Put Your Thoughts on Trial: Cognitive Restructuring

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Description of the Intervention

- Cognitive restructuring involves identifying the specific automatic thought distortions or biases, the antecedent to these thoughts, and modifying the content or credibility of these thoughts.
- Cognitive interventions stem from the belief that human emotions and problems are a result of our biased, distorted, and erroneous interpretations of life events.
- The technique involves identifying the specific rules and assumptions that maintain depression, anxiety, or anger, modifying these assumptions, and developing more helpful, less rigid, and less negative assumptions.
- The common goal of cognitive techniques is to increase awareness of, challenge or test, and ultimately change the dysfunctional cognitive structures that result in biased information processing and increased symptomatology.

Brief Review of the Research

- Cognitive restructuring has been researched and tested alone or combined with other strategies in treatment for almost every disorder found in the DSM V. Some of the earliest research trials focused on the use of cognitive restructuring for depression.
  - Nearly 30 years ago, Teasdale and Fennell showed in study with five chronically depressed patients that the process of changing patients' distorted thoughts produced an improvement in their mood, while a control condition that consisted of simply exploring the thoughts did not.
  - Increases in panic self-efficacy and decreases in catastrophic misinterpretation that occur during treatment have been shown to predict lower panic severity at post treatment.
  - In the case of PTSD, Bryant and colleagues noted that cognitive restructuring is based on the notion that identifying and modifying catastrophic and unrealistic interpretations of one's traumatic experience and future well-being will lead to symptom reduction because the resulting cognitive schema will not result in psychopathological states.
- A debate about cognitive therapy is whether we need to actively restructure thoughts to create affective relief or behavioral changes.

Clinical Problem Addressed

- Patient is a 33 year old, Caucasian, heterosexual male, from Rhode Island.
- Diagnosis: F11.20 Opioid dependence, severe.
- In Methadone Maintenance Treatment Program (MMTP) for 4 years.
- Lives with wife and his two kids. No medical or psychiatric history in family.
- Stable social life; positive support system.
- Patient incarcerated for 1 year in 2014 for possession of illicit substances with no current legal involvement.

Conceptualization of the Intervention

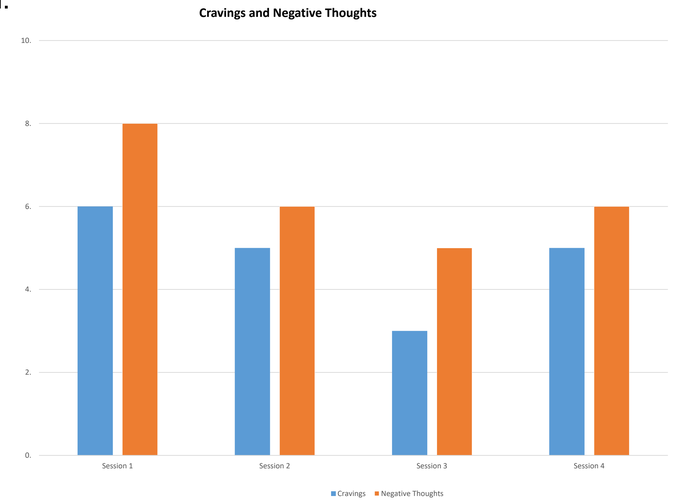
- Patient feels hopeless he can maintain long term abstinence. Patient reports a pattern of relapse every 4-6 months since beginning treatment. His fear is not knowing if he'll be able to stop once he starts using again as he has been feeling overwhelmed with recovery process.
- The goal of the intervention was to support patient in identifying his negative automatic thoughts related to recovery and relapse. Often, substance users often try to self-medicate painful thoughts and feelings caused by fear and self doubt by drinking or abusing drugs. The goal was to help the patient identify certain thoughts, feelings, and behaviors and learn to challenge these.

Implementation

- Throughout sessions I supported the patient in identifying, monitoring, and categorizing automatic thoughts. Self-report tools were used, such as a thought record or daily record of dysfunctional thoughts, in which the patient identifies the situation, the emotion, the thoughts that accompanied these emotions, and the errors of logic in the thoughts.
- Using the double-standard technique was helpful as well. The double-standard technique examined the nature and rationale for applying one standard to the self and a more lenient and tolerant standard to others.
- I introduced the idea of a role-play to examine how the patient would handle certain thoughts about a specific circumstance if another applied to another person. Role-plays also included the patient taking the negative or the rational or alternative response and arguing for or against the negative.

Evaluation and Outcome

- During the beginning of each session, I asked patient to rate the severity of his cravings that week (scale of 1-10; 10 being most intense).
- Patient also rated occurrence of negative thoughts that week (scale of 1-10; 10 being very often).
- Intensity of cravings and amount of negative thoughts varied from week to week. However, there was a positive correlation between both.



References

- DeRubeis, R. J., Evans, M. D., Hollon, S. D., Garvey, M. J., Grove, W. M., & Tuason, V. B.(1990). How does cognitive therapy work? Cognitive change and symptom change in cognitive therapy and pharmacotherapy for depression. *Journal of Consulting and Clinical Psychology, 58*(6), 862–869. 2
- O'Donohue, W. T., & Fisher, J. E. (Eds.). (2012). *Cognitive behavior therapy : Core principles for practice*. ProQuest Ebook Central https://ebookcentral.proquest.com
- Oei, T., Llamas, M., & Devilly, G. (1999). The Efficacy And Cognitive Processes of Cognitive Bevaiour Therapy in the Treatment of Panic Disorder with Agoraphobia. *Behavioural and Cognitive Psychotherapy, 27*(1), 63-88. doi:10.1017/S1352465899271081
- Peterson, C., & Seligman, M. E. (1984). Causal explanations as a risk factor for depression: Theory and evidence. Psychological Review, 91(3), 347-374. doi:10.1037/0033-295x.91.3.347
- Segal, Z. V., Gemar, M., & Williams, S. (1999). Differential cognitive response to a mood challenge following successful cognitive therapy or pharmacotherapy for unipolar depression. *Journal of Abnormal Psychology, 108*(1), 3–10. https://doi.org/10.1037/0021-843X.108.1.3
- Teasdale, J. D. (1983). Negative thinking in depression: Cause, effect, or reciprocal relationship? Advances in Behaviour Research and Therapy, 5(1), 3-25. doi:10.1016/0146-6402(83)90013-9