COMMON LANGUAGE for PSYCHOTHERAPY (clp) PROCEDURES
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COGNITIVE RESTRUCTURING

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Definition: Methods that encourage clients to identify dysfunctional sets of thoughts and beliefs relating to their problem, and to challenge the validity of those in order to produce and use more adaptive alternatives.

Elements: Helps clients to identify and challenge maladaptive thoughts (e.g. *absolute/all-or-none/dichotomous/black-and-white/catastrophising/overgeneralising thinking)* and beliefs concerning the problem through interviews and *daily thought diaries*. May include:
-*Socratic questioning* to weigh evidence for/against each thought and belief
-*Downward arrow (what if?) technique* and *probabilistic reasoning* to challenge maladaptive thoughts and beliefs
-*Behavioural experiments* to *challenge* maladaptive beliefs
-*Distancing/giving perspective* to generate alternative adaptive thoughts and beliefs.

Related procedures: *Rational emotional therapy, self-instructional training, problem-solving.*

Application: Usually taught individually rather than in groups.

1st use? Concept first used by Alexander JM (1928)

References:
1. Alexander JM (1928) *Thought control in everyday life*. Funk & Wagnalls, New York.
2. Beck AT (1967) *Depression: Causes and treatment*. University of Pennsylvania Press, Philadelphia
3. Ellis A (1969) A cognitive approach to behaviour therapy. *Internat. J Psychother*, 8, 896-900;
4. Lovell K (1999) Exposure and cognitive restructuring alone and combined for PTSD. PhD dissertation, Univ of London

Case Illustration (Lovell 1999)

A man of 26 with PTSD for 2 years after being assaulted, injured and scarred was asked to keep *daily diaries* of thoughts to record negative thoughts and beliefs. They related to fear of being re-assaulted. When asked, he rated his belief in the probability of being re-assaulted as 80% *(monitoring)*. This belief was challenged by *probabilistic reasoning* - he was asked to calculate how often he'd been out with friends in the years before the assault and to estimate the probability of a future assault. The self-rated difference between his initially perceived (80%) and the probable (now rated as 10%) risk led him to *identify his thinking error* of over-estimation of danger. He *reframed* his belief as the alternative `My chances of being attacked are no more than other people's', and rated his reframed belief in it as 90%. Soon after this he began to go out with friends and then alone.

He also identified shaming thoughts and beliefs (*diary keeping*) e.g. `I'm a coward as I cried after the attack; men don't cry'. He rated their validity as 85%. When challenged to provide evidence for and against such thoughts, he recalled that his father had been upset after the assault and had cried when visiting him in hospital, but his father was not a coward. He also recalled that he and his friends had wept at a funeral, which was appropriate and not a sign of cowardice. He then reframed his thought to: `Crying is appropriate in stressful situations'.

He *recorded a negative overgeneralising thought*: `People with scars are thought to be criminals, so others seeing my scar will think I'm a criminal'. He rated this thought as 85% valid. He was asked to list the hair colour, height etc of criminals and to compare these features with his own. Mismatch of the two lists led him to rerate his belief that others would consider him a criminal as 40%. For *homework* he listened to the audiotape of the session and was required to think of people he knew with scars and how much he believed them to be criminals, and to spot his thinking error. At the next session, he said he realised he knew many scarred people but did not think them as criminals. He generated an *alternative response*: `Acting suspiciously and having a past criminal record suggest criminality, not a scar'. He rated his belief in this reframed thought as 100%. He *labelled his thinking error* as mind-reading (false attribution).

The PTSD had reduced markedly after 10 sessions and even more so 1 year later.