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Cognitive-Behavioral Methods: A Workbook for Social Workers

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CHAPTER 5: Use of Cognitive Restructuring with Special Populations and Problems



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Use of Cognitive Restructuring with Special Populations and Problems

Cognitive restructuring, as we reviewed extensively in Chapter 4, is a major technique in cognitive-behavioral intervention. It can be very effective when applied appropriately, but sometimes students and beginning clinicians have difficulty knowing when to use it. The following guidelines are helpful for determining when cognitive restructuring may be the technique of choice and assessing whether certain populations of clients are appropriate candidates.

You may consider the use of cognitive restructuring when:

- People are distressed by painful emotions or commit behaviors that are detrimental to themselves or to others. When people talk about distressing feelings or problematic behaviors, asking them about the thoughts they were having during these times might uncover some distortions in beliefs. For instance, a woman described that after breaking up with an abusive boyfriend, her stomach became upset, she started shaking, and she felt compelled to call him back. When asked, “What was going through your mind?” the client reported that she was thinking, “What am I going to do? I’m never going to be able to make it without him. I can’t do it. Without him, I have nothing.” These thoughts were

appropriate to target for restructuring because they were preventing her from making a clean break with her boyfriend.

- A client uses “absolutist” language: “never,” “always,” and “have to.” These words signal that possible erroneous beliefs may be operating. In the previous example, the woman said, “I’m never going to be able to make it without him,” a clue that a distorted belief was operating its influence.
- A belief system seems to pose a substantial barrier to a client’s progress. Recall from Chapter 4, Example 4–3, Malcolm, the young man who was diagnosed with paranoid schizophrenia. The social work intern was working with him on assertiveness, but he seemed to be having difficulty with some of the skills. As a result, the student decided to explore his thoughts during a recent incident in which he had been financially victimized. Only after Malcolm had been through the process of cognitive restructuring was he able to return more successfully to the assertiveness skills training.
- Cognitive restructuring addresses a priority problem for the client. In using cognitive-behavioral interventions, the social worker wants to ensure that he or she is using the technique that most appropriately addresses the client’s priorities and that targets as many different problems as possible.

We start with a scenario in which you are asked to reflect on this client’s circumstances and how best to serve her needs.

EXAMPLE 5-1

Rowena Calvert, a 34-year-old African American mother of three children, lived in a run-down, two-bedroom apartment. Her rent exceeded her ability to pay. Numerous repairs were needed in the apartment, which was part of a Section 8 housing development, but the landlord would not attend to them. To manage her living expenses, Rowena had taken in two boarders.

Rowena had argued with her boarders one night because they took some food that belonged to her. The student involved in

the case decided to use cognitive restructuring because of the anger Rowena experienced in this situation and her subsequent “lashing out.”

Exercise 5-1

How would you address the client’s problems using cognitive-behavioral techniques? Would you use cognitive restructuring? Why or why not?

Exercise 5-2

Consider the guidelines on when to use cognitive restructuring and think about your current or past caseload. Give an example of a case in which it might have been helpful to use cognitive restructuring and explain your rationale.

Box 5-1 Modifications of Cognitive Restructuring for People with Limited Cognitive Functioning

- Present new information slowly and in different ways (say it, show it, do it), and use frequent repetitions.
- Offer shorter, more frequent sessions.
- Ask the client to summarize material more often.
- Use concrete mnemonic devices, such as caricature drawings or other specific visual (e.g., notes written on an index card) and auditory aids (e.g., audiotapes). Tape sessions and encourage people to review them for homework.
- Provide people with folders or notebooks for storing home practice and in-session materials.

Source: K. Laidlaw, L. Thompson, D. Gallagher-Thompson, & L. Dick-Siskin, *Cognitive Behaviour Therapy With Older People*. W. Sussex, UK: John Wiley, 2003.

Special Populations

Are clients who have mental illness or mental retardation appropriate candidates for cognitive restructuring? What about children or the elderly? What about clients who have harmed other people? This section considers each of these special populations and some of the assessments and possible adaptations that the social worker must make to determine the appropriateness of cognitive restructuring. Box 5–1 also covers some modifications to cognitive-behavioral work that can be done when working with people who are limited by their cognitive levels.

Severe Mental Illness

Cognitive-behavioral interventions are often used with people diagnosed with schizophrenia. It is a here-and-now approach, well suited to helping people learn the skills to advance their daily functioning. Several meta-analyses have been conducted on cognitive-behavioral interventions with this population. Pilling et al. (2002) colleagues conducted a meta-analysis of all randomized clinical studies done on cognitive-behavioral interventions for schizophrenia. The researchers concluded that cognitive-behavioral interventions improved clients' mental status and decreased rates of treatment dropout, and that their positive effects persisted through the follow-up period.

The technique of cognitive restructuring requires a client to think in abstract and logical ways. When individuals are actively psychotic, they often cannot distance themselves from their symptoms and are unable to consider other ways of thinking. Therefore, cognitive restructuring can be used with psychotic clients only in areas where their thinking is relatively stable and the client is ambivalent enough to consider other explanations. Better cognitive-behavioral techniques might involve training a client who is susceptible to hallucinations and delusions in thought-stopping and coping self-statements ("I'm okay," "I'm safe"). These are detailed further in Chapter 6. Cognitive restructuring may be appropriate when the client has stabilized. For instance, as demonstrated previously, cognitive restructuring was successfully used with Malcolm. The social work intern was also able to teach Malcolm and other clients diagnosed with

schizophrenia to recognize different cognitive errors and to apply them to their own experience outside of any hallucinations or delusions they had.

Mental Retardation

For clients diagnosed with mental retardation, behavioral therapy traditionally has been the main approach, but as the wide range of abilities, functioning levels, and individualized responsiveness to specific techniques has become recognized, a variety of treatment approaches have been successfully used, including cognitive-behavioral therapy.

Because mental retardation is not a finite illness with a specific set of symptoms universal to everyone with the diagnosis, it becomes difficult to universalize the treatment approach. Each person should therefore be individually assessed for his or her ability to respond to cognitive-behavioral techniques. In general, these techniques are best suited for those with the cognitive abilities to process and understand the approach. For those with mild mental retardation in particular, cognitive-behavioral therapy is recommended as a first-line treatment for some co-occurring mental disorders, including major depressive disorder, posttraumatic stress disorder, and obsessive-compulsive disorder (Rush & Frances, 2000).

EXAMPLE 5-2

Steve, a middle-aged white male, is diagnosed as having mild mental retardation. Steve lives at a residential program and is employed outside the agency for five days a week. Steve recently suffered a spinal cord injury, which forced him to depend on a wheelchair for mobility. Prior to his injury, Steve was physically active, taking many walks around the agency's grounds and playing basketball in the gym. He also enjoyed spending time with the other residents and liked going to movies, unit parties, and other activities. However, since the injury, Steve has withdrawn from nearly all social contact and spends most of his day sleeping.

The social work intern spoke with Steve about his reactions, asking him several questions to ascertain the reasons behind his

lack of participation. Steve said he was too much of a bother for staff because he was the only one in a wheelchair and required more attention than the others, who could walk around by themselves. The intern asked him how he knew this. After thinking for a moment, he said, “I don’t know. No one ever said anything, but it takes them a lot of work to get me in and out of this thing”—indicating the wheelchair—“and someone has to be with me the whole time so they can push me around.”

After more questioning, Steve admitted that staff must not be thinking he was so much of a bother because they regularly asked him if he wanted to join in on activities. He agreed to test his belief and participate in one outing before the next time he saw the social work intern. He was then to share his thoughts and reactions with her.

When he met with the social worker, he agreed that going out with the others had helped him feel better. He reported that the staff did not indicate he “was a bother,” and seemed happy that he was joining them.

Children

Cognitive-behavioral techniques are routinely used with children, but as you know by now, cognitive-behavioral therapy comprises a potentially wide range of techniques to employ, including problem-solving, self-instruction, self-talk, and social skills, among others (see chapters 6 and 7), rather than just cognitive restructuring. For cognitive restructuring specifically, cognitive abilities should be sufficiently developed to enable shifts in thinking about the past and the future, to follow logic, and to grasp abstractions.

In Durlak, Fuhrman, and Lampman’s (1991) meta-analysis on the use of cognitive-behavioral therapy with youth, level of cognitive development was a central factor in the results. The effect of intervention for children ages 11 to 13, who are presumably functioning at the formal operations stage, was about twice that of children ages 5 to 11. However, young children are often participants in cognitive-behavioral interventions, and indeed, cognitive-behavioral therapies are supported by the research literature with effectiveness indicated

for a number of different problems and disorders (McCellan & Werry, 2003). Methods may have to be adapted through artwork, analogies, and puppets (e.g., Webster-Stratton & Hammond, 1997). Many resources for cognitive-behavioral work with children are listed in the appendix.

The Elderly

Cognitive-behavioral interventions have been most often used with elderly clients for the treatment of depression, but also of anxiety (Laidlaw et al., 2003). A review of studies on therapy for depression in the elderly showed that cognitive-behavioral therapy was consistently more effective than usual-care or wait-list control groups, and that treatment gains persisted over time (Areal & Cook, 2002).

The social worker should be aware of several phenomena when working with the elderly as described by Laidlaw and colleagues (2003). The first is the common belief among the elderly (and the general population) that depression is a normal part of the aging process rather than a disruption in functioning. Elderly clients often make comments about being old as if it is synonymous with depression and being decrepit and incompetent “ . . . rather than an indication that they hold ageist beliefs and have set up an expectancy bias for themselves where they expect to be unhappy because of their age.” These beliefs therefore are appropriate targets for cognitive restructuring. The elderly may also have to be educated about the potential capacities that people with old age possess. Laidlaw et al. (2003) recommend *Successful Aging* (Rowe & Kahn, 1999) and the informational brochure *Ageing: Exploding the Myths* (WHO, 1999).¹

With the elderly, it is also often necessary to address some cohort belief systems about accepting help. These beliefs have to do with discussing problems outside the family and the presumed “failure” or “weakness of character” associated with being unable to handle problems on one’s own. If the elderly person does not verbalize these concerns, the social worker may need to bring them up for discussion; otherwise, they might act as a barrier to the older adult’s getting help.

¹ World Health Organization (1999) *Ageing: Exploding the Myths*, accessed at [HTTP://www.who.int/hpr/ageing/publications](http://www.who.int/hpr/ageing/publications)

The older person is typically used to being a patient in the medical model; therefore, the social worker must help the client understand the collaborative nature of cognitive-behavioral interventions and must encourage feedback. Likewise, the social worker will have to explain the necessity of homework, which may be either a foreign or antiquated notion for an elderly client.

The social worker should further be aware that extensive storytelling about the past is common among elderly clients; indeed, older adults often expect that they should provide this level of detail to a person offering assistance. To address this phenomenon, the social worker should describe cognitive-behavioral therapy as a structured and time-limited approach. To keep to time limits, a “ground rule” may need to be set up so that the social worker is allowed to interrupt a prolonged bout of sharing and redirect the client to the topic at hand.

Finally, in working with elderly clients, the social worker should be sensitive to possible sensory and cognitive limitations. Written information provided must be in a font large enough for the person to read. If writing is painful because of arthritis or other conditions, an alternative means of doing homework may be necessary, such as tape recording. If the client has memory problems, the social worker can record salient points of the session, provide handouts, and jot down homework assignments for the older adult to refer to later. Laidlaw and colleagues (2003) further emphasize that cognitive-behavioral treatment can be used with the cognitively impaired elderly person, although goals need to be modest in nature, steps should be simplified, and contacts kept short.

The following example of cognitive-restructuring with an elderly person takes place as part of a social work intern’s hospital placement.

EXAMPLE 5-3

Velma Barnes, an 82-year-old Caucasian female, is on the orthopedic floor of a city hospital. She broke her leg earlier in the week and is awaiting surgery to reset the bones. Because she is on a blood thinner, she has to wait 48 to 72 hours from her last dose before she is ready for surgery. During this timeframe, Mrs. Barnes became increasingly worried about her future. A referral was placed

to the social work student to assist Mrs. Barnes with her discharge planning.

When the social work student met with her, Mrs. Barnes was teary and soft-spoken. She expressed concern for her future because she will be unable to live independently and has no one to take care of her upon her discharge from the hospital. She also talked about her sadness and stress over her son being a widower and raising his daughter alone. Until now, she had been a support resource for him, helping him take care of his daughter. She now perceives her situation as being burdensome to her son, not only leaving her unable to assist him but requiring him to help her instead.

While listening to Mrs. Barnes express her desolation, the social work student empathetically reflected her feelings of concern and sadness. When Mrs. Barnes seemed to have calmed somewhat, the social work student asked her if they could talk about her plans for discharge. Mrs. Barnes agreed and quickly shared her worst fear—that she will have nowhere to go.

In order to help the client gain a realistic appraisal of the situation, the social work student asked Mrs. Barnes if she thought that having nowhere to go was a likely outcome. Mrs. Barnes had to agree that it was not. Mrs. Barnes then returned to the topic of feeling like a burden to her son. The social work student asked how her son was reacting to her upcoming discharge. Mrs. Barnes said he was in the process of preparing his house for her to come live with him. However, it would still take some time for the house to be ready to accommodate her physical needs.

Given the cognitive-behavioral assumption that information delivered cognitively will help with people's distress, the social work student informed Mrs. Barnes of some other options in the meantime, involving short-term community placements (nursing homes). Mrs. Barnes's mood seemed to lighten once she learned that there were some places she could go. But she started crying again, saying she was still concerned about being a burden to her son.

The social work student then turned to deductive questions to ask Mrs. Barnes what she had done to help her son since his wife's

death several years prior. Mrs. Barnes spoke at length about how she helped him raise his daughter and cooked and cleaned for them. When she finished outlining her various supportive activities over the years, the social work student asked if she thought it possible that her son was looking forward to being able to help her in return for the support she provided him. Mrs. Barnes agreed it was possible, saying that they had become very close since his wife's death.

The social work student then inquired about the evidence that Mrs. Barnes's son was feeling burdened by having her move in. Mrs. Barnes had to admit that he had been nothing but helpful and supportive. The meeting concluded with a discussion of how Mrs. Barnes could focus on accepting his help rather than being consumed with worry that he felt burdened by her. Mrs. Barnes's mood improved considerably, and she expressed relief about having met with the social work student to help sort out her concerns.

People Who Harm Others

When clients' actions have been harmful to others, the social worker must be careful not to use cognitive restructuring so that it rationalizes what the client has done. However, cognitive restructuring may be helpful when the client has taken responsibility for his or her behavior and desires change. At this point, cognitive restructuring may be very effective for assisting the client to see the thoughts and rationalizations that are fueling inappropriate behaviors. For example, a person who has been violent with others might have irrational thoughts such as, "I have to hurt people who disrespect me." A client who has been sexually abusive of children might have thoughts such as, "It's not really harmful what I'm doing. I'm just being a friend to this child." These types of thoughts are suitable targets for cognitive restructuring.

EXAMPLE 5-4

An example involves Mikhail, a Russian immigrant to this country, who was admitted to a psychiatric hospital when he tried to commit suicide. He'd divorced his wife 3 years before after a 17-year marriage. The loss of this relationship, among other factors (he'd

lost his job because of his depressive symptoms), was playing into his depression. In the hospital, he reported to the social worker that he kept thinking, “It’s all my fault, it’s all my fault.” When she asked him what this meant specifically, he said, “I wasn’t very good at talking out problems, particularly about the children. My wife thought I was too authoritarian.” Further conversation revealed that he had struck his wife while they were married, and she’d had a protective order issued against him.

Exercise 5-3

How would you address the client’s problems using cognitive-behavioral techniques? Would you use cognitive restructuring? Why or why not?

Crisis Intervention, Grief and Loss, and Trauma

Social workers often see clients as they experience a loss (e.g., death, romantic break-up, physical injury), stress (e.g., isolation, illness, eviction), or trauma (e.g., crime, sexual assault, child abuse, violence). In such situations, the social worker listens to the client's account of what has happened in an empathic way that conveys validation and support. Listening empathetically often represents the bulk of the social worker's response. Cognitive restructuring may not be necessary; it is certainly not used to rationalize clients out of feelings that are natural to have in the circumstances. Indeed, cognitive restructuring should not be used until the client has been validated for his or her experience and feelings related to the situation *and* a distorted belief has presented itself. A way to differentiate between normal stress, loss, or trauma reactions and faulty beliefs may include a statement to the client such as the following: "Your sadness is perfectly natural given what has happened, and the tears are a normal part of the grief process. I wonder, though, when you are saying, 'I know now that no one will love me again.' Can we look at that a little closer?"

One way of combating dysfunctional beliefs that may inhibit a person's recovery is providing direct reassurance or information that counteracts the negative belief. An example follows from a victim services setting:

EXAMPLE 5-5

A social worker employed in a police department was talking with two victims who had been in a convenience store robbery a couple of hours before. The clerk (a woman) and the customer (a man) were watching the surveillance tape to see if they could add to the description of the perpetrator. After viewing it, the man turned to the social worker and said sheepishly, "I look like a chicken." (He had hit the floor when the robber brandished a gun and said, "Everybody down.") The social worker quickly noted that an erroneous belief was operating and provided immediate reassurance, stating that the customer might have been killed if he hadn't followed the robber's directive, and she might not be talking to him now! The important thing was that he was alive, and there was

nothing much he could have done against a gun. He nodded and relaxed, seemingly reassured by her statements. Before he left the police station that night, she checked in with him again about what he was thinking, and he said, “It’s like you said. I don’t know what I could have done. And I’m alive—that’s the main thing.”

Because the area of crisis intervention, grief and loss, and trauma is so large, we continue with some longer case examples that you can read and reflect upon, either by yourself or as part of class discussion. The following two examples are drawn from hospital social work in which people have to cope with serious illness (first case) and injury (second case). Passages of dialogue are included so that you can better understand how the practitioners in these examples used deductive questioning to help examine the validity of the client’s beliefs.

EXAMPLE 5-6

Paula, a 35-year-old white female, was diagnosed with amyotrophic lateral sclerosis (ALS), also known as Lou Gehrig disease, approximately 5 months ago. Paula depends on a ventilator for her breathing. Because she no longer has control over her body functions or the use of her arms and legs, she relies on others for all her self-care needs.

She and her husband have two children, ages 9 and 11, who live at home with their father. Not surprisingly, Paula reports difficulty coping with the progression of her disease and frequently cries during visits with the hospital social worker, who provides empathy and validation of her experience. Lately, Paula has mentioned that she feels like “a failure as a mother.”

The dialogue between the social worker and Paula centers on eliciting the cognitive messages underlying Paula’s feelings:

Social worker: You say you feel like a failure as a mother.

What’s going through your mind when you say that?

Paula: Things like, “I’m not with them often enough, and how can I be a good mother when I’m lying here in this bed and can’t even get up?” I just feel so helpless. I’m failing them as a mother. I’m not there when they go

off to school in the morning. I'm not there when they come home.

Social worker: So what I hear you saying is that because you're not physically there with your children at home every day, you're a failure as a mother?

Paula: Yes, that's right.

Social worker: Do you really believe that?

Paula: Yes, sometimes.

Social worker: But not all the time?

Paula: No, because I can't help it that I'm like this. I would be at home if I could be.

Social worker: How would you describe a "good" mother?

Paula (smiles): Someone who loves their children and would do anything for them. Someone who's always there for them. And if they're hurt or sad, someone they can talk to. A child always needs to know they can come to their mother with anything. I think that's important. It's also important that someone teaches them right from wrong.

Social worker: Which of those things do you do for your children?

Paula: I try to squeeze in as much as I possibly can. My husband brings them by most days. On the days he can't bring them here, we talk on the phone.

Social worker: So you do see your children fairly regularly? You talk to them, spend time with them when they're here?

Paula: Of course.

Social worker: And have your children ever indicated to you that they think you're not there for them or that you're a bad mom?

Paula (smiles): No, but I know this is hard for them.

Social worker: I know how difficult this is for all of you.

(Allows for silence while Paula cries. After a few moments, Paula continues.)

Paula: But we're all doing the best we can, given the circumstances.

Social worker: What does your husband have to say about all of this? Does he think you're a failure as a mother?

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Paula: No, he says I'm doing a good job.

Social worker: Well, let's look back at your original thought, "I'm a failure as a mother." Given the questions I've asked and your responses, what evidence do you really have that you're a failure as a mother?

Paula: None, I guess. It's just the way I feel sometimes.

Social worker: Do you feel that way right now?

Paula: Well, no, not really.

Exercise 5-4

In the conversation between Paula and the social worker, what steps did the social worker take to work with Paula's belief that she was a failure as a mother?

Exercise 5-5

What is the line between validation of Paula's loss of physical capacities and using cognitive restructuring? (This may be a good topic for class discussion.)

EXAMPLE 5-7

The intern in this example was placed in a hospital setting for her field placement. He was asked to talk with a 26-year-old woman, Emma, whose hand had been so badly injured in a traffic accident that it had to be amputated. Her ribs had also been broken.

Before her accident, Emma had led an active life, working as a researcher for an employees' rights organization and living with her friends in a rented apartment in the downtown area. A volunteer for many nonprofit organizations and an active vegan, Emma frequently was involved in protests for social justice issues.

In the hospital, the nurse at morning rounds said that Emma was crying constantly. A psychiatrist had evaluated her and had recommended an antidepressant. Emma adamantly refused this recommendation, stating that she did not want to "feel like a zombie" as a result of the medication.

The student was primarily involved with discharge planning at the hospital and had a heavy caseload. Therefore, he had only about 30 minutes to spend with this client during the first contact.

Emma: (Starts crying after the intern introduces himself.) Well, I'm sure you know what's happened to me. Did the nurse tell you how they sent a psychiatrist in because I couldn't stop crying? He didn't even ask me why I was crying. I think he thought it was because I was in so much pain. Well, it wasn't. I feel utterly worthless now. It's funny how things happen—one minute you're driving to work, next thing you know, you're in the hospital and missing your hand. Everything has changed, and I just cannot deal with it.

Social work intern: It's natural that you are sad. You've gone through a tremendous loss. A lot of what you're feeling is grief for what you've lost.

Allowing some time for Emma to express her feelings, the social work intern provided some information about the grief process: that Emma would continue to feel sadness, and perhaps other emotions, such as anger that she had to go through this and at the person who caused the accident, or fear as she remembered what it was like to be in the accident and how she was going to live her life now. The emotions, although difficult, were part of the natural process of grief.

Emma nodded her understanding and then went on:

Emma: It's not the physical pain that's getting to me. I've gotten used to it. I just feel absolutely useless.

Social work intern: Tell me what you mean by that.

Emma: Well, my friends and I signed up for a bicycle charity ride. This cause is very important to me, and I really wanted to take part in this race. Now I can't do it. I used to volunteer at the free clinic too, and I can't do that now either.

Social work intern: So you're saying that you feel useless because you can't do your part to help out?

Emma: Yes, I mean I know these people from the clinic. I want to help.

Social work intern: You think you're letting people down?

Emma: That, and other things. I can't go with friends to the peace rallies either. I feel strongly about these issues and can't do anything about it.

Social work intern: So you think that because you cannot physically participate in the ride or these demonstrations, you have let people down and are not doing your share. And if you can't do all that, what use do you have?

Emma: Exactly.

At this point, the intern discussed the role of thoughts and emotions, saying that Emma had more control over her thoughts than over her feelings. When Emma was thinking that she was useless and had no right to accept help, those beliefs were hurting rather than helping her, and she could replace those thoughts with some that were more reasonable. The intern gained Emma's permission to examine more closely her belief that she was useless if she didn't participate in social justice activities and in helping people.

Social work intern: What evidence do you have for this?

Emma: Well, nothing specifically. Come to think of it, my friends are the ones coming to see me now instead of the other way around. They are the ones asking me if I need anything. I'm not used to that. I'm always the one helping others, not vice versa. (*Starts crying again.*) I've never had to ask for help before. I'm pretty self-reliant.

Social work intern: Can you think of reasons your friends would want to help you?

Emma: Well, I'm a good friend, and I have always stood by my friends and helped them out. One of them got arrested at a protest last year, and I bailed him out of jail.

Social work intern: You *are* a good friend! Can you think of other reasons that your friends and family would want to help you?

Emma: They feel sorry for me.

Social work intern: What's another way to see this?

Emma: I don't know. That's the way I see it.

Social work intern: I wonder if the offers to help are not meant to make you feel useless, but rather a way of people saying thank you for the help you have given them in the past.

Emma: I never really thought of it that way, but yes, maybe.

Social work intern: So what can you say to yourself instead?

Emma: I've helped out other people. I guess now it's my turn to need help. It won't always be this way.

Social work intern: Very good!

Before the session ended, the social worker assigned Emma some homework. Learning that Emma's family had brought her a tape recorder, the social work intern suggested that anytime Emma caught herself having distorted beliefs, she should record herself and then state an alternative thought. Emma grasped the idea quickly.

The social work intern also wanted to evaluate their work. He posed a 1-to-10 scale, "with 1 meaning you were feeling utterly awful, and 10 meaning you are feeling fine. Then he asked, "Where were you on the scale when we started talking today?" Emma responded, "Definitely a one!" When the intern asked about where Emma would place herself at the end of their time together, she said she was at a 3. "This has put things in a better perspective."

Exercise 5-6

What is your opinion of how this student handled the client's feelings and the crisis she is experiencing? This question is posed as a topic of discussion rather than as a problem with only one right answer.

Exercise 5-7

What irrational or negative beliefs did Emma present in her conversation with the social work intern?

Exercise 5-8

Which beliefs did the intern target for intervention in this example?

Exercise 5-9

What methods did the intern use to help Emma refute her beliefs?

Exercise 5-10

What is your opinion about the way the social work student carried out his evaluation of his work with Emma? Note that this exercise may be appropriate for a class discussion on this issue.

The next day, when the social work intern stopped by, Emma said that she had done her homework and that she was now at a 4 on the scale.

Emma: But I still have these lingering feelings of being useless. My parents brought me up to be pretty self-reliant and to set challenges for myself. Last year, I hiked the Appalachian Trail; now I can't even go to the bathroom by myself.

Social work intern: You're saying that your parents instilled in you the value of being independent. That's fine, but you seem to be saying that you should be fully independent now, and since you're not, you should feel bad about yourself.

Emma: Although it sounds silly put like that, I have been feeling that way.

Social work intern: What would your parents expect of you in this situation?

Emma: What do you mean?

Social work intern: Do you think they would expect you to do everything that you used to do for yourself?

Emma (laughs): Of course not.

Social work intern: And yet, this is the biggest challenge you've faced. Certainly bigger than the Appalachian Trail.

Emma: That's true.

Social work intern: Do you think they want to help you face this challenge, with the things that you can't do for yourself yet?

Emma: Yes, if I asked.

Social work intern: Okay, then I've got another assignment for you. While your parents are here, ask for help on three different occasions. Something like, "Mom, could you help me up to go to the bathroom?" "Dad, can you take me down to the sunroom and sit with me for awhile?" The reason I am asking you to do this is not to make you utterly dependent on your parents, but to challenge your belief that you have to be independent and self-reliant all the time.

The social work intern ended the contact by asking Emma to rate herself once more on the 10-point scale. At this point, Emma reported that she was a 5.

Exercise 5-11

What process did the intern use to help Emma refute her negative belief in this conversation?

In their third and last session before Emma was to be discharged, the social work intern again began by asking about the assignment. Emma responded that she had found the homework hard but that she had done it. She asked her father to help her brush her teeth and her sister to take her to the bathroom. She rated herself a 6 on the scale.

Social work intern: A six. I am impressed. Since you will be transferred to the rehab hospital tomorrow, this will be our last session. You'll be doing a lot of work there and will really be challenged, and you'll have ample opportunity to ask for help.

Emma: Yes, it should get easier for me, but with all the bad things that have happened, I'm really afraid I'll start getting depressed again.

In response, the intern encouraged Emma to keep tape recording her negative thoughts and countering them with more realistic

statements. He also suggested that Emma continue asking for help at least three times a day. Finally, the intern talked with Emma about working with a therapist on a regular basis if these tools were not enough to help her manage. Emma said that it was good to know further help was available if she should need it.

Summary

The final section of this chapter focused on the topic of grief, loss, and trauma and how cognitive restructuring can play a role in that work. The case illustrations demonstrated the need for careful assessment by the social worker to determine the normal reactions a person would have to a particular crisis, stressor, or trauma and when dysfunctional beliefs might be inhibiting the process of recovery. Properly applied, cognitive restructuring can be very helpful for people coping with these types of difficult situations.

The overall purpose of this chapter was to provide some guidelines for the social worker on when to appropriately use cognitive restructuring. Various types of populations and problem areas that the social worker may encounter were highlighted, and information was provided on how to assess whether a particular problem may lend itself to the technique of cognitive restructuring.

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