INVITED ARTICLE

HELPING PATIENTS TO THINK BETTER: COGNITIVE THERAPY FOR INDIVIDUALS AND COUPLES

L H Peh

ABSTRACT

A system of psychotherapy called cognitive therapy, emphasising that mood disorders are affected by distortions in thinking about self, the future and the world, has been found useful in the treatment of diverse neurotic disorders. Helping the patient restructure his thinking by examining such distortions and correcting them would be a vital process in the prevention or recovery of mood disturbances.

Applications of cognitive therapy in depression, panic disorder, hypochondriasis and marital distress are described in this article.

Keywords: *Cognitive therapy, depression, panic disorder, hypochondriasis, marital distress.*

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Psychotherapy differs from informal psychological help in that besides special training needed by the practitioner, it is usually guided by a theory that explains why a patient is distressed and prescribes ways of helping him[1]. Most of the counselling given to patients by general practitioners and non-psychiatric clinicians is termed "supportive" and the components include reassurance, explanation, suggestion and encouragement.

In the last two decades, a system of psychotherapy, developed chiefly by Aaron Beck and his colleagues to help patients overcome emotional problems[2], has been found useful and popular in the treatment of diverse neurotic disorders such as anxiety states, phobic disorders, obsessional disorders, depression and hypochondriasis[3]. As an adjunct treatment for cancer patients facing emotional adjustments, cognitive therapy has been used in a research project in the Royal Marsden Hospital in London[4].

This system of psychotherapy emphasises that mood disorders are affected by distortions in thinking (such as negative interpretations and predictions) about the self or life experiences. Helping the patient restructure his thinking would thus be a vital process in the prevention or recovery of mood disturbances. It is likened to "teaching him to fish, rather than giving him a fish", so that he can examine the distortions in his thinking and correct them himself, thus keeping himself away from dysphoric moods such as depression and anxiety.

In contrast to behaviour therapy, it is inner-directed rather than outer-directed, towards information processing about the self and the world, emphasising logical consistency in thinking. It is different from psychodynamic psychotherapy in that in cognitive therapy the important cognitions are distorted views about the self, the future and the world, whereas in the psychodynamic approach the important cognitions are those that relate to one's history as it affects present functioning[5].

Applications

1. Depression

The cognitive model of depression suggests that early experiences lead people to form rigid dysfunctional assumptions about themselves and the world (eg "Everyone I know must like me"). When critical incidents occur, the personal worth of the patient is affected by his own system of beliefs, triggering depression. Once this happens, negative thoughts are activated, such as misinterpretation of current events (eg on seeing a friend who did not return his greeting, the patient thinks "He dislikes me"), or hopelessness about the future (eg "I will be a social outcast"). Such negative thoughts will lead to rational thoughts being crowded out, forming a vicious circle as negative thinking lowers the mood even more[3].

Here the therapist helps the patient to identify and challenge his negative thoughts eg asking himself whether he can view the situation in other ways and not jump to conclusions or make overgeneralisations. Together the patient and the therapist generate rational ways of thinking about himself and the external circumstances affecting him. Homework and behavioural experiments may be set for the patient to learn to overcome his dysfunctional assumptions. The patient may also be helped with scheduling of activities and assigned graded tasks so as to be engaged in mood-elevating activities.

2. Panic Disorder

The physical symptoms of panic attacks resemble those of an acute myocardial infarct and the patient may have fear of dying or going crazy during such an attack. It is often associated with avoidant behaviour (especially agoraphobia) and anticipatory anxiety.

The cognitive hypothesis is that such patients have a tendency to misinterprete bodily sensations as a sign of imminent catastrophe[6]. The trigger stimulus may arise externally eg general stress, or internally eg a frightening thought. When the patient experiences palpitations he may think that he is having a heart attack; this misinterpretation makes him more anxious and he may start to have even more sensations associated with physiological arousal, such as breathing difficulty, dizziness and chest pain.

In cognitive therapy for panic disorder, the patient and the therapist together generate alternative, accurate and credible explanations for these sensations. The aim here is to provide a non-catastrophic account of these experiences so as to break the vicious circle that is formed when the patient's misinterpretation of his bodily sensations lead to him thinking that his life is in danger, causing even greater apprehension and more physical symptoms[6].

Behavioural experiments in the clinic setting eg letting the patient experience the effects of deliberately hyperventilating, which are similar to those in a panic attack, may be used to

Woodbridge Hospital
Jalan Woodbridge
Singapore 1954

L H Peh, MBBS, MMed (Psychiatry), FAMS
Senior Registrar

"chip" away the erroneous belief that such symptoms must invariably be of cardiac origin.

3. Hypochondriasis

A hypochondriacal patient is preoccupied with the fear of having a serious disease although appropriate physical evaluation does not support the diagnosis of any organic pathology. In particular, he pays selective attention to bodily changes or features and interpretes them as signs of ill-health. Typically he persists in seeking reassurance and information and repeatedly checks his bodily status.

The cognitive model of the development of such severe health anxiety suggests that it may be influenced by previous experiences[7]. For example, when the patient was young, whenever he had any physical symptom he was taken to consult the physician in case it was serious. This may lead to the assumption that bodily symptoms are always an indication that something is wrong. A critical life event such as the death of a close relative may trigger off such an assumption when the stress of the situation leads to physical symptoms such as headaches. The patient may then begin to have negative thoughts and imagery related to his health such as worries that he could be having a brain tumour that was life-threatening.

One of the principles in cognitive treatment of hypochondriasis is to always acknowledge that the patient really has the symptoms and that treatment aims to provide a satisfactory explanation for them[7]. Reassurance is thought to reinforce the health anxiety, so care is taken to give only relevant and not repetitive information to the patient. Questioning in the "Socrates" style is used, as opposed to a combative style which may alienate or offend some patients. Since a patient's beliefs about his health are usually based on evidence that he himself finds convincing, rather than discounting a belief, the physician should discover what it actually is and then work to modify it collaboratively with the patient. Treatment techniques include educating the patient about the frequency and meaning of normal bodily changes, re-attributing or constructing alternative explanations for symptoms. Behavioural experiments are sometimes used eg a patient who believes that a mild discomfort in his throat is a sign of throat cancer may check it by repeatedly swallowing. By demonstrating to him that this checking behaviour is the cause of the throat discomfort getting worse, the patient may be able to change his belief that he has throat cancer and modify his actions so that it does not aggravate the throat discomfort.

4. Marital Distress

Helping couples deal with marital difficulties by getting them to change their behaviour towards each other has been used as a short-term approach to easing their distress[8]. From this purely behavioural approach, adding techniques such as improving communication, problem-solving skills and cognitive interventions has made this form of marital therapy more effective[9].

Many marital problems arise because of a tendency in couples to make inaccurate and unreasonable conclusions about each other. A cycle of misunderstandings can fuel marital hostility. By helping such couples examine the distortions in the way they see each other, they may be able to relate better to each other. An example of such cognitive distortions is "mind-reading" where one spouse tries to read what the other is thinking and attributes the behaviour in question, eg silence, to some negative reason, such as neglect or anger, when it could simply be that the spouse was in a contemplative mood.

Symbolic meanings of actions and signals are often overlooked and may leave one spouse bewildered over the other's reactions. A clash of perspectives, breaking of unwritten but well-formulated rules in the marriage, poor communication and problem-solving abilities may destroy a marriage[9].

The role of the cognitive therapist here is to identify together with the couple the specific nature of the marital difficulties in these areas. Some couples may then need to learn how to deal with the misinterpretation of messages they give each other; others may find the learning of problem-solving and communication skills more important. The cognitive input to such "trouble-shooting" will lead to a fresh approach to helping couples in distress.

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