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Cognitive-behavioral theory and therapy, and Postmodernism

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In K Ecklund, Chair, Postmodernism, psychology, and Christianity: Clinical implications of a changing world view. Symposium presented at the annual meeting of the Christian Association for Psychological Studies, Western Region, La Mirada, CA.

Cognitive-behavioral theory and therapy, and Postmodernism

Recent developments in cognitive-behavioral theory and cognitive-behavioral approaches to psychotherapy illustrate some of the implications of postmodernism for psychology, and especially for clinical practice. Here we will briefly consider some of these developments in cognitive-behavioral theory and therapy respectively, and briefly address some implications for integration.

Cognitive-Behavioral theory. Because of their development in the 70's and 80's, many of cognitive-behavioral approaches are strongly influenced by postmodernist thought. Cognitive therapy models may be loosely divided into two or three groups. A three group model divides the approaches into coping skill, problem solving, and cognitive-structuralist models. In the two group structure there are the cognitive-associationistic models (which combine coping skills and problem solving models into a single group), and the cognitive-structuralist and constructivist models. Among the latter are the approaches of Guidano and Liotti (Guidano & Liotti, 1983; Guidano, 1988) and Mahoney (Mahoney, 1974, 1980, 1988, 1991; Niemeyer & Mahoney, 1995). Table XX provides an overview of several of the major cognitive-behavioral models (adapted from Dobson, 1988).

Ellis' REBT was developed in the 1960's. The remaining C-B therapy models developed in the 1970's and 1980's. Initially these models were developed by academic research clinicians to treat very specific populations with narrowly defined problems. Outcomes were focused on reduction in symptomatic manifestations of these problems. It is these interventions and outcomes that are the core of the psychotherapy "efficacy" research. Gradually the techniques and models have been extended to other problems and populations and integrated into what are now known as "integrative models" of psychotherapy. Most of these developments are deeply rooted in modernist scientific-rationalist traditions.

Because the coping skills and problem solving approaches are largely rooted in a modernist worldview, we will not examine them here. In some ways Ellis' REBT is an anomaly. It was initially developed in the 1960's before the coping skills and problem solving approaches, yet has more kinship with the constructivist models, both in its emphasis on the cognition-affect

nexus rather than the cognition-behavior nexus, and in its tendency toward rationalism or mentalism. Here we will focus on the cognitive structuralist model of Guidano and Liotti (1983) and the recent writings of Mahoney (1980; 1982, 1988; Niemeyer & Mahoney, 1995) and Dowd and Pace (1989).

Guidano and Liotti proposed a deep-structure meta-theory that “emphasizes the active, generative, and intentional dimensions of personal knowing processes . . . aimed at . . . identifying invariant deep structures” (p. 307). For them, “therapy is therefore based upon the elaboration of alternative models of the self and the world such that the deep structures can adopt a more flexible and adaptive articulation” (p. 307). While we cannot do justice to their model here, several points will be helpful. Their model of human knowing includes several features:

1. Evolutionary epistemology
2. Self-organizing: autopoiesis (self-renewal/self-organizing); human knowing system functions are centered around maintenance and renewal of their own organization they possess individuality and uniqueness. [open system]
3. Motor theory of mind: mind is active, producing both output and *much of its own input* (contrasted with notion of mind as passive receiver of incoming sensation); unconscious tacit processes are given a central role as supra-conscious events “the mind is . . . a system of abstraction rules capable of bringing about a relational order of events in order to *produce* experience and behavior” (p. 310).
4. Deep or tacit levels of knowing constrain and direct surface cognitive structures; cognitive change occurs without loss of organization (or identity)

For Guidano and Liotti, the organization of development has several key features. First, “human knowledge is imbued with and biased by all the invariant aspects (evolutionary and cultural constraints) that define human nature” (p. 311) and determine human knowing [compare with imago dei]; thus identity (being) and knowing are intertwined. Second, attachment is viewed as a central organizing principle in cognitive development; because cognitive abilities develop more slowly, emotional schemata direct the unfolding perceptual-cognitive processes and “influence the content that self-knowledge can assume” (p. 313). A set of abstract rules for

interaction which operate mainly tacitly and automatically govern the integrated operation of (thoughts, feelings and behavior). Explicit and conscious appraisal of self emerges only later. Third, developmental stages are viewed as a progression of steps in self-knowledge organization.

Dowd and Pace (1989) proposed that constructivist theory assumes that knowledge flows from the inside out, and that the mind is both active and constructive. “Constructivist metatheory (holds) . . . one common assumption: that *reality is not invariant but is created by each individual* according to his or her self-schemata and tacit rules governing the creation and organization of knowledge” (p. 217; emphasis added).

Mahoney (1988) proposed that the cognitive revolution seems to parallel the leading edge of technological development. According to Mahoney, much of the controversy in these new developments revolves around traditional views of *realism* and *rationalism*.. He contends that critical assumptions about ontology (the nature of reality), epistemology (a theory of knowing), and causality (theories of causation) are central to issues in recent cognitive therapies. “Realism presumes a singular, stable, external reality that is accurately revealed by one’s senses. Rationalism presumes that thought is superior to sense and most powerful in determining experience” (p. 363). It emphasizes thought and mind, over experience, body, and world. “*Constructivism asserts that humans actively create and construe their personal and social realities. . . proponents . . . question whether reality is fundamentally external and stable, and whether human thought is meaningfully separable from human feeling and action*” (p. 364, italics original).

Cognitive-Behavioral Therapy. Constructivist models of cognitive-behavioral therapy emphasize the nexus between thought and emotion; broadly we could describe this as the experiential nexus. Dowd and Pace (1989) distinguished first order change and second order change. They proposed that first order change involved attacking the problem. In their view, first order change works “within a system that itself remains unchanged following unchanging rules of operation” (p. 219); its usual focus is on “applying the opposite of the problem behavior” (p. 219); in the face of failure, it “does more of the same” and/or blames the patient/client (p. 219). The problem with first order change, they proposed, is that basic

assumptions about therapeutic model and client reality construction are never questioned, and may not even be known or accessible to articulation. Change may fail; or one person in system may improve and another deteriorate. They contend that trying harder actually exacerbates some problems, e.g., sleeplessness and anxiety.

Dowd and Pace proposed second order change, or attacking the solution. Here one chooses to focus on the solution rather than the (original) problem. This *decontextualizing* changes the frame of reference and the meaning of the symptom; the resulting disequilibrium prompts the person to develop an alternative belief system (*accommodation*) which may be more viable. The more disequilibration, the greater the resistance and the more intense the emotions which will occur. This model undercuts linear causal notions, opening up the possibility of multiple causality. Second-order change strategies help the person consider her/his role in the problem; it exposes the relativity of reality, opening the person to considering alternative constructions of reality. These implicit and indirect challenges result in reconsidering, and changing, implicit knowledge structures. Because the therapist is not obviously responsible, internal attributions occur, solidifying therapeutic change.

Beutler (1983) proposed that reactance (or resistance) is related to an internal locus of control. Paradoxically, successful therapy increases internal locus of control, hence reactance, making people subsequently more resistant to change! According to Beutler, defiance-based or paradoxical strategies appear more effective with high reactance (internal LOC) clients, while compliance-based strategies are more effective with low reactance (external LOC) clients (Beutler, 1979).

According to this model, the genius of second-order change techniques is that “by modifying the attempts at change and violating the usual rules governing change-producing efforts, it forces the individual to redefine the nature of reality and provides an implicit message that reality is indeed relative” (Dowd & Pace, 1989; p. 224). This forces evolutionary development of knowledge structures, and shifts in meaning which will alter behaviors and emotions. Several second-order change strategies were proposed by Dowd and Pace. These include:

Reframing - best for relatively compliant clients, it involves shifting meaning of problem or event by pointing out opposite values (e.g., benefits of awareness of one's pain)

Symptom prescription - practicing problem behavior generally (e.g., for insomnia, see if you can stay awake all night), or at a specific time or place (e.g., see if you can have a panic attack in the waiting room).

Restraining - discouraging the client from changing at all or for a specific time period (e.g., in sex therapy seeking agreement to not attempt intercourse for the next two weeks), or exploring negative consequences of change and the benefits of her/his present situation

Positioning - agreeing with, rather than challenging, negative self-statements (parallel to judo), thus "breaking the rules" (or extinguishing?) so that reactance is therapeutic (e.g., rather than dispute person's claim to be a "loser" therapist affirms it)

Integrative Reflections on Constructivist CBT. Constructivist models raise a number of issues of interest from a Christian perspective. These have to do with the nature of reality, how it works, how it is known, ethics, and human personhood. Several of these will be addressed by Dr. Buhrow. Here I will address those most pertinent to cognitive-behavioral psychotherapy.

First, a constructivist model lends itself to mentalistic reductionism. While the question of the nature of reality (ontology) remains, the model is biased toward skepticism or outright rejection of the notion of a real external world (realism). Hermeneutics is an alternative to constructivism in explaining many of the same phenomena; people who perceive the same events often interpret them differently. Second, most of the interventions proposed by constructivists are at least partially compatible with alternative theoretical models. Third, because these theories are relatively new, limited amounts of empirical evidence have yet been amassed regarding many of the central questions raised. Among these are questions about the efficacy of treatment following these models. The constructivist models tend to naturally align with worldviews which reject notions of a real world, scientific rationalism, objective knowing, and universal ethics; they join with those views which accept emphasis on relationship and spirituality, but generally limit them to experiential status (versus ontological reality).

On the positive side, postmodernism and constructivism alert us to the reality that all facts are interpreted, and thus inevitably tainted by personal biases. They draw attention to the significance of the personal-subjective frame of reference, the importance of community and relationship (though these are in tension with some basic principles of constructivism), and affirm spiritual awareness.

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Table XX

Overview of Cognitive-Behavioral Approaches

Approach/Author	Year	Title
<u>Cognitive Restructuring</u>		
Ellis	1962	Rational-Emotive Therapy
Beck	1963	Cognitive Therapy
Meichenbaum	1971	Self-Instructional Training
Maultsby	1975	Rational Behavior Therapy
Guidano & Liotti	1983	Structural Therapy
<u>Coping Skills</u>		
Suinn & Richardson	1971	Anxiety-Management Training
Meichenbaum	1973	Stress Inoculation Training
Goldfried	1974	Systematic Rational Restructuring
<u>Problem Solving</u>		
D’Zurilla & Goldfried	1971	Problem-Solving Therapy
Spivack & Shure	1971	Problem-Solving Therapy
Mahoney	1974	Personal Science
Rehm	1977	Self-Control Therapy

Note: adapted from Dobson (1988), p. 12

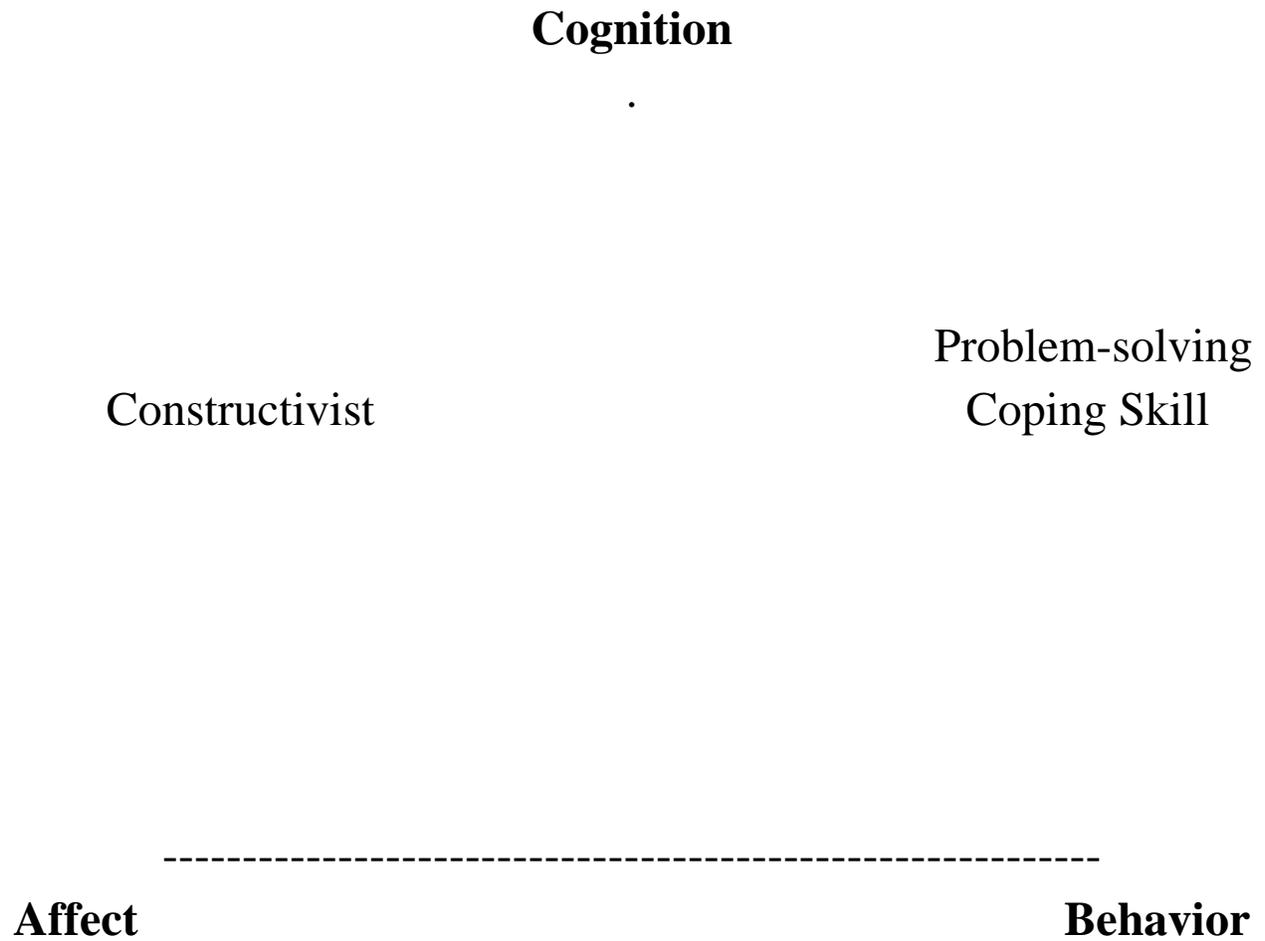


Figure 1: Relationship of cognitive behavioral models to domains of behavior which are emphasized.