the available research data.



- Both CBT and pharmacotherapy (primarily SSRIs) are efficacious for social anxiety disorder.
- CBT for social anxiety disorder includes psychoeducation, cognitive restructuring, and relapse prevention.
- Steps in CBT include identification of thoughts and the emotions they cause, identification of the thinking errors in automatic thoughts, questioning (in a Socratic way) the correctness of the automatic thoughts, creation of a rational response, and gradual exposure to the feared situation.
- Unlike medication, gains secondary to CBT are likely to be maintained (or increased) following cessation of CBT.

IMAGINED UGLINESS: COGNITIVE-BEHAVIORAL TREATMENT OF BODY DYSMORPHIC DISORDER

Sabine Wilhelm, Ph.D.

Dr. Wilhelm defined the syndrome of body dysmorphic disorder (BDD), reviewed its relationship to comorbid conditions, identified its prevalence and described a variety of treatment approaches. She noted that improvements in cognitive-behavioral therapy for BDD were also associated with improvement in depressed mood.

- BDD is a debilitating preoccupation with an imagined defect in appearance.
- The preoccupation causes significant distress and or interferes with daily functioning.
- About 90% of individuals with BDD perform repetitive behaviors to check, improve, or hide the perceived defect.
- Avoidance of social situations is very common among those with BDD.
- BDD sufferers have a difficult relationship with mirrors; they often alternate between episodes of mirror avoidance and mirror checking.
- BDD usually begins during adolescence; the sex ratio is 1:1.
- Approximately 7% of individuals who undergo cosmetic surgery have BDD; 27% of BDD patients have cosmetic surgery.
- SSRIs and CBT each appear to be helpful in BDD.

BEHAVIORAL ASSESSMENT AND MANAGEMENT OF CHRONIC PAIN

David Ahern, Ph.D.

Dr. Ahern focused his presentation on the behavioral assessment and management of chronic pain. He noted that pain disorders, particularly chronic nonmalignant pain are among the most vexing and costly problems for the health care system. Moreover, as data he presented showed, that CBT was an efficacious and cost-effective treatment for chronic pain.

- Chronic pain is one of the most common and distressing of somatic complaints, and it accounts for a disproportionate amount of disability and health care resources.
- Acute pain lasts less than three months and is often related to tissue damage.
- Chronic pain lasts more than six months and is often of unknown etiology.
- One myth about pain is “if there is no known physical damage somatic complaints must be psychological in origin.”
- A semi-structured interview can help assess the nature and history of presenting symptoms, relevant psychosocial stressors and background factors, and the presence of psychiatric disorders.
- The behaviors, thoughts, emotions, and coping strategies associated with pain syndromes should be assessed.
- Reliable and valid instruments (e.g., the West Haven Yale Multidimensional Pain Inventory [MPI], the Coping Strategies Questionnaire [CSQ], and the Pain Stages of Change Questionnaire [PSOCQ]) that can measure behavioral, personality characteristics, and coping abilities should be employed.
- Diaphragmatic breathing, progressive muscle relaxation, and biofeedback techniques and produce improvement in self-confidence and provide symptom relief.
- Reduction of the frequency of symptom complaints and nonverbal pain behaviors can be achieved in part by ignoring non-verbal pain and illness behaviors, and by having the spouse or significant other differentially reinforcing positive coping.



- Activity levels can be increased with behavioral contracting, goal setting, and pacing.
- Mutually agreeable treatment goals should be established with those in chronic pain.
- Obstacles to successful treatment include affect-laden presentations of symptoms of unbearable or overwhelming pain, a passive and helpless stances with regard to coping with pain, an angry response to health care providers for “failing” to relieve pain symptoms, and “doctor shopping.”

COURSE FACULTY

David Ahern, Ph.D., Assistant Professor of Psychology, in the Department of Psychiatry, Harvard Medical School; Staff Psychologist, Massachusetts General and Brigham and Women's Hospitals.

Lee Baer, Ph.D., Associate Professor of Psychology, in the Department of Psychiatry, Harvard Medical School; Director of Research, Obsessive Compulsive Disorder Clinic and Institute, Massachusetts General Hospital.

David Barlow, Ph.D., Professor of Psychology, Boston University; Director, Center for Anxiety and Related Disorder, Boston University.

Ryan Boxill, Ph.D., Clinical Fellow in Psychology, Massachusetts General Hospital.

Corinne Cather, Ph.D., Clinical Fellow in Psychology, in the Department of Psychiatry, Harvard Medical School; Clinical Fellow in Psychology, Massachusetts General Hospital.

Beth Gershuny, Ph.D., Instructor in Psychology, in the Department of Psychiatry, Harvard Medical School; Clinical Fellow in Psychology, Massachusetts General Hospital.

Ross Greene, Ph.D., Assistant Professor in Psychology, in the Department of Psychiatry, Harvard Medical School; Director, Cognitive Behavioral Psychology, Pediatric Psychopharmacology Unit, Massachusetts General Hospital.

John B. Herman, M.D., Assistant Professor of Psychiatry, Harvard Medical School; Director of Clinical Services and Director, Psychiatry Continuing Education Division, Massachusetts General Hospital.

Debra A. Hope, Ph.D., Professor of Psychology, Director of the Anxiety Disorders Clinic, University of Nebraska-Lincoln.

Bruce Masek, Ph.D., Associate Professor of Psychology in Department of Psychiatry, Harvard Medical School; Clinical Director, Child Psychiatry, Massachusetts General Hospital; Senior Associate in Psychiatry, Children's Hospital.

Stephen McDermott, M.D., Clinical Instructor in Psychiatry, Harvard Medical School; Director, Cognitive Therapy Institute and the Cognitive Therapy and Research Program, Massachusetts General Hospital.

Cory F. Newman, Ph.D., ABPP, Associate Professor of Psychology, in Psychiatry, University of Pennsylvania School of Medicine; Director, The Center for Cognitive Therapy.

Michael W. Otto, Ph.D., Associate Professor in Psychology, in the Department of Psychiatry, Harvard Medical School; Director, Cognitive-Behavior Therapy Program, Massachusetts General Hospital.

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UPCOMING COURSES

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