Cognitive Restructuring Technique as a Counselling Strategy for Reducing Psychological Distress of Women with Infertility Problems

[1]Tolulope Oluwatoyin OLAYIWOLA- ADEDOJA
tolulope.olayiwola.adedoja@fuoye.edu.ng

[2]Oluwaseun Bamidele OSCAR-IRETOR
seunakinfasae@gmail.com

[1, 2]Department of Guidance and Counselling
Faculty of Education
Ekiti Stae University,Ado-Ekiti

Abstract

Infertility in marriage can be devastating and should not be overlooked as it causes a major tension in life, imposes stress on couples, especially the women and threatens psychological health which include fear of divorce, decreased intimacy, despair, depression and anxiety. Psychological effects of infertility in the life of a woman can lead to tensions between families and also dissatisfaction of marriage. Psychological distress is one of the main psychological problems of women with infertility which has a noticeable impression on all aspects of their life. The severity and frequency of these stressors can contribute to negative outcomes such as psychological distress or marital dissatisfaction. In an attempt to curb the potential negative consequences of infertility stress, individuals and couples often use a number of coping strategies in an effort to manage the level of stress they experience. Cognitive Restructuring Therapy (CRT) has proved effective in modifying cognitive and behavioural deficits of cancer patients and sexually abused adolescents. It is proposed in this paper that it can be applied as an effective counselling strategy for managing psychological distress among women with infertility. The goals and principles of CRT, its techniques, model and applications for managing psychological distress among women with infertility are discussed in the paper.

Keywords:Psychological distress, infertility problems, cognitive restructuring therapy.

Introduction

The field of human reproduction has recently become a dynamic area of research for social scientists and educational psychologists throughout the world. From the beginning of time, the command, be fruitful and multiply, remains a permanent truth for most societies. In every society a woman's childbearing ability is often closely linked to her status as a woman, so that when a woman experiences difficulty conceiving, she may feel unfeminine. Psychological distress is a common reaction to this problem which is the response to the excessive losses and prolonged stress created by the infertility process.

Infertility can be defined as the inability to achieve a pregnancy after one year of continuous unprotected sexual intercourse without the use of birth control methods. The World Health Organization (2002) refers to infertility as a disease of the reproductive structure defined as the failure to achieve a pregnancy after 12 months or more of regular unprotected sexual intercourse. According to Van den Broeck, Emery, Wischmann and Thron (2010), infertility can also be defined as a bio-psychosocial Infertility can be classified as either primary or secondary. Primary infertility is a situation when no previous pregnancy has occurred and secondary infertility is a situation when prior pregnancy has occurred irrespective of its outcome.

Infertility may be caused by infection in the man or woman but often there is no one obvious fundamental cause as there are many causes. It could also be caused by underlying medical conditions that may damage the fallopian tubes, interferes with ovulation or causes hormonal complications. These medical conditions include pelvic inflammatory disease, endometriosis, polycystic ovarian syndrome, premature ovarian failure, uterine fibroids and environmental factors. Other causes of infertility in females include ovulation problems, tubal blockage, age-related factors, uterine problems, previous tubal ligation and hormone imbalance (Olaitan, 2002).

The consequences of infertility are manifold and can include societal repercussions and individual suffering. Infertility may have profound psychological effects on women. Women may become more anxious to conceive, increasing sexual dysfunction. Women trying to conceive often have depression rates similar to women who have heart disease or cancer (Atwood & Dobkin, 2002).

These feelings can disturb the self-esteem and self-image of women (Tarlatzis, 2003). Most women who are diagnosed with infertility go through a chain of emotional feeling that becomes harmful after increasing its intensity (Crick, 2007). They may have feelings of failure, loss, disappointment and betrayal (Tarlatzis, 2003). Infertility affects a substantial percentage of reproductive-aged women in Nigeria. Community based data suggest that up to 30 per cent of women in some parts of Nigeria may have proven difficulties in achieving a desired conception after two years of marriage without the use of contraceptives

Nigerian gynaecologists frequently report that infertility cases constitute between 60 to 70 per cent of their consultations in tertiary health institutions (Megafu, 2008; Otubu & Olarewaju, 2009). Feelings of psychologically distance and feelings of withdrawal from relatives are more prevalent in these women (Paulson & Sauer, 2001). This may also lead to the fears of separation from their partners (Verhaak & Vaillant, 2001). Other emotions such as depression, anxiety and fear may result from lack of conception (Crick, 2007). Infertility can bring with it intense emotional reactions such as depression, desperation, confusion, sadness, embarrassment, disappointment, humiliation, hurt and fear

(Valentine, 2006). In conjunction with intense emotional reactions, women diagnosed with infertility experience lower self-image with a diminished sense of femininity reducing body image and self-esteem (Abbey, Andrews & Halman, 2002). As a result of multiple losses, women with infertility experience complex feelings, including sadness, anger, guilt, inferiority, loneliness, fear, moodiness, shame, betrayal, helplessness, powerlessness and low self-esteem (Atwood & Dobkin, 2002).

Clinical Psychologists affirm that there are various psychological constructs that women with infertility are predisposed to; one of such is psychological distress. Psychological distress is a negative state of mind and described as an unpleasant emotional experience of mental, social and spiritual nature which interfere with individual's ability to cope with the challenges of everyday living (Lloyd-Williams, Friedman & Rudd, 2000). Studies have shown that infertility can precipitate psychological distress in women (e.g. Brietbart, Bruera, Chochinov & Lynch, 2005).

Psychological distress in women with infertility arises from stigmatization from others as well as the sense of guilt that perhaps past sexual escapades have led to the ailment. Two-thirds of women who were sexually active before the diagnosis do indicate sexual problems which were found to be significantly associated with the women's level of anxiety (Corney, Everett, Howells & Crowther, 2002). Considering the psychological and emotional implications of infertility, there is need for studies on how to reduce psychological distress among women with infertility.

Counselling can prevent or ameliorate these symptoms, if the affected women seek counselling. This is because counselling has tools and techniques which when applied to clients, helps to solve problems and prevent others from surfacing, such as reality therapy, psychoanalysis, cognitive restructuring and so on. There is evidence that cognitive behavioural therapy and particularly, cognitive restructuring in a group format can significantly reduce psychological distress in women with infertility (Domar, 2000). Support groups as well as treatments that emphasize social connectedness and modelling of empathy (Gibson & Myers, 2000) have additionally proven it to be beneficial. There is an increased application of CRT as a preferred form of treatment, which is evidence-based of its effectiveness in assisting people with anxiety, stress and post-traumatic stress disorder (PTSD) (Resick & Schnicke, 1995) as well as complication in grief (Shear, 2003). This paper hence discusses cognitive restructuring therapy as a technique for managing psychological distress of women with infertility. In so doing, the paper highlights the concept and the use of CRT, techniques of CRT as well as application of CRT as a counselling strategy for managing psychological distress of women with infertility.

The Concept and the Use of Cognitive Restructuring Therapy

Cognitive restructuring therapy is a form of cognitive therapy derived from the works of psychologists (Beck, 1976; Miechenbaum, 1977) who recognize that the way in which people interpret events, perceive themselves and judge abilities is central to their mental health. The technique assumes that dysfunctional beliefs are embedded in cognitive schemas. Cognitive restructuring has been found to help to decrease recognition of losses, improve communication with partners, decrease social isolation and facilitate the grieving process (Jaffe & Diamond, 2011) as well as help normalize infertility. Cognitive restructuring intervention for psychological distress focuses on thoughts and their relationship to emotions and behaviours. Understanding and altering one's thoughts can change emotional reactions and accompanying behaviours. For example, frequent, intrusive, uncontrollable thoughts about loss and life changes can cause poor concentration and precipitate feelings of sadness, guilt and worthlessness. (Ellis, 1989) In turn, these feelings can result in increased or decreased sleep, withdrawal and isolation which may affect the woman inability to have sexual relationship to conceive.

Hence, cognitive restructuring is a therapeutic technique that employs modelling, confrontation, disputations, homework and self-statements to make the client observe some irrationality in his or her behaviour and from there, be able to develop positive alternative ways to cope with such irrational behaviour when they occur again (Esere & Idowu, 2000). In effect, cognitive restructuring helps the clients to re-shape his thinking faculty in such a way that he would be more rational and focused.

This intervention thus, focus on the intrusive thoughts, challenging their accuracy or irrationality and noting specific patterns of cognitive distortions with the hope that clients will be helped to develop specific cognitive coping strategies that are designed to alter negative emotional reactions and accompanying behaviours. Several scholarly reviews (Kwon & Oei, 1994; Teasdale, 2003) support cognitive-behavioural model and there is general agreement that cognitive therapy is an effective treatment for depression and anxiety (Onibokun, 2008; Dobson, 2009).

It assumes that emotions, behaviours and somatic (physical) sensations are moderated by cognitive processing of events and hence can be changed or modified so as to alleviate emotional stress. In other words, reviews of events can be changed as a means to alleviating distress. In this paper, the researcher expounds on the application of cognitive restructuring in managing psychological distress of women with infertility.

Techniques of Cognitive Restructuring

Cognitive Restructuring is accomplished in a stepwise manner through the following stages;

- Cognitive Restructuring begins with the therapist building and establishing a collaborative therapeutic relationship and assessment facilities disclosure of clients' perspective about their problems.
- The second stage of Cognitive Restructuring typically involves the therapist providing opportunity to help the client manage or cope with distressing experiences, severe emotional reactions or impulsive actions. The aim is to foster feelings of control, to instill hope and to contain overwhelming feelings of despair, hopelessness or terror.
- The third stage of Cognitive Restructuring involves the therapist skillfully offering a new perspective about the nature of the clients' experiences and general life predicament.
- In the fourth stage, cognitive restructuring proceeds toward a focus on specific delusional beliefs. This entails either offering reality based explanations or working within clients' own belief system to attempt to moderate distress and promote adaptive appraisal.
- The fifth stage of Cognitive Restructuring is targeting dysfunctional assumptions about self and others (feelings of worthlessness, untrustworthy or aim to harm the clients).
- The sixth and last stage of Cognitive Restructuring therapy is concerned with consolidating. It involves empowering the client with behavior skills to enable him to maintain therapy gain and prevent relapse(Ellis, 1962).

Cognitive Restructuring Therapy for Reducing Psychological Distress in Infertility women

At its most general, the cognitive model of depression suggests that there is a strong connection between people's construal of events, their behaviour and their emotional state. The model postulates that incoming information from the environment is processed via meaning-making structures that result in particular interpretations for each individual and that in depression such cognitive structures are negatively oriented in their processing and tone, generating negative emotions and problematic behaviours (Beck, 1967).

Beck (1976) was of the view that psychological distress is activated by a set of three major cognitive patterns that force the individual to view himself, his world and his future in an idiosyncratic way. These three views- the individual view of himself, his world and his future- were called the cognitive triad. The negative way of thinking guides one's perceptions, interpretations and memory for personally relevant experiences, thereby resulting in a negatively based worldview and leading to depression.

They tend to take things too personal and believe the future is bleak and dim (Papalia & Olds, 2008). These inferior feelings lead to more negative experiences such as thoughts of worthlessness and inferiority (Schwartz & Schwartz, 2003). Often the psychological distressed expects too much of him or herself, views failure as an accepted way of life and believes there is nothing she can do about it (Papalia & Olds, 2008). The psychological distressed person can often see two alternatives, neither of which is possible and without change the existing situation is too painful.

Application of CRT Model for Managing Psychological Distress among women infertility

A major task for a counsellor dealing with woman with infertility is to examine the client's automatic thoughts with a view to changing the entrenched feelings about herself and the world. Beck (1962) proposed that the Counsellor should accomplish this process through the following stages: Engage the client, assess the problem, client and situation, prepare the client for therapeutic intervention, implement the treatment programme, evaluate progress and termination.

Engaging the Client

- The first step is to build a relationship with the client using empathy, warmth and respect, understanding the client's challenge and demonstrating that success is possible.

Assessing the problem, person and situation

- Start with the client's view on the causes of the repeated failure in conception. Label distorted thoughts in the life of the client. The counsellor tries to label the irrational thinking pattern of the client by asking the client to list out the thoughts going on in her mind. Examples of such thoughts could be: I hate myself, I cannot be a mother. etc.

Preparing the client for therapeutic intervention

- Clarify the treatment goals, ensuring these are concrete, specific and agreed to by both clients and counsellor and assess the client's motivation to change. For instance, the counsellor clarifies the goal of the intervention which is to change the client's thinking pattern from irrational ones to rational ones in order to help reduce psychological distress.

  The counsellor introduces discussion about the basics of CRT. The counsellor discusses the approach to be used and implications of treatment and develops a contract.

Implementing the treatment programme

Most of the sessions occur in the implementation phase, using activities as follows:

- Challenging absolute: Clients often make generalized absolute statements that are biased. Such statements include: 'Why am I finding it difficult to conceive', God is punishing me for some sins', 'May be I am not destined to have children' etc. It is often helpful for the counsellor to question or challenge the absolute statement so that the client can present the statement more accurately.
- Reattribution: Sometimes clients attribute responsibilities for events to themselves when they do not actually have any control or responsibility for the event. They put blame on themselves which makes them feel guilty or depressed about what they do. Reattribution attempts to challenge and replace this distorted thought with a more rational one.
- Dispelling: This is looking at a normal situation as catastrophic. Clients magnify events by negatively painting events, ideas or their outcomes. To say that 'if I don't conceive this month, my life is finished' is magnifying failure.
- Challenging all-or-nothing thought: In the process of childbearing, the client sees anything below natural conception as a failure. The counsellor makes the client understands that there are other means of conception if natural method fails
- Listing Advantages and Disadvantages: By listing the advantages and disadvantages of a distorted thought, the client is able to see for herself how illogical her thought is and must be ready to replace it with a more rational belief.
- Cognitive Rehearsal: At this level, the client is made to imagine the situation or idea in which she has the distorted thought. She is first made to imagine the event with its negative outcome and later with its positive consequences. Cognitive rehearsals could be done by asking client to rehearse some positive self-statements.
- **Evaluating Progress:** Towards the end of the intervention, there is need to check whether improvements are due to the significant changes in the client's thinking or simply to an unforeseen improvement in external circumstances. This can be done through Socratic questioning and decatasrophing. At the end of the session, client should be able to challenge her distorted thoughts.

Socratic Questioning: The counsellor asks the client to ask the following questions whenever she experiences challenges before drawing a conclusion on her thought: Is this thought realist, Am I basing my thoughts on facts or feeling? What is the evidence of this thought? Could I be misinterpreting the evidence? Am I having this thought out of habit or do facts support it?

Decatastrophizing: The counsellor asks questions such as 'What if you are not successful at conceiving'? What is the worst that could happen?

Evaluation: The client would be asked to express her new feelings

Preparing the client for termination

It is usually wise to prepare the client to cope with the challenges of infertility. Many clients after the period of wellness think they are "cured" for life. Consequently, when a client relapses and discovers her previous challenges are still present to some degree, she is likely to despair and give up working on herself altogether. The Counsellor will warn that all theses stimuli are normal in life, but if perceived wrongly, it will be recorded wrongly in our cognition, then such cognition is bound to make us behave wrongly. Therefore in changing the behavior, there is need to change the cognition first.

Conclusion

Infertility is a chronic condition and for a woman who is not able to achieve a pregnancy with infertility treatment, the grief and sorrow may become recurrent as specific triggers occur that bring to mind the loss of a child which was never born. Traditional milestones such as taking the first steps, the first birthday, the first day of school will all be missed by the 'would-be' parent. Later milestones such as graduation from high school, getting a driver's license, going to college and getting married are also not experienced.

Faced with this reality, women with infertility need help in managing psychological distress such as depression and anxiety in order to cope effectively with the present situation and move ahead with their lives. To achieve this, they need the assistance of helping professionals like counsellors to adjust effectively and efficiently to their situation. Counsellors, on the other hand, need to provide the needed professional service that is hinged on helping women with infertility problems manage the psychological distress they are exposed to and adapt to their circumstances. Therefore, it is expected of counsellors to utilize different counselling intervention strategies that are appropriate in effectively managing psychological distress such as depression and anxiety. Since psychological distress includes behavioural, emotional, cognitive and social elements or reactions to the problem of infertility in women, the Cognitive Restructuring Therapy (CRT) approach is adopted in this paper as a useful therapy that can be engaged by counsellors by provide help to women suffering from psychological distress as a result of infertility. The paper illustrates the CRT Model and provides a step by step application of the model for managing psychological distress among women with infertility problems.

Suggestions

Considering the effectiveness of CRT in managing psychological distress among women with infertility, the following suggestions were made; Cognitive restructuring therapy

should be used to help women including their spouses in managing psychological distress. The therapy can also be used to manage attributions to unsuccessful efforts and attempts in conceiving a baby among women with infertility in Nigeria. The therapy can also be employed by women suffering from psychological distress as a result of infertility by engaging the negative perception of how people view women who are childless through positive beliefs and balanced thoughts.

References

Abbey, A., Andrews, F. M. & Halman, L. J. (2002). Infertility and subjective well-being|: The mediating roles of self-esteem, internal control and interpersonal conflict. *Journal of Marriage and Family Life, 54,* 408-417.

Adetoro, O.O. & Ebomoyi, E.W. (2001). The prevalence of infertility in a rural Nigerian community. *African Journal of Medical Science,20,* 23-27.

Atwood, J. D. & Dobkin, S. (2002). Storm clouds are coming: Ways to help couples reconstruct the crisis of infertility. *Journal of Contemporary Family Therapy*, *14,* 385-403.

Beck, A. T. (1967). *Depression: Causes and treatment*. Philadelphia, PA: University of Pennsylvania Press.

Beck, A. T. (1976). *Cognitive therapy of the emotional disorders*. New York, NY: New American Library.

Corney, J. B., Everett, C. M., Howells, K. L. & Crowther, E. B. (2002). Psychosocial impact of gynaecologic cancer. *Journal of Psychosocial Oncology, 10*(1), 99-109.

Crick, N. R., (2007). Relational aggression, gender, and social psychological adjustment. *Journal of Child Development, 66,* 710-722.

Dobson, K. S. (2009). A meta-analysis of the efficacy of cognitive therapy for depression. *Journal of Consultant Clinical Psychology, 57,* 414-419.

Domar, A. (2000). Impact of group psychological interventions on pregnancy rates in infertile women. *Journal of Fertility and Sterility, 73*(4), 805-811.

Ellis, A. (1989). *Reason and emotion in psychotherapy, revised and updated*. Secaucus, NJ: Carol Publishing Group.

Esere, M. O. & Idowu, A. I. (2000). The effect of cognitive restructuring in resolving marital conflicts among couples in Ilorin. Nigerian. *Journal of Applied Psychology*, *6*(1), 87-98.

Gibson, D. M. & Myers, J. E. (2000). The Effect of social coping resources and growth-fostering relationships on infertility stress in women. *Journal of Mental Health Counseling*, 68-80.

Jaffe, J. & Diamond, M. (2011). Reproductive trauma. Washington, DC: *Journal of American Psychological Association., 14,* 93-111.

Kwon, S. M. & Oei, T. P. S. (1994). The roles of two levels of cognitions in the development, maintenance and treatment of depression. *Clinical Psychology Review, 14,* 331-354.

Lloyd-Williams, M.; Friedman, T. & Rudd, N. (2000). Criterion validation of the Edinburgh postnatal depression scale as a screening tool for depression in women with advanced metastatic cancer. *Journal of Pain and Symptom Management, 20*(4), 259-265.

Megafu, U. (2008). Surgical causes and management of infertility in Nigeria. *Journal of International Surgery, 73,* 144-148.

Miechenbaum, D. (1977). Quality versus quantity: acquisition of coping skills following computerized cognitive behavioural therapy for substance use disorders. *Journal of Behavioral Medicine, 105*(12), 21202127.

Olaitan O.L. (2002) Causes and solutions of infertility in southwest Nigeria. *International Journal of Collaborative Research Internal Medicine and Public Health,* 4(7), 1428-1441.

Onibokun, A. C. (2008). *A cognitive behavioral therapy in the psychological management of pain among breast cancer women at the University College Hospital Ibadan* (Ph. D Thesis), University of Ibadan.

Otubu, J. A. & Olarewaju, R. S. (2009). Hysteroscopy in infertile Nigerian women. *African Journal of Medicine and Medical Sciences, 18*(2), 117-121.

Papalia, D. & Olds, S. W. (2008). *Human development (7th ed.).* Boston: McGraw-Hill.

Paulson,T.A. & Sar,J.U. (2001). Factors affecting embroyo implantation after human invitro fertilization; a hypothesis. *American Journal of Obst. & Gynaecology, 163,* 2013-2020.

Resick, P.A., & Schnicke, M.K. (1995). *Cognitive processing therapy for rape victims: A treatment manual*. New York: Sage.

Schwartz, A., & Schwartz, R. (2003). *Depression: Theories and treatments.* New York: Columbia University Press.

Shear, M. K. (2003). *Complicated grief: A guidebook for therapists*. Unpublished Manuscript. Department of Psychiatry, University of Pittsburgh, School of Medicine.

Tarlatzis, I. (2003). Psychosocial impacts of infertility on Greek couples. *Journal of Human Reproduction, 8(3),* 396-401.

Teasdale, J. D. (2003). Negative thinking in depression: Cause, effect, or reciprocal relationship? *Advances in Behavior Research and Therapy, 5,* 2749.

Valentine, D. P. (2006). Experiencing infertility: Groups for support and mutual aid. In M. Seligman and L. E. Marshak (Eds.), Group Psychotherapy: Interventions with special populations. Boston: Allyn and Bacon.

Van den Broeck, U., Emery, M., Wischmann, T. & Thorn, P. (2010). Counselling in infertility: Individual, couple and group interventions. *Patient Education and Counsel, 81,* 422428.

Verhaak, C. O. & Vaillant, G. E. (2001). Is the U-curve of marital satisfaction an illusion? A 40-year study of marriage. *Journal of Marriage and the Family*, *55,* 230-239.

World Health Organization, (2002). *Infertility: a tabulation of available data on prevalence of primary and secondary infertility.* Retrieved from http:/www.apa.org/journals/webref.html.