Changing Conceptions of Cognitive Behavior Modification: Retrospect and Prospect

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A retrospective analysis of cognitive behavior modification reveals that 3 major metaphors have been offered to explain the role that cognitions play in behavior change. These metaphors include cognition as a form of conditioning, information processing, and, currently, narrative construction. The implications of using each of these metaphors are discussed.

Since its inception, cognitive behavior modification (CBM) has attempted to integrate the clinical concerns of psychodynamic and systems-oriented psychotherapists with the technology of behavior therapists. CBM has contributed to current integrative efforts in the field of psychotherapy. As in most forms of psychotherapy, CBM was the result of an evolutionary process and was part of a zeitgeist of what Dember (1974) called a "cognitive revolution."

Cognitive–behavioral therapies derived from a long tradition of semantic therapists ranging from Dubois to Kelly, and along the way were influenced by the social learning theories of Rotter, Bandura, Mischel, Kanfer, and others. The influential writings of Albert Ellis, Aaron Beck, and both Arnold and Richard Lazarus highlighted the role of cognitive and affective processes in psychopathology and in the behavior change process.

One major catalyst for the development of cognitive–behavioral therapy was the growing dissatisfaction with both the empirical and the theoretical bases of a strictly behavioral therapeutic approach. A number of authors, such as Breger and McGaugh (1965), Brewer (1974), McKeachie (1974), Mahoney (1974), and Meichenbaum (1977), were questioning the adequacy of learning theory explanations of both psychopathology and behavioral change. A second major catalyst was the initial results of cognitive therapists such as Aaron Beck (1970) and Albert Ellis (1962) who demonstrated the promise of their interventions.

This interest in cognitive factors in psychotherapy was often not well received by "behavioral types," who called for the exclusion of "cognitive types" from such organizations as the Association for the Advancement of Behavior Therapy. Such malcontents were supposedly diluting, if not undermining, the "purity" of behavior therapy. But Pandora's box, with all of its difficulties and challenges, had been opened as cognitive–behavioral practitioners struggled with questions as how best to conceptualize their clients' cognitions and how to fit such cognitive processes into the complex reciprocal interrelationships with clients' feelings, behavior, and resultant consequences, as well as with physiological and social-cultural processes. The answers to these research questions have been strongly influenced by the specific conceptualizations and metaphors used to explain clients' thought processes. I will consider three of these guiding metaphors, namely, conditioning, information processing, and constructing narratives.

Conditioning as a Metaphor

Initially, cognitive–behavioral therapists proposed that an individual's cognitions could be viewed as covert behaviors, subject to the same "laws of learning" as overt behaviors. In the tradition of Skinner and conditioning theorists, cognition was viewed as covert operands, or what Homme (1965) called "co-variants," supposedly responsive to both external and internal contingencies and altered by contiguous pairings, as in the case of covert sensitization (Cautela, 1973). Clients' self-statements and images were viewed as discriminative stimuli and conditioned responses that come to guide and control overt behavior. The focus of treatment was to "decondition" and to strengthen new connections, bolster and rehearse adaptive coping skills, and the like. The technology of behavior therapy, such as modeling, mental rehearsal, and contingency manipulations, was used to alter not only clients' overt behaviors, but also their thoughts and feelings.

Information Processing as a Metaphor

A different metaphor soon began to influence the development of CBM, namely, that of the mind as a computer, with the accompanying language of information processing and social learning theory. It was proposed that clients' cognitions could be conceptualized as consisting of a number of processes, including decoding, encoding, retrieval, pretreatment and attention, attributional biases, and distortion mechanisms, the last in the form of cognitive errors. Moreover, these cognitive errors were viewed as being a consequence of the cognitive structures or beliefs, schemata, current concerns, and tacit assumptions that clients brought to situations. It was proposed that such beliefs were strengthened by the manner in which clients behaved. The operable terms to depict this sequence were transactional, interactional, and bidirectional, as described by Lazarus and Folkman, Bandura, Wachtel, Kiesler, and Patterson. Individuals were viewed as "architects" of their experiences, influencing the data they were creating and collecting. Rather than being passive, the information-processing perspective...
proposed that individuals may inadvertently, if not unwittingly and even unknowingly, behave in ways that elicited the very reactions in others (a form of data) that they could take as evidence to confirm their views of themselves and of the world.

A number of investigators (e.g., Beck, 1970, and Hollon, 1990, who studied depression; Barlow, 1988, and Clark, 1986, who studied anxiety disorders; Dodge & Coie, 1987, and Novaco, 1979, who studied aggression in children and in adults, respectively; and Marlatt & Gordon, 1985, who studied clients with addiction problems) have used an information-processing perspective to explain their clients’ difficulties and to formulate an intervention plan.

From an information-processing perspective, clients are seen to be depressed because they distort reality as a result of a number of cognitive errors (e.g., dichotomous thinking, magnification, and personalization) and because they hold so-called irrational beliefs. They also hold negative views of themselves, of the past, and of the future, emitting characterological attributions of self-blame when they encounter failures and frustrations. Anxious clients who have panic attacks are seen as misinterpreting bodily cues and viewing them as personal threats given their preoccupation with physical well-being and the need to maintain a sense of personal control. Such misinterpretations or appraisals lead to “catastrophic” anxiety-engendering ideation with accompanying physiological arousal, as a vicious self-perpetuating cycle is established and maintained.

Those clients who have problems with anger and who are aggressive, especially if that aggressive behavior is reactive as opposed to instrumental in nature, have been found to hold hostile attributional styles; to interpret ambiguous interpersonal cues as provocations, retrieving from memory other aggressive events; and to fail to generate and implement socially acceptable alternatives. Moreover, aggressive clients, both children and adults, behave in ways that elicit the coercive and reciprocal reactions that confirm their aggressive outlooks. Thus, their expectations and self-statements become self-fulfilling prophecies.

Cognitive-behavioral therapists have developed intervention programs that are designed to help clients become aware of these processes and teach them how to notice, catch, monitor, and interrupt the cognitive-affective-behavioral chains and to produce more adaptive incompatible coping responses. Moreover, cognitive-behavioral therapists help clients to identify high-risk situations that they are likely to encounter and to consider ways to prepare, handle, and deal with failures if they should occur (namely, a form of relapse prevention). When positive results occur, clients are encouraged to make self-attributions for the changes that they have been able to bring about. Often, clients will require specific skills training, and treatment frequently involves significant others (spouse, family members, teachers, and peers) to increase the likelihood of generalization and maintenance.

Constructive Narrative as a Metaphor

The notion that clients are architects and constructors of their environments has given rise to a third metaphor that is guiding the present development of cognitive-behavioral therapies. The constructivist perspective is founded on the idea that humans actively construct their personal realities and create their own representational models of the world. This constructivist perspective finds root in the philosophical writings of Immanuel Kant, Ernst Cassirer, and Nelson Goodman and in the psychological writings of Wilhelm Wundt, Alfred Adler, George Kelly, Jean Piaget, Viktor Frankl, and Jerome Frank. More recently, the constructivist perspective has been advocated by Epstein and Erskine (1983), Mahoney and Lyddon (1988), McCann and Perlman (1990), Neimeyer and Feixas (1990), Meichenbaum (1990), and White and Epston (1990). Common to each of these proponents is the tenet that the human mind is a product of constructive symbolic activity, and that reality is a product of personal meanings that individuals create. It is not as if there is one reality and clients distort that reality, thus contributing to their problems; rather, there are multiple realities, and the task for the therapist is to help clients become aware of how they create these realities and of the consequences of such constructions. Bruner (1990), writing from a narrative psychology perspective, described how individuals make meaning or construct stories to explain their symptoms and situations. For instance, clients may use metaphors to describe their emotional experience. One client recently reported that she “always stuffed her feelings down” and then she would explode; another patient described “how he built walls between himself and others.” The therapist helped these clients to appreciate the nature and impact of using such metaphors.

What is the implication, what is the emotional toll, what is the price they pay for behaving in accord with such a metaphor of “stuffing feelings” and “building walls”? At this point, the therapist explored collaboratively and experientially the “price” they paid. “If this is not the way they would like things to be, then what could they do?” It is not a big step for clients to suggest that perhaps they should “not stuff feelings” and “not build walls.”

The therapist then says, “Not stuff feelings, not build walls—this is interesting. What did you have in mind?” In this manner the therapist enlists the client as a collaborator in engaging in what Shafer (1981) called “narrative repair.”

The metaphor of a constructive narrative to explain clients’ problems has a number of important theoretical and practical implications for the further development of CBM.

1. The therapist is viewed as a co-constructivist helping clients to alter their stories, as Spence (1984) proposed. The therapist must first listen empathically and reflectively to the initial story line of the patient and then collaboratively help the client to transform his or her story. A nurturant, compassionate, nonjudgmental set of conditions is required for distressed clients to tell their story at their own pace. A number of clinical techniques, including reflective listening, Socratic dialogue, sensitive probes, imagery reconstruction of stressful experiences, and client self-monitoring, are used to help clients relate what happened and why. Thus, the role of relationship variables is critical, as is the role of affect in the therapeutic process.

2. The therapist helps clients to cognitively reframe stressful events and to “normalize” their reactions. From this perspective, it is not the symptoms of depression, anxiety, and anger per se that interfere with functioning; rather, what clients say to themselves and others about these reactions, the stories they construct, are important to the adaptive process. The therapist not only helps to validate clients’ reactions but indicates
that such symptoms are normal. In fact, their emotional distress is viewed as a normal spontaneous reconstructive and natural rehabilitative adaptive process. This reconceptualization process is an attempt to formulate a "healing theory" of what happened and why (see Meichenbaum & Fitzpatrick, in press, for a fuller discussion). The therapist also helps clients relate examples of their strengths, resources, and coping abilities to convey "the rest of the story" (to use a popular metaphor). The therapist avoids holding a pathology bias, instead looking for and building on those exceptional occasions when clients cope effectively.

3. From a narrative perspective, the therapist not only helps clients to break down global stressors into behaviorally prescriptive events so they can use problem-solving and emotionally palliative coping techniques, but also helps them build new assumptive worlds and new ways to view themselves and the world (Meichenbaum, in press).

The cognitive therapist helps clients to construct narratives that fit their particular present circumstances, that are coherent, and that are adequate in capturing and explaining their difficulties. As Shafer (1981) indicated, therapy allows clients to retell their tale "in a way that allows them to understand the origins, meanings and significance of present difficulties, and moreover, to do so in a way that makes change conceivable and attainable" (p. 38). What matters most about this story telling or narrative construction is not its "historical truthfulness," as Spence (1984) observed, but its "narrative truthfulness."

4. One of the implications of adapting the constructive narrative metaphor is that it suggests that one look at therapeutic interventions in a different fashion. Perhaps, one can even find therapeutic suggestions from the way that teachers teach narrative writing. It also suggests different types of dependent measures that individuals can use (e.g., indicators of narrative transformations).

The field of CBM has come a long way since its inception. The story continues to unfold and to change as new metaphors are adopted and new narratives constructed.

References


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