Cognitive Strategies For Getting Through A Breakup

Ayelet Boussi, Ph.D. January 3, 2019

We’ve all been through it. The end of a romantic relationship comes with a special pain that can be difficult to manage. A unique quality of romantic breakups, and what makes them differ from other losses, is how deeply they can impact our thinking about ourselves and the future. Some examples of maladaptive thinking that can come up after a breakup include:

*If only I were more chill about things, this wouldn’t have ended.*

*I can’t hang on to a relationship, I must be unlovable.*

*What a horrible waste of two years, now I’m even more desperate.*

*I’ll never have the kind of love that I see my friends have.*

All of these examples are rooted in cognitive distortions, and for some women, getting caught in negative thinking traps after a breakup can lead to longer lasting symptoms of depression, anxiety, sleep disturbance, and general stress. At CTWPS we help women to identify these distortions, and to develop healthier, reality-based thinking about the breakup process, which can help speed up her healing and get her moving in a more constructive direction. If you find yourself struggling through a breakup, below are important common cognitive distortions to keep in mind.

1) *Should Statements:* “I should be handling this better”. A common distortion for some women is “shoulds thinking”, which means having strict expectations about how things should be, or how one should feel and behave. This distortion can be especially strong in the initial days of a breakup, with should statements popping up in many ways, i.e. “we should still be together”, “I should be feeling stronger about this”, “we should be communicating less”, “I shouldn’t feel so needy right now”. Inherent in all of these statements is self-criticism and judgment, as well as arbitrary rule-making. These thoughts can set a woman up for even further distress and disappointment if not kept in
check. If you find yourself using the language of “shoulds” frequently in those early days, you’re not alone! The first strategy for addressing shoulds thinking is to catch it, recognize it as a distortion, and rework it more realistically in your mind. For example, for the thought “I shouldn’t feel so sad”, we would first identify it as a should statement, and then break it down and rework it, i.e. “Why shouldn’t I feel sad? It is a common, expected emotional reaction that has a natural course. It is quite important to be flexible with myself in the early days of a breakup, to allow myself permission to feel my feelings and to cut myself some slack, understanding that I may not be operating at my full capacity at first. I won’t feel sad forever, but for now I will be more patient with my sadness and give myself what I need.” By reworking the distortion in this way, a woman is able to comfort and nurture herself, rather than judge and criticize. Be mindful of moments in which you are slipping into “shoulds”, and remind yourself that there is no one correct way to manage the first few days after a breakup. Accept the breakup, expect some pain, and be patient with yourself.

2) Personalization/Control Fallacies: “I could have avoided this”. Often after a breakup women look for reasons to blame themselves, or go through the relationship with a fine-tooth comb looking for where she may have gone wrong; i.e., “If only my expectations weren’t so high, we’d still be together”, “I’m so damaged of course the relationship was bound to end”, “I messed up by not maintaining his/her happiness”. These thoughts and behaviors are examples of how the personalization and control fallacy distortions can slow down a woman’s healing after a breakup. As the name implies, the personalization distortion occurs when a woman takes personal responsibility and blame for all negative things that happen, even without evidence for doing so. The control fallacy distortion has a similar effect; it is predicated on the belief that one is in complete control of one’s life, experiences and environment, making one responsible for anything that might happen. The danger of these distortions is that they can prolong a woman’s pain, and reinforce negative beliefs about herself as unlovable or incapable of maintaining a relationship. The way we might address this kind of thinking in therapy is by recognizing it for what it is, and replacing the distorted thinking with more reality-based assessments. For example, if a woman comes in saying “We broke up because I’m such a mess”, we may break down the personalization and self-blame, replacing it with something more rooted in reality; “We broke up because we hit a wall in our compatibility, and could no longer fulfill each other’s needs. That goes both ways, and it is no one’s fault. Neither of us is perfect, but this relationship did not end because of a fundamental flaw in me. Rather breakups happen all the time - more often than not, in fact - to even the most ‘together’ individuals.” Look for where you might be personalizing your breakup, and practice critically analyzing your logic. Neutralize self-blame and practice balance in the story you tell about the breakup.

3) Fortune telling: “I’ll never find love”. This is a big one! Many of us find that after a breakup we draw conclusions about ourselves and our futures based on the pain we are feeling in the moment, i.e. “I’ll never find love”, “I’ll be alone forever”, “I’ll never stop feeling this miserable.” These are examples of the cognitive distortion of fortune telling, or the tendency to make predictions or jump to conclusions based on little or no evidence, and clinging to them as absolute truth. As with the other cognitive distortions in this list, fortune telling only serves to perpetuate one’s pain and hopelessness after a breakup. We all know that there is no way to know for certain what is going to happen in the future, so by committing to our fortune telling we are mourning an outcome that has not and may not ever happen! In therapy we would try to integrate a more balanced approach, by first acknowledging when fortune telling is occurring, then evaluating our real data, and then generating alternate possible outcomes. For example, with a woman who says “I’ve gone through several breakups at this point, I’ll never be able to maintain a relationship”, the work of therapy would be to evaluate what we can say is true and we cannot. We may restructure her statement as follows: “Looking back at my past breakups, I see behaviors that I would want to work on, like communicating my feelings more openly and feeling more confident in my needs, but I have no reason to believe I can’t develop those skills and meet a
Tips for Managing Social Anxiety

Do you feel self-conscious in social settings? Do you avoid meeting new people or new social situations because of a fear of being negatively judged by others? If so, you may have social anxiety. According to the National Institute of Mental Health, 12% of adults experience social anxiety disorder at some point in their lifetime, with women being nearly twice as likely to experience social anxiety as compared with men.

Here at CTWPS, we recognize the negative impact that social anxiety can have on a woman’s capacity to develop and sustain friendships and romantic relationships, as well as her career growth. In treatment, we help women overcome their social anxiety by identifying their “thinking traps” and changing the behaviors that prevent them from achieving their goals. If you struggle with social anxiety, consider whether you may engage in any of the below thinking traps:

1. **Fortune-Telling Error**: The fortune-telling error occurs when a woman assumes that a future event is going to have a negative outcome. Instead of considering the probability of the negative outcome, or evaluating the evidence that either supports or contradicts the occurrence of such an outcome, the woman instead believes that this prediction is already an established fact. For example, before going to a networking event in New York City, a woman with social anxiety may engage in thoughts such as: “My mind will go blank and I won’t know what to say” or “I will say something embarrassing.” After the event, this woman might continue to engage in distorted thoughts about the interaction, such as: “What’s the point of putting myself out there, I will continue to mess up when I meet new people.” Engaging in these types of distorted thoughts may result in negative feelings such as anxiety, sadness, or hopelessness, which in turn may cause this woman to avoid or dread future social interactions. In treatment, we would work with this woman to consider alternative outcomes and evaluate past data from social interactions to help her arrive at a more realistic, neutral narrative about the upcoming networking event. For example, we...
might ask her to consider past social interactions in which her mind did not go blank and she was able to have a “successful” conversation with a colleague or friend. We would also help her generate alternative predictions for how the upcoming event might unfold, such as “I may not always have the perfect thing to say but that doesn’t mean I’m not a good conversationalist” or “Even if my mind goes blank momentarily, it is okay to have lulls in a conversation.”

2. Mind Reading: The mind reading error occurs when a woman assumes that she knows what other people are thinking without investigating whether or not her assumption is true. Often, women with social anxiety assume that others are perceiving them in a negative manner when in fact this may not actually be the case. For example, during a perfectly pleasant conversation on a date the above woman may think to herself: “He notices that I’m blushing and sweating and can tell how nervous I am” or “He thinks I’m awkward.” In treatment, we might help this woman generate a list of alternative possibilities for how her date may have experienced her. For example, he may not have actually noticed that she was blushing or sweating, or he may have thought she was sweating because she was warm. We would also invite her to consider how catastrophic her “worst case scenario” would actually be - what if her date did notice that she was nervous? Would that necessarily make her awkward or unlikable? Or, is it possible that he could find her nervousness endearing, or even relieving in light of his own nervousness?

3. Labelling: Labelling occurs when a woman generalizes a single error or negative event into a negative global judgment about herself. For example, a woman attending a networking event for work may engage in distorted thoughts about how she will perform, such as: “This is not going to go well because I’m incompetent.” After the event, this woman may engage in distorted thoughts about her social interactions, such as: “I didn’t network with the people I should have. I’m a failure.” Such thinking traps are likely to make this woman feeling sad, or even angry, at herself. In treatment, we might approach such critical self-labelling by asking the woman how she would interpret the same situation if it happened to a friend. For example, if a friend of hers went to a work event and did not talk to people she would have liked to network with, would that mean she was as failure? Most likely the woman would not judge her friend as harshly as she judged herself, and she may even be able to generate evidence of times when her friend was successful at work. If we wouldn’t label someone else a failure for such a mistake, than we shouldn’t label ourselves!

Most women have experienced some social anxiety at some point in their lives, and for some women it can be debilitating. While social anxiety can be distressing it does not have to prevent you from achieving your goals or developing fulfilling relationships! CBT has been shown to be the most effective treatment for relieving social anxiety and helping women feel more comfortable and competent in social situations. If you’re experiencing social anxiety, and you’d like to make a change, please reach out to us for support.

Victoria Felix, Ph.D. November 14, 2018

Letting Go of the Struggle with Body Image

Victoria Felix, Ph.D. November 14, 2018

When you think about describing your experience with body image to others, what comes up for you? For many women, body image is described only as negative thoughts and feelings that they have about their bodies. Emily Sandoz, Ph.D., a clinical psychologist and leading
body image researcher, argues that the definition of body image is broader than just the negative perceptions of the body. She defines body image as a person’s whole experience of her body, including perceptions about outward appearance, awareness of internal body experiences, and all of the thoughts and feelings that are associated with these experiences.

When women only focus on certain aspects of their body experience, especially the ones they do not like, they may notice engaging in their world in limited ways to manage their discomfort with their bodies. For example, a woman may avoid going to the beach during a summer vacation because she does not want to be seen in a bathing suit. She may avoid dating because she wants to feel more comfortable with her body first. The cost of engaging in these avoidance behaviors includes spending less time and focus on present moment experiences that really matter.

In her book, *Living With Your Body and Other Things You Hate*, Sandoz describes an approach to changing one’s relationship with body image that allows one to focus on living the life you are currently living, rather than being governed by body image distress. Below are some techniques that can facilitate creating a healthier relationship with your body image.

**Present Moment Awareness**

The practice of present moment awareness involves noticing the ongoing experiences of your body and your environment as they are happening within and around you. For women experiencing body image distress, they may notice their awareness being pulled into the past or pushed into worries about the future. For example, while attending a luncheon, a woman’s awareness may be stuck in remembering a past unpleasant experience in which she was judged for her appearance, and she has trouble separating from those thoughts to enjoy the luncheon. She may find it difficult to enjoy the luncheon because her awareness is preoccupied with worries about others’ perceptions of her body, and she engages in behaviors to manage body image. Being present requires practicing the ability to notice when you are focused in on your body image and not paying attention to your experience in the moment, and then mindfully choosing to shift your awareness back to luncheon.

**Seeing Thoughts as Simply Thoughts**

A key way to change your relationship with body image includes noticing your thoughts about your body without giving them the power to rule your experience. When a woman gets stuck on a body image thought, for example, “my stomach looks big in this shirt and people are going to judge me,” she will likely use that thought to shape and explain her experience at the luncheon. She may decide to remain seated for most of the luncheon, even when she wants to get up and speak to others. She likely missed when others were engaged in what she contributed to the conversation, or when someone laughed at her joke. Her distressing body image thought ruled her experience. But interestingly, thoughts can be just that - simply thoughts. They do not have to dictate our experience.

**Accepting Experience**

Acceptance involves tolerating distressing thoughts and feelings, while still engaging in and committing to actions that matter. By letting go of efforts to keep body image distress at bay, a woman may find relief from the struggle and room to invest time, energy, and resources in more meaningful experiences. So she may decide to wear the colorful shirt (rather than worrying about what other people think), committing to focusing on the people around her and the content of shared conversations.
Here at CTWPS, we support women with changing their negative thoughts and feelings related to body image. If you are struggling with your body image, consider reaching out to us for support.

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Female Anger

One of my favorite moments as a psychologist is when I can help a woman access and express her anger. It’s no surprise that the character of the Incredible Hulk holds a soft spot in my heart (Yes, the scientist-action hero who mutates into a rageful green monster when angry - to the initial apprehension of my husband when we first met!). Conventional, gendered prescriptions for women include traits like “relational”, “sweet”, or “maternal” - characteristics that not only limit the socially acceptable roles for women, but also label “anger” as an undesirable and unfeminine quality. (The permissible exception, of course, is an angry mother who protects her children from harm!). But in spite of the societal repression of women’s anger, as therapists we remain curious about anger and view it - and the full range of emotions - as important data.

Let’s challenge some maladaptive assumptions about anger we see most often in therapy:

1. **Anger is a bad (i.e., unhealthy, irrational, selfish) emotion.**

   Anger is a valid emotion - similar to sadness or fear - that can communicate relevant information about our experience and interpretation of events. Just as sadness helps us appreciate loss or fear signals possible threat, feeling anger helps us recognize that something has gone awry. Whether we feel hurt, invalidated, disrespected, or deceived this is always valuable data for us to reflect upon. Ignoring the clues that anger leaves us often results in more harm in the long run, such as increased stress from stifling our feelings, somatic complaints, social withdrawal, mood lability, and poor self esteem. Just as it is crucial not to ignore an unexpected physical pain in your body since pain functions as our body’s “first responder” to a site of injury, anger serves an important function - to draw our attention to something deserving attention.

2. **Anger is destructive and always leads to negative or unwanted consequences.**

   This can be partially true. Since anger is an activating emotion, we may react when angered in ways that are exaggerated, hostile, or shortsighted because we want to quickly resolve feeling uncomfortable or discontent. However, this does not need to be the outcome of our anger. It is also important to distinguish between angry actions (i.e., behaving out of control) and taking action when angry (i.e., creating boundaries with a disrespectful co-worker). First of all, if we accept that anger is a legitimate feeling for women and that it is often informative, we can pause to treat it with the respect it deserves, and consider the long view instead of reacting in the moment. At its core, anger signals that some type of change may be warranted and it mobilizes us towards constructive action. Our goal as cognitive-behavioral psychologists is to help women be agentic whenever possible. While it is helpful to consider your goal when expressing anger
and regain a reasonable amount of control before responding - these steps serve as ways to help women affect positive change with their anger - not repress or react to it.

3. **“Getting angry won’t change things so I should just ignore it”**

It’s true that sometimes being angry does not lead to the specific outcomes that we want, and sometimes we may choose to let go of being angry, especially when perseverating on it harms us. Also, it is important to acknowledge that sometimes the cultural, political, or familial expectations for a woman make it extraordinarily difficult to convey anger, no matter how warranted her feeling may be. Here, we can remember that while the outward expression of anger may be discouraged in certain contexts, anger can still be acknowledged by the individual in other ways that preserve her experience and sense of self. Again, since anger is informative, even if actionable steps may not be immediately realistic, anger can point us in a helpful direction. So even if anger needs to be redirected through alternative activities or relationships (e.g., journaling, providing anonymous feedback when given opportunity, discharging anger through exercise, attending a protest, sharing with a therapist), acknowledging and honoring our anger - as part of a full and healthy range of emotion - is an integral step in maintaining our mental health.

All women with a menstrual cycle experience an accompanying fluctuation in hormones and physiological changes. While for some (lucky!) women this is unnoticeable business as usual, many women struggle with symptoms that become debilitating month after month. An often minimized aspect of this fluctuation is the impact on mental health. Researchers of women’s health concerns are increasingly insistent that psychological treatment be a component of treatment for endocrine and gynecological conditions, and we at CTWPS are here to help identify and treat those psychological symptoms. While we work with a range of experiences at CTWPS, the following is a discussion of some common gynecological and endocrine disorders that we see.

**Polycystic-Ovarian Syndrome (PCOS)**

PCOS is an endocrine (hormonal) disorder which impacts 7-10% of women of reproductive age. It is associated with an elevation in certain hormones which can cause irregular periods, excessive body and facial hair, weight gain, and acne. If you have PCOS, you may be familiar with some of the stressors - months without a period, or a period that lasts weeks, insulin resistance, difficulty with weight loss - but what you may not have identified as being part of PCOS are mood changes. Research by Thomas Berni and colleagues (2018) found that women diagnosed with PCOS were significantly more likely to have depression, low self esteem, anxiety, and eating disorders. While PCOS manifests differently in each woman, it is important to take seriously any signs of sadness, hopelessness or anxiety. At CTWPS, we might help...
a client grapple with the meaning of a PCOS diagnosis, fears or beliefs about it, and help ensure that her mental health is managed. Below are examples of emotional experiences related to PCOS that we might address:

1. A client struggling with the weight gain associated with PCOS may have experienced blame from others, such as “just eat less!” or “take better care of yourself!” When this blame becomes internalized, a woman is at higher risk of maladaptive, depressive thinking about herself. We might identify distortions in her thinking, such as personalization or the control fallacy, in which she is taking emotional responsibility for things outside of her control.

2. The excess body hair or male-pattern hair loss sometimes associated with PCOS can cause extreme distress for a client and cause her to struggle with beliefs about her femininity. For example, a client may feel hopeless about her appearance, believe she is unattractive, and avoid engaging socially. We would work with this woman to identify and deconstruct any maladaptive beliefs, and give her tools for managing anxiety while re-engaging in her life.

Endometriosis

Endometriosis is a condition in which cells of the uterine lining move outside the uterus and attach to other areas of the body, such as the ovaries, fallopian tubes, bladder, bowel, or other organs. When a woman has her period, the same hormones that cause her uterine lining to shed also cause the endometriosis to swell and bleed, which in some cases can cause severe pain, nausea, gastrointestinal distress, fatigue, and infertility. While relatively common, affecting 10% of women, endometriosis often goes undiagnosed or misdiagnosed for years before properly identified. Many studies have linked endometriosis to mental health diagnoses, specifically depression and anxiety, as well as social isolation and diminished sexual interest. One study by Antonio Simone Laganà and colleagues (2017) observed that high levels of pelvic pain due to endometriosis increased a woman’s anxiety and depression, which further amplified her pelvic pain, leading to a mind-body cycle in which both physical and mental health are compromised by the other. The study concludes that psychological treatment is a critical component of pain management associated with endometriosis. At CTWPS we are equipped to treat the anxious and depressive symptoms associated with the condition. Below are examples of issues that might come up in treatment:

1. A woman struggling with chronic pelvic pain due to endometriosis may find that her family and friends are critical and invalidating of her pain, attributing it to normal menstrual cramps or telling her to “toughen up”. As a result, she may become depressed or excessively question her own experience. We would work with this woman around connecting to her physical experience, replacing negative beliefs about herself, and developing strategies for communicating with her loved ones.

2. Struggling with severe menstrual pain, a woman may find her period to be very difficult to manage and dread it every month. She finds that in addition to her pain spiking, her anxiety spikes as well, exacerbating the pain. We would work with this client on addressing her fear of pain, helping her to articulate the beliefs she holds, i.e. “I have no control over my body” or “this pain is going to break me”, and reframe them. We might also help her to develop behavioral tools for coping, such as mindful relaxation or positive self-talk.

Premenstrual Dysphoric Disorder (PMDD)

PMDD is a psychiatric diagnosis involving symptoms of depression, irritability, trouble concentrating, feeling overwhelmed or moody, or disturbances to appetite and sleep during the week leading up to a woman’s period. While 3-8% of women meet strict criteria for PMDD,
many women experience sub-clinical symptoms monthly. In fact the American College of Obstetricians and Gynecologists estimates that up to 85% of women experience at least one physical or psychological PMS symptom around the time of menstruation. A common challenge for women is having this experience invalidated, or being called “crazy”, “irrational” or “hysterical”. Many women with PMDD or PMS may hesitate to assert themselves or communicate openly for fear of not being taken seriously. As psychologists at CTWPS, we see these symptoms present challenges to women of all walks of life. Below are some ways we might address these challenges in therapy:

1. Some women are aware of intensifying stress around their periods, but do not have a clear sense of timing or specific symptoms. A first step in therapy would be to collect data; keeping a journal or a log of symptoms can not only be illuminating, but can help identify targets for intervention. For example, a client’s log may indicate that when she engages in certain behaviors, such as going to yoga or meeting a friend for coffee, her mood symptoms are less severe. This allows for development of a behavioral treatment plan for PMDD.

2. A woman with PMDD finds that her male deskmate at work makes snide, teasing comments when she feels moody, making her feel dismissed and humiliated. We might work with this client on critically evaluating her subsequent beliefs about herself, such as “he’s right, I’m a mess”, or “I don’t deserve to work here.” We might also help this client assess her options for how to address this treatment at work.

Receiving a diagnosis of PCOS, Endometriosis, or PMDD can be distressing, but it also provides a roadmap for treatment. If you find yourself struggling emotionally around these or other gynecological or endocrine conditions, take it seriously and give yourself permission to seek support.

Emma Levine, Ph.D. August 20, 2018

Part I: Behavioral Interventions for Insomnia

Emma Levine, Ph.D. August 20, 2018

Do you lay in bed at night tossing and turning, unable to fall asleep? Or do you wake up in the middle of the night, consumed by worrisome thoughts or the fear of not being able to fall back to sleep? If so, you’re not alone. According to the America Insomnia Survey, one in four women struggle with insomnia.

Here at CTWPS, we recognize the host of negative consequences insomnia may have on a woman’s emotional, physical, and cognitive health, and we specialize in developing targeted treatment plans to help women regularize their sleep patterns and, in turn, improve their overall sense of well-being.

As cognitive behavioral psychologists, we understand insomnia to be caused by learned thoughts and behaviors that can be unlearned. Whether you occasionally struggle to have a restful night’s sleep, or are battling with chronic insomnia, you may consider implementing tenants of the two behavioral strategies below into your sleep routine:

1. **Schedule Appropriate Times for Sleep**
When a woman first begins behavioral treatment for insomnia, we typically collaborate with her to obtain a comprehensive snapshot of her current sleep schedule: when she goes to bed and when she rises, how much time she spends in bed, how much time she spends sleeping, and her napping behaviors. We find that many women attempt to compensate for a bad night’s sleep by taking naps or sleeping later on the weekends. While these behaviors offer relief in the short-term, they actually cause insomnia to persist!

We would then help this patient set a regular rising time, such as 6am, which means getting out of bed at 6am each day (sorry, including weekends!), irrespective of how poorly she slept. We would also encourage her to temporarily reduce the time allowed for sleep. We find that many women who worry that they won’t be able to sleep get into bed earlier than they otherwise would to “increase their odds” of getting quality sleep. Problematically, though, the more time you spend awake in bed, the stronger the association between “bed” and “wakefulness” becomes.

For this reason, we would coach this patient to either go to bed later or wake up earlier so that the time she spends in bed more closely reflects her average sleep time. We would determine the maximum time she should allow for sleep by adding one hour to her average amount of nightly sleep for one week. For example, if she averages six hours of sleep per night, we would encourage her to allow for no more than seven hours of sleep. To this end, we would also ensure that she knows when to go to bed by calculating what psychologists have termed her “earliest allowable bedtime.” To do so, we would subtract from her regular rising time of 6am her maximum time allowed for sleep (seven hours) in order to arrive at 11pm as the earliest time at which she should attempt to go to sleep.

Lastly, we would also encourage this patient to limit naps to no more than 45 minutes, beginning at no later than 2pm. There are many well-evidenced benefits to short “power naps,” such as improved mood and focus. Research indicates, however, that longer naps, especially those taking place later in the day, often consist of “deep sleep,” which weakens your sleep system’s capacity to sleep deeply during the upcoming night.

2. Strengthen Your Brain’s Association Between “Bed” and “Sleep”

The next area of focus in treatment with this woman would be to help make her bed a stronger cue for sleep. To achieve this goal, we would first assess whether she does any activities in bed that are cues for wakefulness, such as chatting on the phone, watching Netflix, attempting to work through a conflict with her partner, or lying in bed for long periods of time trying to fall asleep. While these activities may seem innocuous, they are actually counterproductive in that they strengthen the brain’s association between “bed” and “wakefulness.” Thus, we would invite this woman to modify her behaviors so as to only use the bedroom for sleep and sex.

Additionally, we would teach this woman to not stay in bed longer than 30 minutes, both before turning off the lights and after waking up in the morning. We understand that many women are simply not interested in relinquishing their habit of reading or watching TV in bed before falling asleep. In these instances, we coach women to start out by reducing the time they spend reading or watching TV in bed to no more than 20 minutes.

Importantly, we would also teach this woman to not lay in bed awake for longer than 30 minutes. If you’re still not asleep after about 30 minutes have passed (and you likely won’t be at first!), get out of bed and engage in a quiet, restful activity for another 30 minutes, such as drinking a cup of hot tea, reading a book on the couch, or engaging in some gentle stretching or yoga poses. Then, return to bed.
We recognize that for some women, consistently implementing these behavioral techniques may not be enough to fully repair their sleep cycle. While we do believe these behavioral interventions are critical prerequisites to healthy sleep hygiene, we also recognize that women live demanding, high stress lives with multifaceted responsibilities and, as such, have a lot on their minds! This is why we also make space in treatment to address the cognitive component of insomnia - the beliefs, thoughts, and worries - that tend to create distress and inhibit sleep.

For tips on how to obtain greater cognitive control so as to further improve your sleep, stay tuned for Part II: Cognitive Interventions for Insomnia.

Engorgement, mastitis, thrush, vasospasms, milk blebs... oh, the glamour of being a newly nursing mother! (See also: oversupply, undersupply, poor latch, tongue tie... and the list goes on.) If you are not familiar with these terms, you are one of the lucky ones. However, many new mothers experience some degree of breastfeeding difficulty soon after giving birth; and yet, the multitude of complications that arise are a surprise to many. When breastfeeding represents a dominant cultural value – as it has in the United States for several decades – the public messages and images surrounding the topic tend to be misleading for new mothers. We are fed images of mothers lovingly gazing at her newborn as it peacefully and easily suckles at the breast. However, when breastfeeding does not easily function, causes physical pain or emotional distress, the private experience may be quite a different picture.

Despite the “Fed is Best” movement that began in 2016, both research and clinical experience indicates that mothers in the US still feel immense pressure to only breastfeed their newborns, even when physical, emotional or practical limitations present significant challenges. A new mother can be then vulnerable to feelings of shame, failure, inadequacy and guilt if she feels she has not fulfilled cultural expectations nor provided the “best” for her child. In vulnerable postpartum moments, it is too easy for a new mother to blame herself and her body for not meeting expectations. After all, isn’t this what our bodies were meant to do??
Another crucial element of postpartum psychotherapy is to support women in developing kindness, compassion, and flexibility for themselves as new mothers. In the exhausting haze of caring for a newborn, it is easy to become discouraged when— for example— our bodies do not cooperate by producing enough milk, or we cannot induce our baby to latch on properly. Self-critical thoughts about ourselves, our bodies, and ultimately our mothering can run rampant. Thus, in treatment it is important to identify, examine, and challenge self-critical beliefs so a more balanced and compassionate perspective can be constructed. It is often helpful in therapy to gather evidence to disconfirm self-critical beliefs by identifying the myriad ways in which one’s body has, and continues to serve her (and her child) well. By acknowledging the aspects of mothering that are going well, we can help construct a more nuanced and compassionate perspective that more accurately reflects reality.

Once a roadblock is hit with breastfeeding or any other aspect of new mothering, we can be vulnerable to overgeneralizing and labeling oneself as a “bad mother.” Overgeneralizing and labeling occur when we assign judgments of value to ourselves based on a very limited set of experiences (rather than the whole). These judgements can then lead to overly negative thoughts that are psychologically damaging. In the case of breastfeeding, too often a woman’s ability to breastfeed is conflated with her love for her child and her aptitude as a mother. Challenging the logic of this thinking, we might ask her to consider whether she would make these same judgements about a good friend or a sister. We might ask her to identify and embrace the ways in which she is succeeding in tending to the needs of her child. Or, we might ask her to consider the fallacy of “emotional reasoning” – the belief that “I feel it, therefore it must be true.” In fact, when real-life evidence points to the contrary, our emotions may not be true, and may not be serving us well.

On the journey of becoming a mother, there are both emotional and physical stumbling blocks nearly all women encounter. In our culture, breastfeeding is one of the most emotionally-laden topics, and can also be one of the most physically demanding. At CTWPS, we are well-versed in how these difficulties can impact a woman’s mood and mothering experience. If you or someone you know is struggling with any aspect of becoming a mother, we would welcome the opportunity to support you through this journey with compassion, care and expertise.

As a psychologist, I marvel at the tenacity and courage it takes for women to discuss traumatic experiences in therapy. It may not feel courageous in the moment; in fact, it may feel like the exact opposite. Trauma has been defined in a number of ways, but here I use psychologists John Briere and Catherine Scott’s (2015) definition: “an event is traumatic if it is extremely upsetting, at least temporarily overwhelms the person’s internal resources, and produces lasting psychological symptoms (p.10)”.

In the cognitive-behavioral model, we believe that what we think influences our emotions and behaviors, and that our thoughts and beliefs are foundational to how we experience our lives. By its definition, traumatic experiences are unexpected, overwhelming, and significantly impactful. How then, do we think about (let alone make sense of and integrate) something like a traumatic event? The beliefs we hold after a
For example, let’s consider a woman (we will call her Liz) who believes that 1) she is a capable person and 2) she is generally safe as a single woman dating in the world. Liz agrees to be set up by friends and goes on three dates. While the first few dates were fun and enjoyable for Liz, at the end of their fourth outing her date starts to initiate sex despite Liz’s clear discomfort and attempts to slow it down. She ends up having sex that was unwanted and unsatisfying. Afterwards, Liz feels multiple emotions, including confusion, anger, shame, fear, and hurt. How does she think about and make sense of this experience in light of her prior beliefs about herself in the world? How might her thinking affect her next steps? Research supports that much of how we manage the impact of a trauma comes down to our thoughts and beliefs about the experience, even long after the event itself has occurred.

Below are some common examples of how Liz might have responded to the traumatic experience if we were to focus just on her thoughts and beliefs. Please keep in mind that the following examples are limited and meant to highlight a few of the ways that we may think about a traumatic event. They are not meant to present a “right” or one-size-fits all way of responding to trauma.

Recall that Liz’s prior beliefs included: 1) I am a capable person and 2) I am generally safe as a single woman dating in the world.

Response 1: Maybe this means my date felt chemistry and that meant sex. But it felt like a violation to me because I did not want to move this quickly, and I tried to slow things down. It didn’t work - I felt disregarded in the process and unsafe. I will not date this person again, and will move on to date someone who is more respectful.

Here, Liz’s belief that she is capable manifests as a healthy sense of self-worth and motivates her to an action plan that includes honest self-assertion. She acknowledges that she did not feel safe having sex at the time and will take steps to ensure her safety by dating people who are more respectful. In this example, Liz’s original two beliefs remain intact and produces action that reinforces those beliefs following an unwanted sexual encounter.

Response 2: Why did that happen? Maybe there’s something wrong with me for not wanting to have sex that night. I’m probably overreacting and this is completely normal on a fourth date.

In this response, Liz modifies her first belief to a belief that I must be out of touch and overly sensitive. Instead of viewing herself as a capable person, she wonders if she is inept when it comes to dating. If she changes her original belief about herself, her reaction to the sexual experience doesn’t reflect perhaps fair misgivings, but points to her as the one with unreasonable expectations. The second belief that she is generally safe dating in the world is maintained because she rethinks her experience as normative rather than a traumatic event.

Response 3: I can’t believe that happened. How could I have allowed myself to be in such an unsafe situation? Something is seriously wrong with me. It’s my fault and I should have known I would be in danger. The world has become a dangerous place.

This example draws attention to an instance where a trauma results in a rejection of all prior positive beliefs. Following the experience of unwanted sex, Liz no longer believes that she can trust herself. Instead, she views herself as flawed and to blame, and she sees the world as inherently dangerous.

These examples show just some of the ways our thoughts play a key role in life and in our suffering after a traumatic event. In therapy at
CTWPS, we help our patients talk about and manage the effects of their traumatic experiences on their beliefs and worldview. Our work with our patients leaves us radically hopeful, as we are able to see just how much influence we can have in calibrating our beliefs to our most consistent realities, even following trauma.

If you recognize your own responses in the examples above and would like support in discussing them further, please consider reaching out to us for an initial consultation.

What does being vulnerable mean to you? Many women associate being “vulnerable” with feeling uncomfortable, exposed or even scared. Pioneering vulnerability researcher Brené Brown describes vulnerability as expressing our true selves, rather than the selves we believe we “should be,” to intimate partners. Vulnerability does not guarantee that each partner’s needs will be met, or that the relationship will last, but we also cannot have lasting intimacy without it.

If you struggle to express your true self in intimate relationships, consider these three common myths that foster and maintain avoidance of vulnerability:

**Myth #1: “Being vulnerable means that I must share my deepest and darkest secrets.”**

Many women believe that being vulnerable requires that they unveil deep thoughts and personal experiences with their dating partner, often early in a relationship or in an intense “let it all out” fashion. Women who carry this belief often avoid self-expression altogether, due to the burden of vulnerability feeling too overwhelming. Here at CTWPS, we support the concept that healthy vulnerability involves doing so with someone who has gained your trust over time. The ways that you express vulnerability can grow as that trust grows. In therapy, we work with women to build efficacy and confidence in expressing themselves (e.g., being vulnerable) in ways that are tempered and intentional.

For example, consider a woman who is uncomfortable expressing preferences with her girlfriend when planning activities to spend time together. In therapy, we may first challenge her to take more tolerable risks, such as practicing communicating these preferences (e.g., restaurant preference) to her partner. As she develops confidence, we may then work toward increasing her capacity to tolerate more intimate disclosures, such as desire to feel more connected in the relationship, or readiness to take the next step in the relationship.
Myth #2: “Being vulnerable is a sign of weakness.”

Our culture perpetuates the myth that “not being vulnerable” is a form of strength that protects one from getting hurt, and that, conversely, being vulnerable is a sign of weakness. By contrast, here at CTWPS, we view a woman’s capacity to be vulnerable with those that appear worthy of her trust, as a sign of strength. It is ironic that it is women who avoid vulnerability who often experience their relationship needs not being met, as they may avoid all sorts of assertions within their relationship.

In therapy, we may ask a woman to track her thoughts and beliefs regarding what it means to be strong and weak in an intimate relationship. We would then specifically focus on beliefs that may be leading to unhealthy behaviors. For example, if she believes that being strong in a relationship means hiding unpleasant emotions (e.g., sadness or anger) from her partner, we would then explore ways that hiding those emotions may make her feel distanced and unheard by her partner, and ways that avoiding the expression of these emotions may lead to increased frustration and resentment. As she develops an understanding of ways that these thoughts and behaviors make weaken her, rather than strengthen her, in the relationship, we may then work toward increasing her confidence in sharing her emotions, appropriately and effectively, with her partner.

Myth #3: “To show vulnerability is to be needy.”

There is a difference between “being needy” and “having needs” in a relationship. Everyone has needs in a relationship. Vulnerability then is the honest expression of one’s genuine, legitimate, and healthy needs in a relationship to a trusted partner.

For example, consider a client who wants to feel more connected in her relationship, but is fearful of being perceived as “needy” by her husband. Because she is afraid to honestly express her desire to feel more connected in the relationship, she may end up feeling frustrated and isolated. Then she may pick a fight with her husband because he spends too much time on his phone, nag him about the amount of time he spends at work, or complain when he starts watching television after dinner rather than pitching in with household chores. Ironically, while she is fearful of being perceived as needy, these indirect attempts at communicating her desire to feel more connected are likely to be perceived as needy or aggravating to her partner! In therapy, we would help this client develop tools and confidence to communicate in a way that is directly congruent with her goal of getting her needs met in the relationship.

While there is fear and risk associated with being vulnerable, there is also potential for the reward of deepening intimacy. In therapy here at CTWPS, we work with our clients to create a more flexible definition of vulnerability, and provide tools to build safety, confidence, and efficacy in being vulnerable in intimacy.
Even the most accomplished and confident woman may find herself from time to time questioning her capabilities or value. Whether on the first day of a new job, on a date with a desirable partner, bringing home a first child, or talking to a big client, a woman may think, “I’m not good enough for this”, “I don’t belong here”, or “someone else would be better suited for this than me.” If these thoughts persist, however, it may reflect what psychologists Suzanne Imes, PhD, and Pauline Rose Clance, PhD named “imposter syndrome” - a phenomenon that manifests as self-doubt, a lack of confidence, and a belief that one is unqualified for her position and happened into it by luck or circumstance. For some women, the belief persists that she has somehow “cheated” or “tricked” her way into convincing others that she is capable. But internally, she feels like a fraud.

Studies have shown that imposter syndrome is significantly more common in women than in men, perhaps because women are more likely to attribute successes to luck or help from others rather than hard work, and more likely to attribute setbacks to personal deficiencies rather than outside factors. In other words, when a high achieving woman gets a promotion, she is more likely than a man in her position to attribute it to factors other than her own talent and skills. This sets the stage for skewed thinking about her abilities, and over time, it can reinforces the fallacy that she is “faking her way” through her achievements.

At CTWPS we see this kind of thinking often - ironically, often in especially brilliant, talented and accomplished women! The first steps toward managing imposter syndrome involve identifying thinking traps, working toward a more balanced self-view, and engaging in constructive behaviors. Below are action items that we might engage in therapy for reducing feelings of fraudulence:

1) Reframe your thinking. Part of battling imposter syndrome is recognizing that it involves some non-truths. While a woman may be justified in feeling some nervousness about taking on a challenging new role (who doesn’t?!), it is usually not true that she is completely unprepared for it. Most likely, she is not actually a fraud - she has some training and experience that have led her to this position. We would encourage a client to practice telling herself the whole truth, and challenge black and white thinking, by taking an honest accounting of her work and accomplishments. When a client sees herself as undeserving of a promotion, we might ask her to concretely list out her qualifications and accomplishments, as well as her areas for development. It is important to be honest and realistic about the gaps in one’s expertise, but often the focus on this detracts from a woman’s attention to her accomplishments. By asking our clients to be explicit with us about her achievements, we can come to a more balanced perspective.

2) Challenge the presumption that you are a superb con artist (and everyone else is gullible). Because the belief that one is an imposter is hard to shake, it is important to seek out as much outside evidence as possible to balance one’s view. Dr.s Imes and Clance suggested an experiment to help a woman let go of the belief that she has tricked everyone. We would have the client imagine a person she believes she has tricked (i.e. a boss), have her role play telling that person specifically how she has tricked them (i.e. "you gave me that promotion because I've charmed you and you like me as a person, but you don't realize that I'm not really capable of managing the new role"). Next, we would the client to talk back to herself from the perspective of that person (i.e. to say as her boss, "I don't just give promotions to the people I like, I give them to people who show promise"); or "It is insulting that you think my judgment is so skewed by liking people - I know talent and skill when I see it"). Giving voice to disconfirming evidence is an important part of challenging the idea that you have tricked everyone. Developing an open relationship with a mentor or other experts can also be helpful, both as a learning opportunity, and as a source of reliable feedback.
3) Change your language. An important behavior to address is in how a woman speaks to and about herself. If a woman finds herself consistently attributing her successes to luck, she can edit this by engaging in productive self-talk, i.e. “I contributed to this project by...”, “I closed that deal by...”, “I got an A on that paper by...” We encourage clients to practice demonstrating evidence of her competence on a daily basis, and credit herself verbally for her achievements. This can also be practiced by having a mindful moment at the end of a project, successful or not, in which a woman writes down for herself what strengths and skills she brought to the table. While increasing positive self-talk is important, it is also useful to share one’s successes with others. We encourage clients to celebrate their achievements! Share them with your family, friends, and colleagues. While many women tend to focus on negative feedback, it is important to balance this tendency with the positive. Practice internalizing praise and practicing pride in your work by talking about it to yourself and others; this will help your accomplishments to become integrated into your self-view.

4) Develop your “inner expert” and increase your self-efficacy. While we want to focus on our achievements, there is always room to grow! We might invite a client to set learning goals for herself, and develop expertise about the field in which she is feeling deficient. For a new mom this can mean taking a parenting class or spending time with other moms to share tips. For a rising professional this can mean taking continuing education classes, attending conferences, or reading books about her field. The behavior of building mastery is self-perpetuating; by learning more, a woman builds confidence and faith in her own legitimacy. Developing the quality of self-efficacy requires a “walking the walk” or “fake it until you make it” attitude, in which a woman pushes herself to embody and emulate the person she wishes to be, even if she does not completely feel it. We might encourage a client to push herself to volunteer for challenging tasks and take on the goals that are a bit intimidating. By “acting as if” and doing the behaviors of someone who is confident about a project, she can further rewire her thinking. The important thing to remember is to take ownership of one’s self-doubt and take action. Learn by doing! Anxiety is designed to make us avoid danger; we encourage clients to practice mindfully disobeying her anxiety and feelings of self-doubt, and delve into honing her skills.

It is essential to remember that those who struggle with imposter syndrome may be no less successful, competent, or capable than those who do not struggle with it. Our goal is to help clients who experience feelings of insufficiency and fraudulence to change their thinking and their behavior in ways that can help them fully inhabit their successes.
There's a S.M.A.R.T. Way to Write Management's Goals and Objectives. Management Review, 70, 35-36. has been cited by the following article: TITLE: Community Monitoring of Forest Carbon Stocks and Safeguards Tracking in Kenya: Design and Implementation Considerations. The paper utilised policy analysis approach used to derive monitoring goals and objectives by assessing the compatibility of Kenya's policy and legislative framework with monitoring elements provided in the UNFCCC REDD+ policy mechanism. The elements included monitoring goals, objectives, questions, indicators, and methods and tools. Two goals were identified which included, reduction of forest carbon emissions (ER) and monitoring of multiple social and environmental safeguards (SG). The first use of SMART criteria to describe goal-setting occurred in the November 1981 issue of Management Review in George Doran's article, “There's a SMART Way to Write Management's Goals and Objectives.” Doran wrote that objectives should be: Specific – They should target a specific area for improvement. Exactly what do you want to accomplish? Who, what, when and where? Measurable – They should quantify or suggest an indicator of progress. How will you track your progress? How much and how many? Achievable – They should aim for a realistically achievable result. Do you have what you need to