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MISCONCEPTIONS OF COGNITIVE THERAPY

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Cognitive therapy has been misconstrued in several domains. Seven critical areas are identified and relevant recent advances in cognitive therapy are discussed. These areas include: personality change, conceptualization, childhood experiences, interpersonal factors, the therapeutic relationship, compensatory strategies, and emotions. It is hoped that this review of the literature will clarify understanding of the cognitive therapy model.

One of the tenets of cognitive therapy is to evaluate beliefs through the systematic accumulation of evidence. It appears that some mental health professionals are not guided by this principle in their own understanding of the cognitive therapy model. More specifically, a comprehensive review of the literature suggests that many practitioners and researchers have an incomplete or erroneous understanding of the principles of cognitive therapy (for complete reviews, *see* Gurnani & Wang, 1990; Karasu, 1990; Mahoney, 1993; Power; 1989; Robins & Hayes, 1993; Weishaar, 1993). This article will consider seven recurring criticisms of cognitive therapy by providing evidence that the model does address these diverse issues. The seven areas to be examined include: 1) personality restructuring; 2) the broad conceptual basis of cognitive therapy; 3) the importance of early experiences; 4) interpersonal relationships; 5) the therapeutic alliance; 6) motivation and compensatory strategies; and 7) the critical role of emotion in therapy. By examining these seven major misconceptions, it is hoped that professionals will have a clearer and more factual understanding of the cognitive model of therapy.

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Misconception #1: Cognitive Therapy Focuses on Techniques for Immediate Symptom Reduction While Ignoring Personality Reorganization

Although individuals may associate cognitive therapy with simply evaluating negative automatic thoughts to improve mood, Beck has described four levels of cognitions that are examined in therapy (*see* Weishaar, 1993) which differ in their accessibility and mutability. These levels of cognition are hierarchically arranged. Voluntary thoughts are highly accessible and easiest to modify. Automatic thoughts may seem to occur without awareness but clients can be quickly taught to identify these cognitions. Modifying these thoughts is associated with immediate symptom reduction. At the third level are assumptions and values. The patient may have more difficulty articulating or recognizing these beliefs and they are more difficult to change as they are tacit, stable rules. At the deepest level are the schemas which organize information and operate outside of awareness. These core beliefs guide how we process information in that they dictate how we perceive, interpret, and recall stimuli. Beck and associates (1990) suggest that schemas have four qualities: breadth, flexibility versus rigidity, prominence, and valence, which reflects the level of activation. All cognitive and affective systems derive from these schemas. Beck et al. (1990) have suggested that there are two primary categories of schemas: *helpless* and *unloved*. An individual with a helpless schema may believe that he or she is ineffective, powerless, or incompetent. Unlovability may be associated with beliefs of unattractiveness or defectiveness. Although these beliefs may not be consciously articulated in problematic situations, they do exert a powerful influence. For example, a woman with panic disorder may have automatic thoughts of "I won't be able to control my symptoms . . . I need a safe person

to be with me at all times." Underlying these thoughts may be assumptions of vulnerability and a core belief of helplessness. Cognitive therapy can help her to evaluate the automatic thoughts, underlying beliefs, and schema, leading to symptom reduction *and* a changed personal view.

Beck (Beck & Hollon, 1993) has stated that the therapists should focus on the automatic thoughts initially in treatment as a means of uncovering the deeper and critical schemas. The automatic thoughts represent the data from which the schemas are inferred.

Dysfunctional schemas are particularly prevalent in the personality disorders and theorists have suggested that the identification and modification of core beliefs is essential in treating these clients (*see* Beck et al., 1990). Schema-focused cognitive therapy has been developed by Young (Bricker, Young, & Flanagan, 1993; Young, 1990) who has identified fifteen maladaptive schemas grouped in four domains: connectedness, autonomy, worthiness, and limits and standards. He believes that schemas are perpetuated through three processes: schema maintenance which occurs via cognitive distortions and self-defeating patterns of behavior; schema avoidance in which the individual avoids activating the schema or experiencing any associated affect; and schema compensation, which involves developing certain behaviors and cognitions that overcompensate for the core beliefs and may be manifested as the opposite of the true schema. An example of schema maintenance is a man who believes "I'm undesirable" and picks cold and distant women who consistently leave him. The schema is thus perpetuated. Schema avoidance may be seen in a woman who believes "I'm incompetent." She may turn down difficult work assignments because of this belief. By avoiding challenging situations which activate the painful schema, she does not experience emotional distress. Schema compensation may occur in an individual who beleives "I'm unattractive." To counteract this belief, the person might spend much time and energy on making him or herself look appealing.

Young (1990) argues that early maladaptive schemas are responsible for the development of personality disorders. These schemas are developed early in childhood, due to ongoing negative experiences with significant others. Chronic aversive events result in rigid core beliefs about oneself and others. These belief systems guide information processing and behavior throughout childhood and subsequently become more elaborate, fixed, and dysfunctional. They may have had functional utility during childhood but the beliefs are not adaptive for the adult. For example, a child who grows up with abusive parents may learn that people cannot be trusted and that one should be acquiescent. These beliefs and associated behaviors may have been adaptive for the child but cause difficulty for the adult who is no longer in that environment. Ursano & Hales (1986) point out that analytic therapists may also be working on a schematic level in that "schemata underlying the faulty cognitions . . . are unconscious assumptions that the psychodynamic model sees as derived from earlier experience" (p. 1514).

The schemas become especially activated when the adult experiences an event which is similar in theme to the particular underlying vulnerability. For example, Beck (1983) has identified two personality styles which are differentially affected by environmental stimuli and may be related to the core beliefs of unlovability and helplessness. Sociotropic individuals are sensitive to interpersonal events. They may be devastated when they perceive that others are ignoring them or when they are alone. Autonomous individuals value achievement over interpersonal relationships. They experience heightened affect in achievement situations, but may not react intensely when they experience a relationship loss.

Beck and colleagues (1990) suggest that therapists can produce personality reorganization in three ways. One strategy, schema restructuring, involves completely eradicating the old belief system and developing different more adaptive core beliefs. Thus the client who believes "I am unlovable" gradually comes to accept "I am lovable." Information processing is altered and the individual can attend to and believe the positive feedback he or she receives from others. Schema modification is a less extreme intervention in which the old schema is adapted to take in new, discrepant information. A client may initially have a core belief of "I'm unlikable." It is often easier to modify this type of belief because it is not as extreme or problematic as "I am unlovable" or "I am worthless." Finally, schema reinterpretation includes teaching the client to identify where and how the belief system is operating and evaluating the evidence more thoroughly to determine if the interpretation is correct.

Young (1990; *see also* Beck et al., 1990) pinpoints four categories of interventions including emotive, interpersonal, cognitive, and behavioral, which produce schema change. Initially, emotive techniques are particularly powerful in the process of identifying the maladaptive schema. These strategies include using a two-chair technique or imagery. A powerful imagery strategy includes having the client relive critical childhood events. This helps him or her to understand the origin of the problem, enables the experience to be restructed in a less biased manner, and produces the strong affect necessary for identifying key cognitions. Interpersonal interventions place an emphasis on the therapeutic relationship, so that the patient can see how his or her interpersonal beliefs affect behavior, as well as how he or she is perceived by others. The therapeutic relationship can also serve as a powerful means of contradicting early maladaptive schemas. For example, the therapist can represent an accepting and warm figure who teaches the client that he or she will not always be rejected, unlike he or she might have previously experienced with a cold parent. Cognitive techniques are also relevant and include strategies such as identifying beliefs, examining the evidence for negative and positive schemas, and teaching the client about how he or she may be distorting information. Finally, behavioral strategies are also necessary for changing chronic maladaptive behavior patterns. Assertiveness training, for example, can lead to new behaviors and beliefs of controllability. These interventions can give the client tangible coping tools as well as providing evidence against the old schemas.

Misconception #2: Cognitive Therapy Is Superficial and Mechanistic

Closely related to schema work is the importance of individualized case conceptualization. Kuehlwein (1993) reviews evidence suggesting that each disorder has distinct associated cognitions but the therapist must always attend to the personal meaning which differs across individuals. Beck (*see* Wieshaar, 1993) has stressed that the therapist must develop an ideographic understanding of clients, although a common profile may occur within a diagnostic category. By focusing on the individual and the specific contents of his cognitions, rather than the diagnostic label, the therapist can individualize the treatment plan. Beck (*see* Weishaar, 1993) argues that any given observable behavior or emotion may be due to a variety of different schemas. Therapists develop hypotheses about which schemas may be prominent and tailor their interventions based on this conceptualization.

Safran & Segal (1990) acknowledge that it may be tempting to apply cognitive techniques in a quick attempt to alleviate distress but strongly caution against this practice. Haphazardly applying techniques without an understanding of the relevant underlying cognitive processes leads to treatment failure. For example, two clients with panic disorder may have similar automatic thoughts of "I'm going to die or go crazy." However, a core belief of inadequacy may apply to one client while the other has a core belief or uncontrollability. An understanding of the particular underlying schemas can thus guide treatment more effectively. Safran et al. (1986) argue that cognitive processes vary in their degree of centrality or peripherality. Altering peripheral beliefs may produce temporary symptom reduction but lasting change is due to the modification of core beliefs. Thus, focusing on the automatic thoughts alone is not adequate. They suggest that these central beliefs can be assessed by examining patterns and themes in the client's automatic thoughts. In addition, the most critical cognitions are associated with a high degree of emotional arousal. Thus, therapists should attend to marked changes in affect; an increase in emotionality indicates that a central cognition is operating.

Persons (1993, 1989) has also argued for the necessity of accurate case formulation because it aids in choosing interventions, improves outcome, enhances understanding, and contributes to a positive therapeutic relationship. She believes that clients have problems at two levels—their overt pathology such as depression or anxiety, and on an underlying cognitive level which includes dysfunctional beliefs about the self, others, and the world. These underlying mechanisms, in conjunction with particular life events, cause and perpetuate the overt symptoms. For Persons, case formulation includes seven stages: describing the overt problems, theorizing about the underlying cognitive mechanisms, understanding the association between the underlying processes and the outward distress, articulating the catalysts of the current symptoms, theorizing about the origins of the tacit mechanisms, developing an individualized treatment plan, and hypothesizing about obstacles that may develop. This initial conceptualization guides treatment but the therapist must be

flexible about changing this formulation as new evidence develops or if the client does not respond.

Misconception #3: Cognitive Therapy Ignores the Role of Childhood Experiences in Determining Adult Psychopathology

In the landmark work on cognitive therapy, Beck et al. (1979) explicitly state that dysfunctional assumptions "may be derived from childhood experiences or from attitudes and opinions of peers and parents. Many of these assumptions are based on family rules" (p. 245). The influence of childhood experiences has received much recent focus in the cognitive therapy literature. As described above, Young's (1990) work, as well as Beck et al. (1990), suggests that the core schema are developed early in childhood and become associated with specific vulnerabilities throughout the lifespan. Distinct environmental events encountered as an adult, such as losses in the achievement or affiliation realms, may trigger psychopathology due to beliefs developed in childhood. Beck (Beck & Hollon, 1993) has maintained that the child's environment either encouraged or inhibited the growth of particular belief systems. In his discussion of personality disorders, he argues "you simply cannot get at . . . the important cognitive structures without recreating the pathogenic childhood experiences . . . the problems in relationships often can go right back to the beliefs that people have taken over from their families" (p. 92).

Safran & Segal (1990) agree that early events have a critical impact on the formation of schemas. They see a historical review as beneficial for the client in that it can enhance one's perspective on how the beliefs developed and that they can be changed, viewing the beliefs as previously adaptive diminishes current guilt, and that understanding one's history produces a sense of mastery. However, they warn that historical review may not always be therapeutically appropriate. With certain clients, it may result in intellectual, abstract knowledge but not systematic change. Other clients may wish to focus on the past as a means of avoiding work on current stressors and the problem may be maintained.

Misconception #4: Cognitive Therapy Neglects Interpersonal Factors That Contribute To and Maintain Psychopathology

In recent years, much interest has been generated about the importance of addressing interpersonal variables in cognitive therapy. Safran & Segal (1990) stress that these external factors greatly affect the maintenance and reduction of symptomatology. They argue that cognitions about others may currently be negative because of realistic interpersonal difficulties. Clients do not live in isolation. Therapists must recognize that problematic relationships might partially be due to significant others. Therapists must work with these realistic constraints, not by having the client disregard the negative beliefs but by evaluating them and choosing an adaptive course of action.

In addition to current strained relationships, Safran & Segal (1990) discuss the importance of interpersonal schemas. These schemas develop out of significant interpersonal experiences early in life. They may have been adaptive historically in predicting interactions with attachment figures but are no longer accurate. However, they influence how interpersonal information is processed and thus can remain stable and affect relationship beliefs and behavior. Interpersonal schemas are hypothesized to be particularly problematic in personality disorders.

Westen (1991) has also written extensively about interpersonal schemas, within an object-relations framework. He defines object relations as mental representations which include cognitive and emotional components. Object representations refer more specifically to the cognitive model of particular significant others. Westen argues that dysfunctional object representations, which may be due to a history of abuse or deprivation, may lead to problematic relations in adulthood. He concludes that the encoding and storage of social information determines subsequent interpersonal functioning.

Misconception #5: The Therapeutic Relationship Is Irrelevant in Cognitive Therapy

Beck and his colleagues (1985) have consistently emphasized that a necessary condition for therapy is a solid therapeutic relationship which the therapist must foster through trust and acceptance. They have cautioned (1979) that therapists should not disregard the importance of the therapeutic alliance in their enthusiasm for applying cognitive techniques. They emphasize that cognitive therapists must always show warmth, concern, and understanding.

In addition to describing the attributes therapists should possess, Beck et al. (1979) have addressed

the importance of transference reactions and the need to examine these beliefs thoroughly. The therapist must acknowledge and encourage the client to discuss these reactions openly. They recommend that if a transference reaction is apparent, the counterproductive views must be clearly identified, the therapist must be nondefensive and not critical of the beliefs, and should collaboratively examine evidence which supports or refutes the transference reaction. Therapists are explicitly encouraged to examine the client's reaction to any behavior of the therapist that might be viewed in a negative way. These reactions suggest that particular schemas may have been activated and these data can then be used therapeutically.

Others have also suggested that the therapeutic relationship is a rich source of information about the client's belief system. Goldfried & Castonguay (1993) propose that the relationship with the therapist is a sample of the client's behavior that may be similar to how he or she interacts with others. Fodor (1987) recommends that cognitive therapists use the relationship to provide the client with objective feedback about his or her interpersonal style as well as teaching him or her how to effectively manage emotional reactions to others. Cognitive therapists can also use the relationship to enhance positive expectations about outcome and to increase their perceived value which may influence compliance (Raue & Goldfried, in press). Safran & Segal (1990) point to the importance of the therapist's reaction to the client and stress that the therapist is a participant in the process as well as an observer. The therapist must be cognizant when the client evokes a strong reaction and use this information to enhance the conceptualization.

Westen (1988) has also written about the therapeutic relationship and activation of interpersonal schemas. He argues that the transference can be used in several ways including identifying and changing dysfunctional scripts, wishes, and expectancies; evoking state-dependent memories and affect related to core beliefs; and modifying maladaptive affect-regulation processes activated in interpersonal situations. Westen believes that ignoring transference phenomena means disregarding a critical source of information about the client. For example, a client may express intense anger at a therapist who begins a session late. Beliefs which drive this emotion may include "He doesn't care about me. I'm being treated poorly. No one cares about me. I'm worthless." The therapist can use the anger evoked at his behavior to uncover and refute these beliefs. This process will help to modify the beliefs and strengthen the therapeutic relationship.

Recent empirical studies have tested the hypothesis that the therapeutic alliance is a critical element for change in cognitive therapy. In a review of the literature. Raue & Goldfried (in press) cite several studies which assessed alliance, as rated by both clients and therapists, across theoretical schools. No differences were found across orientations. In their own work, Raue, Castonguay, & Goldfried (1993) compared observer ratings of alliance in cognitive–behavioral and psychodynamic–interpersonal therapy sessions. They found that cognitive–behavioral therapists had significantly higher total alliance scores, as well as in specific ratings of the bond and therapeutic goals. Burns has also studied alliance in cognitive therapy. Person & Burns (1985) found that within-session modification of a belief and the patient's rating of the therapeutic relationship independently and in interaction were significantly associated with mood change. More recently, Burns & Nolen-Hoeksema (1992) found that client's perception of therapist's empathy had a significant impact on treatment outcome. All of this work provides strong evidence that the therapeutic relationship is an integral aspect of cognitive therapy and it contributes to symptom reduction.

Misconception #6: The Cognitive Model Does Not Address the Motivation for Maintaining Problematic Symptoms

In their discussion of schemas, Beck et al. (1990) suggest that these core processes are responsible for the perpetuation of maladaptive strategies. Schemas are associated with conditional assumptions which lead to specific patterns of behavior. For example, a person may have a helplessness schema. This core belief may produce the assumption that "If others take care of me, I won't be hurt." Subsequently, the person may be overly dependent in relationships and frantically avoid abandonment. The symptom cannot be fully extinguished until the underlying assumptions and schemas are modified. Clinicians must have a clear conceptualization of what underlying beliefs drive the dysfunctional behavior. Muran (1991) has also discussed the "rules for action" which are contained within schemas. He finds that these rules are initially difficult for

the client to recognize but they can be ineferred through an understanding of the underlying beliefs. He argues (*see also* Beck et al., 1990; Young, 1990) that these rules are developed through experiences as well as learned from early significant others. Safran & Segal (1990) have also discussed the role of inferred motivation in cognitive therapy. They argue that examining motivation helps to articulate underlying processes and assumptions and is useful in explaining current action.

Particular interest has focused on resistance or noncompliance in treatment. Beck et al. (1990) suggest that this is especially problematic with personality disorders. Several diverse factors may be motivating the client to resist change. These include an environment which rewards the dysfunction or some other type of secondary gain from the symptom. With these clients, it is important to assess what change would mean for them. Symptom reduction may be associated with new vulnerabilities. It may feel safer and less threatening to maintain their problematic strategies. If the negative core beliefs are not altered, new adaptive strategies are impossible to develop.

Misconception #7: Cognitive Therapists Are Only Concerned with Distorted Thinking and View Emotions as Minimally Important

From his earliest works, Beck has emphasized the necessity of arousing affect in therapy, arguing that efficacy is largely due to the client's ability to "experience and express his feelings during the therapy session" (Beck et al., 1979, p. 40). The presence of an intense emotion signals an important thought. Emotions are the most immediate cures that signal a cognitive shift. Beck argues that thoughts vary in their importance to the individual which reflects their position on the cognitive hierarchy. Thoughts which are associated with a strong emotional reaction are more representative of core beliefs and assumptions (*see* Weishaar, 1993, for a review). Newman (1991) discusses how arousing negative emotion in session prevents avoidance of painful triggers. The client can then work on the dysfunctional beliefs associated with this mood. He suggests that therapists use strategies to increase affect in session including imagery, role plays, and *in vivo* experiments.

Greenberg & Safran (1984, *see also* Safran & Segal, 1990) also stress that affective arousal is necessary for change and that therapists should not attempt to avoid it or always keep it at a low level. They view schemas as mental representations of previous emotionally charged experiences. Access to core beliefs may depend on a similar experience of heightened arousal. In addition, changes in beliefs may not be processed unless they are associated with a powerful affective response. Challenging thoughts in an abstract, mechanical manner will not produce lasting change at the core belief level.

Summary and Conclusion

Cognitive therapy has been practiced for almost three decades. Since that time, new developments in the model have emerged. However, a review of the literature has pointed to seven major misconceptions about cognitive therapy: 1) it does not address personality structure; 2) it is simplistic and mechanistic; 3) it ignores early experiences; 4) it does not address interpersonal relationships; 5) it disregards the importance of the therapeutic relationship; 6) it does not examine underlying motivation and compensatory strategies; and 7) it neglects the role of emotion in the therapeutic change process. By examining recent work in the cognitive therapy literature, as well as by highlighting aspects of the original works which may have been overlooked, it is hoped that this review has caused professionals to reevaluate their own assumptions about cognitive therapy. As new developments occur in the cognitive model, it is likely that the evidence against these misconceptions will continue to grow. Cognitive therapy represents a well-developed comprehensive model and should not be underutilized or disregarded because of faulty assumptions. Hopefully, the advances in theory and practice outlined here will encourage practitioners of diverse orientations to broaden their views and applications of the model.

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