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Assessing the Cognitive-Interpersonal Cycle[1]

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This article argues that Harry Stack Sullivan's conceptions of interpersonal psychotherapy have a number of important implications for both the theory and practice of cognitive behavior therapy. Sullivan's formulations, while compatible with cognitive behavioral theory in many respects, add both motivational and interpersonal contexts that are missing from cognitive behavior therapy. With regard to the first theme, it is argued that Sullivan's theory on the role of anxiety in the development and maintenance of dysfunctional cognitive structures has important implications for both cognitive assessment and modification. With regard to the second theme, it is argued that the therapist's role as a participant-observer in the therapeutic relationship provides him with a valuable opportunity for identifying maladaptive interpersonal patterns and assessing dysfunctional cognitive activities that are linked to these patterns.

In a recent article (Safran, 1984) I have discussed a number of ways in which Harry Stack Sullivan's conceptions of interpersonal psychotherapy are compatible with the contemporary cognitive behavioral tradition, and described some specific ways in which the incorporation of principles and practices derived from the Sullivanian tradition would potentially broaden and enrich both the theoretical and practical scope of cognitive behavior therapy. Since the primary objective of that article was to bring Sullivan's interpersonal theory to the attention of cognitive therapists and to stimulate an interest in interpersonal conceptualizations, certain aspects of Sullivanian theory were either simplified or neglected in order to avoid distracting from the main thesis of the article.

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The first objective of the present article is to expand upon and clarify certain aspects of Sullivanian theory that were presented in a more simplified fashion in the previous article. The second objective is to present a more detailed account of the manner in which interpersonal and cognitive approaches can be interfaced in practice, bearing in mind the clarifications that have been made. First, however, let me briefly review some of the features of Sullivan's theorizing that are responsible for its compatibility with contemporary cognitive behavioral theorizing, as well as some of the ways in which incorporating principles and practices derived from the Sullivanian interpersonal approach can potentially enrich the cognitive behavioral tradition.

As Goldried (1980) has argued, a central obstacle to the integration of different therapeutic traditions and the identification of common effective mechanisms is the fact that proponents of different theoretical systems use different jargons, which obscure similarities between different theoretical traditions and highlight the differences. In light of this problem, a valuable feature of much of Sullivan's theorizing is that it is formulated in terms that are compatible with today's cognitive experimental psychology. As I have discussed previously (Safran, 1984), there are a number of similarities between Sullivan's notion of personification of the self and the concept of self-schema emerging from the social-cognition literature, both of which can be defined as "cognitive generalizations about the self, derived from past experience, that organize and guide the processing of self related information contained in an individual's social experience" (Markus, 1977). There is also a strong parallel between Sullivan's observations about the manner in which the personification of others biases our perception of other individuals and recent research that demonstrates the manner in which expectations bias the processing of information about other people (Cantor & Mischel, 1977; Cohen, 1981; Rothbart, Evans, & Fulero, 1979; Zadny & Gerard, 1974). Finally, Sullivan's hypothesis that selective inattention is one of the major mechanisms through which the processing of social information can be biased or distorted receives support from contemporary theory and research on the role of selective attention in human functioning (Shevrin & Dickman, 1980).

Given the fact that there is a certain metatheoretical compatability between the Sullivanian tradition and the cognitive behavioral tradition, the question that arises is: What are the advantages that would result from attempting such an integration? Elsewhere (Safran, 1984) I have argued that the incorporation of certain principles derived from Sullivan's model has the following benefits for cognitive therapy: (1) It provides a useful model for understanding and dealing with problems in therapeutic compliance. (2) It provides a framework for understanding what variables can lead to problems

in therapeutic maintenance. (3) It provides a systematic framework that will allow cognitive behavior therapists to broaden their conceptualization of the role of emotions in psychotherapy from one that views emotions only as undesirable experiences that should be controlled, to one that recognizes the adaptive role of emotions in human functioning. The need for this type of perspective has been suggested recently by a number of authors, including Glass and Arnkoff (1982), Greenberg and Safran (in press), Mahoney (1980), and Safran and Greenberg (1982a).

Since the details of these three arguments will not be reiterated in the present paper, the interested reader is referred to the Safran (1984) article. The most central theme, however, and one that will be returned to again in the second part of this article, is that all individuals experience distinctive regularities in the social interactions in which they participate. Sullivan referred to these interactional regularities as *me-you patterns* (Mullahy, 1970). Interpersonal therapists (e.g., Carson, 1982) hypothesize that these me-you patterns are maintained by the fact that people's expectations result in certain interpersonal behaviors, which elicit predictable responses from others, which in turn confirm their expectations. Since the therapist tends to become integrated with the client's me-you patterns in the same manner as other people, he can provide the client with important feedback about his impact upon other people, on the basis of his own feelings and action tendencies.

HOT INFORMATION PROCESSING IN THE REAL WORLD: ANXIETY AND THE DEVELOPMENT OF THE SELF

While it is true that formulations such as self-personification, personification of others, and selective inattention are essentially "cognitive" in nature, there is an important respect in which these concepts differ from comparable concepts emerging from the social cognition literature. Cognitive information-processing theory, in general, deals with the way in which people process information from the environment in a nonemotional context. It is thus a theory of "cold" information processing. As Folkman, Schaefer, and Lazarus (1979) and Safran and Greenberg (1982b) have argued, this may limit its applicability to clinical situations. Sullivan, in contrast, is very much concerned with "hot" information processing in an emotional context. In his model, self-schema consistent and inconsistent information receive differential processing, not only as a by-product of a normal information processing confirmatory bias (Nisbett & Ross, 1980), but also because inconsistent information arouses anxiety in the individual, who subsequently does whatever he can to minimize this anxiety and restore his sense of security and self-esteem.

Since this notion is so central to Sullivan's model, I will outline it in greater detail. Sullivan spoke about three aspects of the personified self: the *good me,* the *bad me,* and the *not me.* The *good me* consists of those feelings, psychological experiences, and characteristics that the individual values and feels good about in himself. The *bad me* consists of those feelings and characteristics that the individual believes to be part of who he is, but that he devalues or feels badly about. The *not me* consists of those feelings and characteristics that the individual views extremely negatively, and that are cognitively symbolized as a part of personal experience only in a very primitive, rudimentary, and elementary fashion (Sullivan, 1953). For example, an individual may value those aspects of himself that he sees as strong (*good me*), may feel badly about those aspects of himself that he sees as angry (*bad me*), and may not acknowledge to himself that he ever feels weak (*not me*).

According to Sullivan, personifications of the self are learned by the child through interactions with significant others as he develops. Those feelings, experiences, and potential aspects of the self that are viewed positively and are rewarded by significant others become personified as the *good me.* Thus, for an example, a young child who is rewarded for independent behavior by his parents, comes to value those aspects of his self that are associated with independence. Those feelings and characteristics that are not valued by significant others, however, also become devalued by the child. They come to be personified as either the *bad me* or the *not me.*

The determining factor here is the degree of *anxiety* that becomes associated with the feeling or experience. Anxiety is a central explanatory concept in Sullivan's system, and he uses this term in a specialized way to designate all forms of emotional distress related to a loss of self-esteem (Chapman, 1978). Anxiety is thus a noxious tension, which is inversely related to the experience of feeling good about oneself. According to Sullivan, the young child experiences anxiety whenever a significant other disapproves of him. Anxiety can also be directly transmitted in social interactions. Thus, for example, the mother who feels tense and anxious when she is breast-feeding her child can transmit the experience of anxiety to the infant. Sullivan maintains that the experience of anxiety obstructs the perception and understanding of experience. Anxiety thus makes it difficult for the individual to accurately perceive and process that which is occurring both around him and within him. When the degree of anxiety that the child experiences in a social interaction is moderate in intensity, the child personifies associated experiences as the *bad me.* He processes these experiences and accepts them as part of the self but views them as bad. When the anxiety becomes extreme, associated psychological experiences cease to become fully personified as part of the self, and thus become the *not me.*

Since, in Sullivan's framework, the individual is fundamentally an interpersonal being, his basic feeling of well-being and *security* in the world is thus integrally linked to the manner in which he is valued or perceives himself to be valued by other people. As long as he is able to view himself in a manner that is consistent with his personified *good me,* he experiences a sense of self esteem and security in the world. When, however, this picture of himself is threatened by feelings, thoughts, or feedback that are consistent with the way in which he has come to personify either his *bad me* or his *not me,* the individual experiences anxiety and a loss of self-esteem and security.

The particular character of the experiences that will precipitate anxiety in later years is thus determined by the child's early learning experiences with significant others. According to Sullivan, people are constantly acting to maintain their self-esteem and sense of security, and to minimize the experience of anxiety as much as possible. Psychological processes and behaviors that function to maintain the individual's self-esteem and to restore his sense of security when it is threatened are referred to by Sullivan, simply enough, as *security operations.*

One of the major security operations takes place through a process of selective inattention. Experiences that are associated with anxiety are attended to and processed less fully than those that are not. The more intense the anxiety, the less processing the related experience receives. It is this attenuated processing that is responsible for the fact that the *not me* is personified only in a rudimentary fashion.

Selective inattention thus controls the contents of focal awareness. Consistent with contemporary cognitive theory, Sullivan (1953) recognizes that selective inattention has both adaptive and nonadaptive consequences: "This control of focal awareness results in a combination of fortunate and unfortunate uses of selective inattention. The sensible use is that there is no need of bothering about things that don't matter, things that will go all right anyway. But in many cases there is an unfortunate use of selective inattention, in which one ignores things that do matter; since one has found no way of being secure about them, one excludes them from awareness as long as possible" (p. 233).

It is important to note that Sullivan employed the concept of selective inattention in a fairly broad sense to refer not only to the specific situation in which the individual selectively ignores sensory information from the environment but also to any situation in which he fails to draw obvious inferences from either his or other people's actions (Sullivan, 1953). He also categorized behaviors that function to avoid dealing with anxiety-arousing topics as forms of selective inattention. Examples of such behaviors are changing the topic, becoming confused, and becoming preoccupied with topics that distract from the area associated with anxiety.

In addition to selective inattention, Sullivan spoke about a variety of other security operations, such as avoiding interpersonal situations to minimize anxiety, blaming others or other events for one's problems, actual dissociation (disowning one's experiences), transforming anxiety into other emotions (e.g., experiencing anxiety as anger or apathy), and thinking about and behaving toward others in a critical or derogatory fashion so that one's perception of his own value becomes enhanced relative to one's perception of the other (Sullivan, 1953, 1956).

ANXIETY AND THE THERAPEUTIC PROCESS

Because of these security operations, valuable opportunities for learning new things about the self and others are lost. This has important implications for the therapeutic process, which were alluded to in the Safran (1984) article, but which were not spelled out in detail. The concepts we have been discussing suggest that many dysfunctional belief structures are maintained at least partially by a need to minimize anxiety, and that the process of confronting these beliefs and assumptions in therapy can generate anxiety. In fact, on the basis of Sullivanian theory, one would predict that to the extent that a belief can be modified simply by providing disconfirming evidence, without arousing substantial anxiety, it suggests that the belief may not be central to the person's view of himself or the world.

It is thus important to have some notion of overall cognitive organization, which recognizes that (1) not all belief structures are equally central in the individual's organization of knowledge about himself and the world, (2) those belief structures that are most central will be most difficult to change, and (3) challenging more central belief structures will arouse more anxiety than challenging less important belief structures.

Guidano and Liotti (1983), for example, speak about two types of cognitive changes that can take place in therapy: "peripheral changes" and "central changes." According to them, "a peripheral change coincides with the reorganization of the patient's attitude toward reality within the limits allowed by the maintenance of his or her attitude toward self." In contrast, they view a "central change" as "the modification of the attitude toward oneself that follows the restructuring of personal identity" (p. 97). They argue that although peripheral changes may result in some reduction of distress and improvement in the patient's adaptation to his environment, in many cases, changes of this type will be short-lived, or of limited value.

It is thus important to have some way of distinguishing between central and peripheral cognitive structures. Since challenging more central structures is likely to result in more anxiety than challenging peripheral structures,

increases in the client's anxiety level and concomitant mobilization of security operations are important to monitor for diagnostic reasons. According to Sullivan, "There is bound to be anxiety, and in fact the anxiety probably serves as pain and tenderness do in a physical diagnosis, being used by the doctor as a guide to the outlining of diseased areas" (p. 120).

In discussing Sullivan's clinical style, White (1952) states: "To Dr. Sullivan, tonal variations in the voice were frequently dependable clues to shifts in the communicative situation. He also was alert for other slight manifestations of anxiety, such as a change of subject, or not comprehending what the analyst has said, or a question that did not bring a response" (p. 123). In *The Psychiatric Interview,* Sullivan (1954) describes a number of other such cues, including peculiar misunderstandings or mistaken interpretations of the interviewer's questions, stereotyped verbal expressions that are not particularly communicative, mannerisms, stereotyped gestures, postural tension, contortions of the face, fatigue, habitual qualification of statements, failure on the client's part to remember what he was talking about, and complete blocking.

For the cognitive therapist, shifts in communication of this type should function as markers to probe for the client's feelings and cognitions immediately preceding the shift. For example, the therapist notices that while he is pursuing a particular line of inquiry, the topic subtly shifts. At this point he might stop his client and say: "I noticed that first we were talking about one thing and then you began to talk about something else. What was going through your head, just before that happened?"

Alternatively, rather than probing for cognitions following a communication shift, the therapist may wish to file the information away and use it to generate hypotheses about the nature of the client's self-personification. For example, the client who becomes confused while discussing anger may personify anger as part of his *bad me.*

Let me make it clear at this point that I *am not* making any claim such as "cognitive therapists are not sensitive to their clients' nonverbal behaviors." In fact, I have no doubt that effective cognitive therapists are sensitive to their clients' nonverbal behaviors. What I *am* stating is that Sullivanian theory suggests that monitoring the client's anxiety level and security operations on an ongoing basis is the essence of good therapy and that its importance cannot be overemphasized. It is also important to emphasize that changes in the communicative situation can be sufficiently subtle to elude easy detection. As I will argue in the next section, it is thus important for the therapist to become skilled at monitoring his own feelings and reactions, since they provide important clues regarding the nature of his relationship with the client at any given time. This self-monitoring process thus helps the therapist to generate hypotheses about what the client is experiencing. It should also be

emphasized that the therapist must vigilantly monitor *himself* for security operations that may be masking anxiety. When he does become aware of such anxiety he should ask himself, "What particular interaction of my own sensitivities and my client's behavior are responsible for my anxiety?" As Sullivan (1954) stated, "the psychiatrist has an inescapable, inextricable involvement in all that goes on in the interview; and to the extent that he is unconscious or unwitting of his participation in the interview, to that extent he does not know that is happening" (p. 19).

In addition to serving an important diagnostic function, monitoring subtle shifts in the communicative situation provides the therapist with guidelines for modulating his own comments and behavior to avoid needlessly threatening the client's self-esteem and mobilizing his security operations. This is essential since (1) the excessive mobilization of security operations will impede an accurate cognitive assessment, and (2) excessively high levels of anxiety will militate against the possibility of new learning, and changing important dysfunctional cognitive structures. As Sullivan states: "Skill therefore addresses itself to circumventing these security operations without increasing their scope; this amounts to avoiding unnecessary provocation of anxiety without, however, missing data needed for a reasonably correct assessment of the problem" (White, 1952, p. 119).

Another useful guideline for circumventing the client's security operations is that an accurate assessment of the client's self-personification on the basis of all the data that have emerged over the course of therapy can help to develop hypotheses about what type of areas are likely to be "secure areas" and what type of areas are likely to be sensitive areas that should be handled with increased tact. Data for this type of assessment can be obtained from biographical information, self-descriptions, statements of beliefs and values, observations of general affective style (e.g., the client who rarely expresses fear is likely to personify the experience of fear as part of his *bad me*), and the observation of areas associated with mobilization of security operations.

Other guidelines for circumventing security operations in therapy can be found in a recent article by Wachtel (1980), in which he discusses a number of general principles involved in wording comments in a manner that decreases their threat value. For example, the comment "I think you're feeling very angry at me, and the boredom is a cover" has an implicitly accusatory message. In contrast, the statement "I wonder if you're staying silent because you feel that you'd better not say anything if what you're feeling is anger," rather than accusing the client of "hiding something," conveys the message that it's all right to be angry, and that if the client is not expressing anger, he is probably doing it for psychologically important reasons.

Making the Cognitive-Interpersonal Link

A central thesis in the Safran (1984) article was that one of the most effective means the therapist has of assessing the nature of the interpersonal behaviors of his client that are most socially dysfunctional is to monitor his own emotional reactions and behavior tendencies which arise in response to the client. This follows directly from Sullivan's postulate that the therapist is a *participant observer* in interaction with the client, who will tend to respond to the client in a manner similar to that of other people. It was also argued that it is essential for the therapist to become aware of his client's characteristic interpersonal pull and to *unhook* himself from the interaction in order to disconfirm the client's dysfunctional expectations about interactions. Kiesler (1982) has done an excellent job of operationalizing this process, by specifying a number of procedural steps. He argues that in addition to unhooking himself from the interaction with the client, it is useful for the therapist to metacommunicate about the impact that the client has on him. It is important for the therapist to pinpoint for the client, as specifically as possible, the particular client behaviors and communications that create this impact, since increased specificity will maximize the usefulness of the feedback for client.

Kiesler (1982) provides the following example of such a communication. Having identified certain client behaviors that seem to be distancing him, the therapist says to his client:

> I realize it's important for you to be cautious and rational in what you do or say to others, and I agree that it is important in many situations. Yet it seems in our sessions you sometimes send messages you don't intend to send as a result of this caution. For example, you often show long, silent pauses with me after I've said something to you, and frequently a quick smile flashes on and off. Several times when you did that I thought you were really disagreeing with what I was saying, or were thinking my comment was a little stupid. But I found out later that that wasn't the case, that actually you were feeling a little stupid about yourself.... I wonder if others might misread you sometimes in the same way, feeling that you are disapproving of them, which is not your intent at all. (p. 289)

Kiesler then goes on to add that by bringing the impact of this behavior to the client's attention, he can help the client to change a behavior that is distancing people in everyday life—in this particular case, by making them feel foolish and irritated.

While the Safran (1984) article spoke about the manner in which the adoption of similar procedures by the cognitive therapist would expand the scope of his clinical practice, it said less about what the integration of the two approaches would add to the practice of interpersonal therapy. The

integration of cognitive and interpersonal approaches suggests an additional step in the previously described procedure. In addition to pinpointing and providing feedback to the client about the interpersonal impact of dysfunctional behaviors, the process of pinpointing dysfunctional interpersonal behaviors can provide the cognitive therapist with markers indicating the need for cognitive exploration. A central tenet of a truly *cognitive-interpersonal* perspective is that cognitive activities, interpersonal behaviors, and repetitive interactional or *me-you patterns* are linked together and maintain one another in an unbroken causal loop, which will be referred to here as the *cognitive-interpersonal cycle.* The assessment of any one aspect of this cycle facilitates the assessment of the remaining aspects. Thus, as I will illustrate in a moment, the correct identification of important dysfunctional behaviors paves the way for the exploration of associated cognitive activity. Conversely, the identification of important automatic thoughts can facilitate the further identification of maladaptive security operations and interpersonal behaviors. The possibility of effective therapeutic intervention is maximized when all aspects of the cycle have been thoroughly assessed. It is thus important for the clinician to thoroughly assess the type of cognitive activity that gives rise to or supports the pinpointed dysfunctional interpersonal behavior on a long-lasting basis, since it may be difficult to modify the behavior if he does not concurrently modify the cognitive activity that supports it.

In the above illustration, for example, the therapist who has pinpointed the behavior that has the negative impact could interrupt the interaction the moment the client becomes silent and smiles, and say: "I'm aware that when I asked you that question, a smile flashed on and off your face, very quickly. What was going through your mind when that happened?" If the client is not immediately aware of the relevant cognitive activity, the therapist can have the client intentionally engage in the relevant behavior, in order to provide himself with behavioral cues that may trigger the associated cognitions. In the above situation, if the client appears to be registering disapproval or condescension on his face, it is probable that some aspect of his cognitive activity corresponds to his communicative behavior. In other words, it is unlikely that experiencing a sense of foolishness has arbitrarily become paired with looking scornful.

In terms of the Sullivanian framework, which was discussed earlier, one hypothesis would be that the client does indeed experience a scornful feeling toward the therapist, but that this is at least in part a security operation, which functions to raise his self-esteem when he feels foolish. The best way to evaluate the veracity of such a hypothesis is to explore the client's cognitive processes in collaboration with the client, in as nonthreatening a fashion as possible.

Once the therapist has conducted a comprehensive assessment of the dysfunctional cognitive activity that is linked to the relevant dysfunctional interpersonal behavior, he can begin to modify this cognitive activity at the same time that he is giving feedback about the impact of the dysfunctional behavior, and remaining *unhooked* from the dysfunctional interactional pattern.

In this particular case, it would be vital for the therapist to access the client's feelings of being foolish, and related automatic self-defeating thoughts, before he could begin challenging them. It is important to emphasize that these cognitions might not emerge without the therapist first taking the intermediate step of exploring and listening to the client's scornful and disapproving thoughts and feelings in an accepting fashion. This is because acknowledging automatic thoughts related to the feeling of being foolish may initially be too anxiety-provoking for the client. The process of listening and accepting the client's scornful thoughts, however, helps him to feel secure enough to begin exploring feelings and cognitions that are associated with his *bad me.*

Before proceeding to a second example, let me briefly summarize and amplify upon the steps involved in assessing the cognitive-interpersonal cycle.

1. The therapist explicitly identifies the characteristic feelings and responses that the client evokes in him.

2. The therapist explicitly identifies the particular client behaviors and/or communications that evoke these responses. It is important to remember here that, as Kiesler (1982) has noted, many of these behaviors or communications can occur on a nonverbal or paralinguistic level (e.g., a client evokes feelings of protectiveness in the therapist when he speaks in a soft, fragile-sounding voice).

3. Once the therapist has identified the relevant behaviors in the client, he begins to explore automatic thoughts that accompany or precede the behaviors. It is important to probe for automatic thoughts as close as possible in time to the appearance of the relevant behavior, since this is when they will be most easily accessible.

4. Once some of the automatic thoughts and beliefs have been identified, the therapist can assign a variety of different homework tasks. These assignments serve the dual function of heightening the client's awareness of what particular behaviors are problematic for him, as well as gradually increasing his awareness of the dysfunctional cognitions that are linked to these behaviors.

One type of assignment consists of monitoring the behaviors that have been pinpointed and using their occurrence as a cue to begin monitoring cognitions. This can help the client to conduct a more detailed assessment of the relevant cognitive activity. A second assignment consists of intentionally

engaging in the pinpointed behaviors and then observing what type of automatic thoughts tend to be linked to these behaviors. This assignment is particularly useful when the client has difficulty monitoring the dysfunctional behavior, and it functions as well to help the client gain some sense of control over the behavior. A third assignment consists of monitoring the automatic thoughts that have been identified in therapy, and then observing what types of behaviors are linked to them. In addition to heightening the client's awareness of the link between the pinpointed behaviors and the relevant automatic thoughts, this third intervention can serve the function of helping him to identify other *me-you patterns* that may not have been pinpointed in therapy but may nevertheless be problematic. Once the client has a clear sense of what the dysfunctional beliefs and automatic thoughts are, as well as what the dysfunctional behaviors are, he can begin to challenge his cognitions and modify his behaviors at the same time.

The following case will illustrate the implementation of these steps. A 35-year-old man presented in therapy with feelings of general dysphoria and dissatisfaction with life. In the first session the therapist was aware of a general feeling of confusion and frustration in himself but was unable to identify the cause. In the second session, the therapist experienced the same feelings as well as a growing sense of irritation with, and distance from, the client. He was able to pinpoint the fact that his feelings of frustration, confusion, and distance seemed to be related to his client's style of continuously sidetracking the conversation, thus making it difficult to stay on any one topic. The therapist then discussed the impact that the sidetracking had upon him in a nonthreatening fashion and related it to the way in which other people seemed to maintain a distance from his client. This was then related to his client's feelings of loneliness and isolation.

The therapist then waited for the next incident of sidetracking in the interview, and at that point began probing for feelings and thoughts that his client was experiencing. His client indicated that he was experiencing some anxiety. In response to the therapist's continued probing, the client indicated that he was afraid that the therapist might get too close to him. The therapist asked his client what he imagined the therapist would think of him if he got closer. The client replied that he imagined the therapist would think that he was "weak" and that he was "a baby." He also imagined that if he discussed his real feelings, the therapist would be bored and wouldn't listen.

The therapist continued to probe for automatic thoughts and in this manner was able to access a variety of specific fears and automatic thoughts that were associated with his client's sidetracking behavior. In addition, he was also able to explore a number of aspects of his client's self-personification. It emerged that his client personified any feelings of weakness or vulnerabil-

ity as part of his *bad me.* He believed that it was essential for him to always be reasonable, strong, and in control of himself and the situation. At the end of the session, the therapist assigned his client the task of monitoring his sidetracking behavior and associated thoughts over the week.

When the client returned the following week, he had been very successful at monitoring his cognitions. The session was spent exploring the emotional impact that these cognitions had upon him, and identifying the situations in which these cognitions were most likely to occur. At the end of the session, the therapist assigned the client the task of monitoring the identified cognitions and observing the corresponding behaviors, using the common precipitating situations that had been identified as cues. When he returned to therapy the following week, the client reported that he had observed that he was distancing people not only by sidetracking but also by speaking in a very formal voice.

This case provides a second illustration of the manner in which the cognitive therapist can interface the process of metacommunicating with the client about his dysfunctional *me-you patterns* with exploring the cognitive processes that are linked to and support those patterns. There are a number of observations worth making about this illustration.

1. If the therapist had not used his own feelings and action tendencies diagnostically, he may not have pinpointed a *me-you pattern,* which turned out to be a major problem for his client.

2. If the therapist had not metacommunicated with his client about this pattern and unhooked himself, he would have confirmed his client's negative expectations that people would find him boring and uninteresting, and would reject him.

3. If the therapist had not explored the cognitive processes that were linked to the *me-you pattern,* the fears that supported them would still persist, thus making it more difficult to change them.

4. If the therapist had not used the pinpointed *me-you pattern* as a point of departure for cognitive assessment, he might have had difficulty assessing some very important automatic thoughts. This is true both because the behavior was creating an obstacle to the cognitive assessment process and because the relevant cognitive processes were most readily accessible when the client was sidetracking.

CONCLUSIONS

In summary, I have argued that a full assessment in the context of a *cognitive-interpersonal* therapy requires that the therapist conduct a com-

prehensive exploration of both the specific interpersonal behaviors and *me-you patterns* that impair the client's interpersonal relations, and the particular cognitive activities that are linked to them. The assessment of this *cognitive-interpersonal cycle* must be conducted in full awareness of the fact that cognitive information-processing activity in the real world is "hot cognition" and that the therapist must use his skills to, in Sullivan's terms, circumvent the client's *security operations,* in order to obtain the relevant data.

As Sullivan (1954) stated in his inimitable way: "Anyone who proceeds without consideration for the disjunctive power of anxiety in human relationships will never learn interviewing. When there is no regard for anxiety, a true interview situation does not exist; instead there may be just a person (the patient) trying to defend himself frantically from some kind of devil (the therapist) who seems determined (as the patient experiences it) to prove that the person (the patient) is a double dyed blankety-blank. This can be a spectacular human performance, but it does not yield psychiatric data relevant to therapeutic progress" (p. 108).

A final point I have made is that the assessment of any one aspect of the cognitive-interpersonal cycle can facilitate the assessment of other aspects. Thus, the explicit identification of subtle, but nevertheless dysfunctional, behaviors and paralinguistic communications can facilitate the exploration of associated cognitive activity. Conversely, the identification of important automatic thoughts can facilitate the discovery and exploration of recurring dysfunctional interactional patterns that are linked to them. For this reason it is valuable for the therapist to be guided in his case conceptualization by the recognition of the complete interdependence of cognitive and interpersonal realms.

In attempting to clarify some aspects of Sullivan's system that were presented in a more simplified fashion in the Safran (1984) article, I am all too aware that I may have neglected other aspects of the system that are just as important. In particular, I am concerned that some of the cognitive implications of Sullivan's theorizing may have been emphasized at the expense of some of the more interpersonal aspects of his work. My hope is that Sullivan himself would feel that these aspects, although perhaps somewhat neglected, are not entirely forgotten, and that in his view, the unfortunate consequences of my selective inattention would not outweigh the fortunate consequences.

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