TOWARDS A REFINEMENT OF COGNITIVE THERAPY IN LIGHT OF INTERPERSONAL THEORY: II. PRACTICE

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ABSTRACT. This article is the second of a two-part series on the refinement of cognitive behavioral theory and practice in light of interpersonal theory. Building upon the theoretical framework outlined in the first paper, a number of suggestions are provided for systematically integrating therapeutic concepts and intervention strategies derived from interpersonal theory with the practice of cognitive therapy. Similarities and differences between the current perspective and certain developments in contemporary interpersonal and psychodynamic thinking are discussed, and suggestions for future research are provided.

In the first article in this series (Safran, 1990) a preliminary framework was articulated for incorporating certain concepts derived from interpersonal theory into cognitive theory in a systematic fashion. It was suggested that a framework of this type could enhance cognitive therapy theory by facilitating the clarification of the fashion in which cognitive and interpersonal processes interact in the development and maintenance of psychological problems and in the change process. The concept of the interpersonal schema was proposed as a construct useful for integrating cognitive and interpersonal perspectives. The interpersonal schema, which can be thought of as a cognitively oriented elaboration of Bowlby's (1969) internal working model concept, was defined as a generic representation of self-other interactions. Finally, it was hypothesized that interpersonal schemas activate and in turn are maintained by cognitive-interpersonal cycles in which people evoke schema-consistent responses from others.

In this article a number of therapeutic implications of this perspective will be considered. It will be argued that the therapeutic relationship provides an impor-
tant vehicle for both assessing and challenging core cognitive structures. Many of the concepts to be articulated and therapeutic suggestions to be offered are taken directly from other theorists (e.g., Carson, 1969, 1982; Cashdan, 1973; Kiesler, 1988; Strupp & Binder, 1984; Wachtel, 1977; Weiss, Sampson, & the Mount Zion Psychotherapy Research Group, 1977). What distinguishes the current approach is not the novelty of the component concepts, but rather the attempt to articulate a systematic theoretical framework to guide the integration of interpersonal and cognitive perspectives.

**ASSESSING THE COGNITIVE INTERPERSONAL CYCLE**

In recent years a number of cognitive behavioral theorists have begun to distinguish between what are referred to as core versus peripheral cognitive structures (Arnkoff, 1980; Guidano & Liotti, 1983; Mahoney, 1982; Meichenbaum & Gilmore, 1984; Safran, Vallis, Segal, & Shaw, 1986). The precise definition of core cognitive structures varies from theorist to theorist. There is, however, a general agreement that they play a central role in organizing the individual's cognitive and behavioral processes.

Moreover, a number of theorists hypothesize that these core cognitive structures are related to the fundamental assumptions the individual holds about the self and the world (Guidano, 1987; Liotti, 1987, in press; Kelly 1955; Safran et al., 1986). These theorists also hypothesize that core cognitive structures must be modified in order to bring about enduring change (Biran, 1988; Guidano & Liotti, 1983; Safran et al., 1986). In contrast, it is hypothesized that the modification of peripheral cognitive structures, while resulting in symptom remission, will leave the client vulnerable to relapse, since the fundamental structures which predispose the client to the problem remain intact.

If these hypotheses are valid it would seem vital for cognitive therapists to clarify the nature of these core structures more precisely and to have some way of accurately assessing them. With this objective in mind, the following proposition is now advanced. It is hypothesized that the core cognitive structures underlying clinical problems are interpersonal schemas. In other words, it is the individual's generic representation of self-other interactions which predispose him or her to develop clinical problems and which ultimately must be modified if change is to be maintained. As discussed in Safran (1990), these interpersonal schemas are embedded within distinctive cognitive-interpersonal cycles in which characteristic construal processes lead to characteristic behaviors and communications, which in turn evoke schema consistent responses in others.

Because of the intrinsic connection between cognitive and interpersonal levels, it is difficult to accurately assess the cognitive processes that are central to an individual's problems without an understanding of the interpersonal aspect of the cycle. Since a large component of interpersonal communication takes place at the nonverbal level (Ekman, 1972; Kiesler, 1982; Mehrabian, 1972), the interpersonal or behavioral link in a dysfunctional cognitive-interpersonal cycle is often particularly subtle in nature. For example, a client may communicate with a slightly arrogant tilt of the head or a confrontative gaze that evokes irritation in people; or in a wooden or excessively vague fashion that elicits boredom and detachment; or he or she may speak with a tentative voice tone that evokes feelings of nurturance in others (Carson, 1969; Kiesler, 1982). For these reasons,
assessing the nature of a specific dysfunctional cognitive-interpersonal cycle can be a challenging task.

How is the therapist to identify the often subtle nuances in interpersonal style that constitutes part of the client's dysfunctional cognitive-interpersonal cycle? While cognitive therapists have generally discouraged the therapeutic use of the transference, some have argued that the client's behavior in therapy can provide a useful sample of his or her problem behaviors (e.g., Arnkoff, 1983; Goldfried & Davison, 1976).

However, cognitive therapists still tend to ignore the fact that one of the most important clues available regarding the client's dysfunctional behaviors and communicational style is the therapist's feelings and action tendencies (Safran, 1984a, 1984b). As Sullivan (1953, 1956) suggested, the therapist can function as a participant-observer in the interaction with the client. The therapist responds to the client's interpersonal pull like others, yet is able to monitor his or her own feelings and response tendencies and to use them to generate hypotheses about the client's dysfunctional interpersonal style.

Kiesler (1982, 1988) also suggests that the therapist can use his or her own feelings to help pinpoint specific client behaviors and communications that are problematic. These pinpointed behaviors and communications can be thought of as interpersonal markers indicating useful points for cognitive exploration (Safran, 1984a; Safran & Segal, 1990). For example, the therapist notices that while she is pursuing a particular line of inquiry, the topic subtly shifts. At this point she might stop her 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 mind just before that happened?"

These interpersonal markers indicate unique and ideal junctures for cognitive exploration since it is likely that the occurrence of those interactional patterns that are most characteristically problematic for the client will be accompanied by those cognitive processes that play a pivotal role in the dysfunctional cognitive-interpersonal cycle. The client who distances people with his wooden tone will have best access to the associated cognitive processes when this behavior is particularly in evidence. The client who distances others with vagueness will have best access to the relevant cognitive processes when she is being particularly vague. The therapeutic employment of interpersonal markers of this type can be extremely useful for therapists since the correct identification and modification of core cognitive processes may be vital if change is to be maintained.

The use of the therapeutic relationship to assess the client's cognitive-interpersonal cycle can be illustrated with the following example: A young, intelligent graduate student has no intimate friends and comes to therapy complaining of interpersonal isolation and feelings of loneliness. In the first few sessions the therapist becomes increasingly aware of his own feelings of distance from the client and a lack of warmth and engagement in himself. Through carefully monitoring his own feelings and the interaction between them and his client's behavior,  

A marker is a term developed by Rice and Greenberg (1984) to refer to a distinctive client behavior or communication indicating a readiness for a particular kind of therapy intervention.
he is able to identify certain fluctuations in his client's behavior, he is able to identify certain fluctuations in his client's communication style that appear to be related to his own feelings of distance. He notes that at certain points in the interview, his client communicates in a particularly pedantic, intellectualized, abstract, and excessively qualified way, and that he feels most distant from him at those points.

Subsequently, by probing for his client's feelings and automatic thoughts at points when the identified interpersonal marker is most prevalent, the therapist is able to identify specific events and themes that trigger a negative self-evaluation and evoke anxiety in his client. For example, on one occasion the identified interpersonal marker is preceded by an interaction during which the therapist has responded empathically to something the client has said.

Rather than follow his automatic inclination to withdraw from his client, the therapist metacommunicates to the client about his own reactions and helps him to explore his own feelings and automatic thoughts. In this particular situation it emerges that the client has been feeling warmly toward the therapist, and is anxious that he will be rejected if he shows his feelings. Once this information is obtained, the therapist is able to work with the client to help him see the fashion in which his own self-criticism and anticipation of rejection has led to an interpersonal act with a distancing impact. He is able to help him challenge his automatic thoughts and devise ways of empirically testing his expectation that he will be rejected.

Exploration of cognitive activity associated with the identified marker on other occasions helps to clarify another important feature of the client's dysfunctional cognitive-interpersonal cycle. The client is able to identify a general feeling of anxiety and tension associated with an increase in his pedantic style, along with a desire to command the therapist's respect. This disclosure is consistent with previous evidence gathered in therapy that the client's self-esteem is very much linked to the perception of himself as being intelligent, knowledgeable and verbally articulate. Information gathered by exploring cognitive activity associated with the identified interpersonal marker thus helps to further clarify the therapist's understanding of the client's core cognitive processes and the relationship between them and his problematic interpersonal style.

While the above example illustrates the fashion in which the therapist can use his or her own feelings and reactions to facilitate the assessment process, it must always be remembered that these feelings are not infallible indicators of problematic client behaviors. They may, in fact, reflect specific therapist sensitivities that are triggered by a specific client. Interpersonal theory hypothesizes that the probability that the therapist's reactions to the client parallel the reactions of others increases as the intensity and rigidity of the client's dysfunctional interpersonal style increases (Carson 1969, 1982; Kiesler, 1982, 1986; Leary, 1957).

In the final analysis, however, it is always an interaction. As Sullivan (1954) remarked, "The psychiatrist has an 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 what is happening" (p. 19). The ability and willingness to honestly acknowledge one's own role in the interaction is thus crucial (Gill, 1982; Kiesler, 1988; Strupp & Binder, 1984).

The therapist's feelings and reactions and pinpointed interpersonal markers provide only starting points for further investigation. Ultimately, only a collabora-
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Interactive exploration with the client will clarify whether the particular interpersonal pattern which emerges in the therapeutic relationship and the particular cognitive processes which the client accesses in this context are relevant to the client's everyday problems (Safran & Segal, 1990).

DISCONFIRMING DYSFUNCTIONAL INTERPERSONAL SCHEMAS

The theoretical framework summarized in Safran (1990) suggests that to the extent that one has rigid expectations of how others will be, and rigid beliefs about how one has to be in order to maintain relatedness, one's interpersonal repertoire will be rigid and stereotyped. Interpersonal theory hypothesizes that since behaviors invite or pull for complementary behaviors from others (Benjamin, 1974; Kiesler, 1983; Leary, 1957), people with rigid interpersonal repertoires experience less diversity in their interpersonal experience than those with more flexible repertoires (Kiesler, 1982).

A corollary of this hypothesis is that the maladjusted individual has little opportunity to encounter new interpersonal experiences that will help to modify his or her interpersonal schemas. A major objective in interpersonal psychotherapy is for the therapist to intervene in a fashion that elicits new, adaptive and noncharacteristic behaviors from the client. This in turn will elicit new behaviors from the client's significant others, thus providing them with new interpersonal experiences (Kiesler, 1982, 1988). This objective is accomplished in a number of ways.

First, the therapist identifies the reactions that are evoked in him or her by the client. The therapist then "unhooks" himself or herself from the client's interpersonal pull by consciously and intentionally refraining from carrying through the automatically elicited action tendency (Kiesler, 1982, 1988). By not reacting to the client in a complementary fashion, the therapist provides the client with a new interpersonal experience and begins to elicit new interpersonal behaviors that are not characteristic of the client. For example, the therapist responding to the quarrelsome client without hostility exerts a pull for new behavior from the client.

A second mode of intervention consists of metacommunicating with the client about the reactions that the client evokes in the therapist, and providing the client with feedback about the nonverbal behaviors and paralinguistic communications that evoke these reactions (Kiesler, 1982, 1986, 1988). Clients are often unaware of the precise impact they have on others, or the fashion in which they evoke these reactions. By providing feedback of this type, the therapist can help the client identify and subsequently change aspects of his or her communication style that maintain the dysfunctional interactional cycle.

In addition, the process of metacommunicating in this fashion facilitates the unhooking process by helping both participants in the interaction to step outside of it and explore it in a collaborative fashion. Moreover, pinpointing the relevant client behaviors and communications helps them to decenter from their immediate experience by beginning to see their own contributions to the interaction (Safran & Segal, 1990).

Augmenting the interpersonal perspective with a cognitive emphasis can further illuminate the mechanisms through which in-session therapist behavior can bring about change, and provide additional guidelines for assessing what type of therapist interactional style will be maximally therapeutic. Therapists who cor-
rectly assess the nature of their clients’ dysfunctional interpersonal schemas will have at their disposal important additional information that can guide them in understanding the impact of their behaviors on the client and in avoiding countertherapeutic behavior.

The integration of cognitive and interpersonal perspectives generates the following hypothesis. An important mechanism mediating the therapeutic impact of noncomplementary behavior is the experiential disconfirmation of dysfunctional interpersonal schemas. Thus, the therapist who refrains from responding to the hostile client with hostility may be disconfirming the client’s belief that others will always be hostile toward him. The therapist who unhooked from the interpersonal pull to take charge of a client’s life disconfirms the client’s perception of himself or herself as “a helpless person who must be taken care of by others.” The therapist who values and accepts the client even when the client is sad, disconfirms the client’s belief that they must always be happy in order to maintain relatedness to others. Thus, as Carson (1982) suggests, the client-therapist interaction provides an opportunity for “. . . generating perturbations in extant, maladaptive cognitive schemata and restructuring them into a more functional processing system” (p. 78).

An adequate assessment of core dysfunctional interpersonal schemas thus facilitates predictions about what type of interpersonal stance will be therapeutic in a more specific and refined way than the classical psychoanalytic prescription of therapeutic neutrality. Conversely, failure to adequately assess a core interpersonal schema can result in unanticipated reactions to therapeutic interventions. For example, Safran et al. (1986) describe a case in which the client complained to his therapist of consistently feeling unloved and uncared for by others, particularly his wife. In the therapist’s assessment, the client had a demanding, implacable quality to him and it was the therapist’s impression that the client failed to attend to those instances in which people were emotionally supportive. The therapist thus worked with the client to scale down his excessive expectations and to modify his selective abstraction. The client responded to this intervention by canceling the next appointment and by threatening suicide.

A subsequent reformulation of the case assessed the client’s core dysfunctional interpersonal schema to revolve around a belief that he would be abandoned if he ever fully expressed his needs to others. It was hypothesized that his belief in the unacceptability of his own needs, and expectations of rejection, led to difficulty in expressing his needs directly, and to a tendency to do so in an angry, blaming, indirect fashion, if at all. It was further hypothesized that this interpersonal style made it particularly difficult for people to be emotionally supportive.

In light of this reformulation, it was hypothesized that the therapist’s attempt to help the client scale down his expectations of others confirmed his expectations that he would be abandoned or rejected if he expressed his needs, and resulted in feelings of hopelessness and anger at the therapist. Subsequent interventions, guided by this reformulation, resulted in a considerable improvement in the working alliance and in ultimate therapeutic movement.

CONVERGENCE WITH OTHER PERSPECTIVES

The current perspective converges in some respects with the Mount Zion Groups’ (Weiss et al., 1987) view of the role that the disconfirmation of what they term pathogenic beliefs plays in psychodynamic therapy. They postulate that neurotic
problems arise from these pathogenic or dysfunctional beliefs about interpersonal relationships which individuals develop as a result of maladaptive learning experiences with significant others. An example of a pathogenic belief would be the belief that one will be abandoned if they show vulnerable feelings or that one will hurt others if they are independent.\(^2\) They further hypothesize that clients in therapy unconsciously behave in a fashion that will test whether their therapists will confirm their pathogenic beliefs and that the disconfirmation of these beliefs is a central mechanism of change in psychodynamic therapy.

These hypotheses have now been evaluated in a series of studies. For example, Silberschatz (1987) demonstrated that the disconfirmation of pathogenic beliefs is significantly correlated with an immediate reduction in patient anxiety, an increase in relaxation, and an increase in the extent to which the patient confronts or elaborates bold or nontrivial material. Caston, Goldman, and McClure (1987) found a relationship between the in-session disconfirmation of pathogenic beliefs and immediate increases in insight and the elaboration of nontrivial material. Silberschatz, Fretter, and Curtis (1986) found a relationship between immediate increases in patient Experiencing Level (Klein, Mathieu, Gendlin, & Kiesler, 1969) and the disconfirmation of pathogenic beliefs. They also found that good ultimate outcome was associated with a higher proportion of interventions disconfirming pathogenic beliefs to those confirming them. One particularly interesting finding is that the disconfirmation of pathogenic beliefs appears to play a role in the change process even when the therapist does not explicitly hold this hypothesis as a model of change (Weiss et al., 1987).

While the proposition that clients submit their therapist to transference tests either consciously or unconsciously is not a necessary component of the current position, the perspective that I am outlining does accord a central role in the therapeutic process to the disconfirmation of dysfunctional beliefs about self-other interactions through the therapeutic relationship.

There is also a similarity between the current view and Kohut's (1984) perspective on the mechanisms of therapeutic change. Kohut maintains that the central mechanism of therapeutic change in psychoanalysis is the process of *transmuting internalization*. According to him, the therapist, by providing the type of empathic, "mirroring" environment not provided by parents, helps the client to build new psychic structures. He further maintains that an important part of the change process often consists of empathically interpreting the client's reactions to inevitable lapses in the therapist's empathic behavior.

The current perspective recasts Kohut's formulation in a researchable framework. As Eagle (1984) argues, concepts such as "transmuting internalization" or "building structure" lack clear empirical meaning. A transmuting internalization may be understood in more cognitive terms, however, as the restructuring of a dysfunctional interpersonal schema through the provision of schema inconsistent information at the experiential level. The concept of interpersonal schema helps to clarify in cognitive terms *the nature of the structure* that is being rebuilt—a generic

\(^2\)Eagle (1987) has previously pointed out the similarity between Weiss et al.'s (1987) concept of the pathogenic belief and Beck's concept of the dysfunctional attitude. He has also noted that pathogenic beliefs are dysfunctional attitudes of a particular type, that is, dysfunctional beliefs about interpersonal relationships. There is thus a close parallel between the concept of pathogenic belief and the concept of interpersonal schema as articulated in the current perspective.
cognitive representation of self-other interactions. In cognitive terms the internalization of the therapist is more readily understood as the development of a new working model of self-other interactions in which the generalized other is represented as potentially available.

A client's initial tendency to overreact to an experienced lapse in empathy can be understood in cognitive terms as what Beck (1976) refers to as dichotomous thinking (e.g., "either my therapist is completely empathic and available to me or he does not care"). This type of dichotomous thinking is fuelled by the client's perception of self as inherently unlovable and of others as abandoning. Responding to an experienced lapse in empathy by withdrawing or acting in a hostile fashion may constitute an important component of a dysfunctional cognitive-interpersonal cycle, by precipitating the very abandonment that is anticipated.

DISTINCTIVE FEATURES OF AN INTEGRATIVE COGNITIVE-INTERPERSONAL APPROACH

Because the current approach has drawn heavily on Kiesler's (1982, 1986, 1988) systematization of interpersonal therapy, there are obviously many similarities between the two approaches. There are, also, important similarities between the therapeutic approach outlined here and certain trends in contemporary psychodynamic thinking. The notion of the cognitive-interpersonal cycle is similar to Wachtel's (1977) cyclical psychodynamic perspective and to Strupp and Binder's (1984) conceptualization of the dynamic focus. It also bears some similarity to Luborsky's (1984) concept of the core conflictual relationship theme.

There are, however, some important features of the current approach that are distinctive products of the integration of cognitive and interpersonal approaches. While metacommunication about the therapeutic relationship plays a central role in most psychodynamic and interpersonal therapies, the current approach emphasizes a particular style of metacommunication. This involves the adaptation of cognitive techniques such as operationalizing expectations and reality testing (Beck, Rush, Shaw, & Emery, 1979) for exploring and challenging clients' dysfunctional interpersonal schemas. Although unhooking from the client's cognitive-interpersonal cycle may in itself challenge their dysfunctional beliefs about interpersonal relationships, the client may still fail to process schema inconsistent information. It would seem reasonable to assume that the processing of information in the context of the therapist-client interaction follows the same rules of confirmatory biasing that information processing in other domains follows (Nisbett & Ross, 1980).

It may be that any therapeutic metacommunication which is effective, whether it draws links between the current situation and others (as is more common in psychodynamic approaches) or focuses more intensively on different aspects of the current transaction (as is more common in Kiesler's approach) helps the patient to clarify and test out their dysfunctional expectations in context of the therapeutic relationship (Safran & Segal, 1990).

The client's subjective experience in session is regarded as a live sample of potentially relevant cognitive processing and the emphasis is on exploring this material and helping the client to articulate his or her expectations as they emerge
in the moment as clearly and explicitly as possible. The emphasis here is phenomenological rather than interpretive in nature.

The present approach articulates clear guidelines regarding optimal points in the interaction for exploring the client's cognitive processes. The notion of the interpersonal marker as a useful juncture for cognitive exploration is derived from the specific conceptual framework outlined here and in Safran (1990) for clarifying the nature of the relationship between cognitive and interpersonal realms.

Once the client has articulated his or her expectations in the context of a specific therapeutic interaction it is important for the therapist to maintain an ongoing exploration of whether the client experiences their expectations as being confirmed or disconfirmed. This process can be facilitated by encouraging the client to specify as clearly and concretely as possible what type of events would confirm their expectations and what events would disconfirm them. This process further facilitates the processing of schema-inconsistent information. In addition, the therapist can encourage the client to find active ways of testing the dysfunctional expectations that have been identified in session.

Weiss et al. (1987) theorize that clients unconsciously evaluate their pathogenic beliefs by submitting their therapists to transference tests. The current approach integrates this type of perspective with the stance of collaborative empiricism proposed by Beck et al. (1979), by encouraging the client to treat their perceptions as hypotheses and to actively seek ways of using the therapeutic relationship to evaluate hypotheses. The assumption is that promoting this type of active and intentional hypothesis testing will facilitate the change process by encouraging a conscious hypothesis testing set rather than leaving this process to chance.

Finally, the present approach reflects the cognitive behavioral emphasis on the generalization of changes to out of session situations. Thus, rather than assuming that learning which occurs through the therapeutic relationship will automatically generalize, clients are explicitly instructed to use out of therapy interactions to test expectations and beliefs that have been explored and evaluated through the therapeutic relationship. In this fashion, the client is encouraged to become an active collaborator in the therapeutic process and to continue the work between sessions.

The following example illustrates a number of the above principles. A careful assessment of a particular client's interpersonal schema suggested the presence of a belief that any suggestion of independence or emotional interest in other people by the client would be construed by the therapist as disloyalty and would lead to retaliation and abandonment. After explicitly clarifying the details of this working model in collaboration with the client, the therapist suggested that he generate a strategy for evaluating the accuracy of his expectation through action. The client suggested that he might try being more friendly with the clinic secretary. Once the client had developed this strategy, the focus switched to clarifying how the client would know whether or not his hypothesis had been confirmed or unconfirmed. Would the client be able to tell by evaluating the therapist's manner in the following session? Was there any possibility that he might misread the therapist's manner? In this fashion the client was encouraged to actively test out his dysfunctional belief and to be wary of his tendency to interpret events in a schema consistent fashion. In subsequent sessions the client was encouraged to look for similar patterns in his relationships with other people and to generate other active strategies for evaluating this interpersonal working model between sessions.
THE RELATIONSHIP BETWEEN TECHNICAL AND RELATIONSHIP FACTORS

In recent years there has been a growing body of empirical evidence suggesting that the specific techniques associated with specific therapies are less important than therapy nonspecific factors such as positive qualities of the therapeutic relationship and the client's expectation that therapy will help. Lambert (1986) and Lambert, Shapiro, and Bergin (1986) estimate on the basis of their comprehensive reviews of the empirical literature that while only 15% of the variance in outcome can be attributed to specific technical factors, up to 45% of the variance can be attributed to nonspecific factors. An illustrative study by Luborsky, McLellan, Woody, O'Brien, and Auerbach (1985) found that while drug dependent clients respond equally well to cognitive therapy plus drug counselling, supportive-expressive therapy plus drug counselling, and drug counselling alone, there were significant differences in the effectiveness of the individual therapists. The variable that was most highly predictive of outcome was the therapeutic alliance. This finding is consistent with the growing empirical evidence indicating the centrality of the therapeutic alliance to the change process. Orlinsky and Howard (1986), for example, in their comprehensive review of the research relating psychotherapy process variables to psychotherapy outcome, estimate that up to 80% of research relevant to the predictive value of the therapeutic alliance has produced significantly positive results.

This type of evidence is open to the interpretation that specific therapy techniques are unimportant and that it is the therapeutic relationship which is crucial to change. As Butler and Strupp (1986) point out, however, this interpretation is based upon the false assumption that specific and nonspecific are theoretically separable. As they argue, the traditional distinction between specific and nonspecific factors is based on the inappropriate assumption that psychotherapy is analogous to medical treatment. Unlike treatment through medication, however, wherein biological action is distinguishable in theory from the symbolic meaning of the treatment, psychotherapy techniques are intrinsically linked to the interpersonal context in which they take place. As Butler and Strupp (1986) point out, the impact of the therapist's intervention on the client will ultimately be determined by the meaning of that intervention to the client. The current conceptual framework suggests that this meaning will ultimately be mediated by the interpersonal schema that the client brings to bear upon the interpersonal situation. For example, a client who has an internal working model in which he or she is inadequate and others are critical may experience the cognitive therapist's attempt to examine the evidence relevant to a particular belief as invalidating and critical.

The exploration of factors leading to failed cognitive interventions and ruptures in the therapeutic alliance can lead to a deeper understanding of the client's internal working model of self-other relationships (Safran, Crocker, McMain, & Murray, in press; Safran & Segal, 1990). These inevitable events should be seen as opportunities rather than as obstacles to therapy.

RESEARCH

There are two general types of research relevant to empirically evaluating the various propositions that have been advanced in the current article. The first focuses on the evaluation of the efficacy of the therapeutic approach suggested.
The second focus involves the evaluation of specific hypotheses regarding the process of change.

1. Outcome

Although evaluating the efficacy of the proposed approach may at first consideration appear straightforward, closer examination suggests some obstacles be overcome. The most obvious approach would be to evaluate the relative efficacy of the proposed approach with a more traditional approach to cognitive therapy, (e.g. the protocol that was employed in the recent NIMH collaborative study on the treatment of depression (Elkin, Shea, Watkins, & Collins, 1986). The problem here, however, is the consistent failure of psychotherapy outcome research to find significant differences between treatments (e.g., Elkin et al., 1986; Luborsky, Singer, & Luborsky, 1975; Sloane, Staples, Cristol, Yorkston, & Whipple, 1975; Smith, Glass, & Miller, 1980).

Various hypotheses have been advanced regarding the factors which make it difficult to demonstrate differential treatment efficacy (e.g., Kazdin; 1986; Stiles, Shapiro, & Elliot, 1986), and I will not recount them all here. One particularly relevant factor, however, is that standard clinical trial studies obscure individual differences in outcome (Barlow & Hersen, 1984; Chassan, 1979; Kiesler, 1966; Safran, Greenberg, & Rice, 1988). Although the average client may show moderate gains in a particular study, in reality some clients do extremely well, others do moderately well, some do not change, and others deteriorate. The failure to find treatment differences may result, in part, from what Kiesler (1966) has termed the uniformity myth (i.e., the assumption that all clients are the same and benefit equally from all treatments). A clinical trial study which lumps together both clients who would be expected to benefit from a more traditional cognitive therapy and those who would not would have difficulty demonstrating the incremental utility of an integrative approach since many of them would be expected to do relatively well without it.

This type of methodological dilemma has prompted some psychotherapy researchers to follow Kiesler's (1966) recommendation to employ factorial designs to evaluate treatment by client type interactions. The problem with this approach, however, is that it assumes that the relevant client characteristics can be identified at the beginning of treatment. However, as Luborsky et al. (1980) conclude, it is often difficult to identify clients who will benefit from a particular treatment until therapy has commenced and an adequate sample of the client-therapist interaction is available. It is this fact which has been partially responsible for stimulating researchers to move towards the investigation of the therapeutic alliance, rather than static patient characteristics in an attempt to predict the outcome (Greenberg & Pinsof, 1986).

For these reasons, rather than conducting a standard clinical trial study comparing cognitive therapy and the current approach, a better strategy may be to identify patients who either are not benefiting from standard cognitive therapy or are not establishing an adequate therapeutic alliance by a certain point in the treatment protocol. These clients would then be randomly assigned to either continue the standard treatment or shift to a therapeutic focus guided by the framework outlined in the current article.
2. Process Studies

Although the research design proposed above should be able to shed light on the efficacy of the current approach, it does not address the various hypotheses advanced regarding the mechanisms of change. In this section we will briefly consider a number of possible studies relevant to evaluating some of these hypotheses. A first important study entails the evaluation of the hypothesis that the disconfirmation of interpersonal schemas through the therapeutic interaction is an important mechanism of change. Weiss et al. (1987) have now conducted a number of studies demonstrating that “pathogenic beliefs” can be assessed reliably, and that therapist interventions which are rated reliably as disconfirming pathogenic beliefs are, as previously indicated, related to both immediate and ultimate outcome. It is beyond the scope of the present article to describe the elaborate methodology employed by Weiss et al. (1987), but there is sufficient similarity between the two theoretical approaches to permit the adaptation of their methodology to the present context. Collins and Messer (1988) have recently demonstrated that the basic Mount Zion Group methodology can be adapted to be used reliably with a different theoretical orientation. A first step would involve the adaptation of Weiss et al.’s methodology to reliably assess dysfunctional interpersonal schemas as formulated in Safran (1990) and to evaluate the hypothesis that therapist interventions which are schema inconsistent are related to change.

A second related study would involve evaluating the hypothesis that the therapeutic alliance is mediated by whether the therapist behaves in a fashion which either confirms or disconfirms the client’s core dysfunctional interpersonal schema. This could be accomplished by dividing therapy sessions into high and low therapeutic alliance sessions on the basis of a validated measure of the alliance and then comparing these two session types with respect to the prevalence of interactions that are rated as schema disconfirming, using an adaptation of Weiss et al.’s (1987) methodology. This type of study could be conducted either as a between subjects or a within subjects design.

A third related study would involve evaluating the hypothesis that one of the factors mediating the immediate outcome of a traditional cognitive therapy challenging intervention (e.g., examining the evidence or considering alternatives) is whether that intervention is at an implicit level either confirming or disconfirming of the client’s core dysfunctional interpersonal schema.

As indicated previously, it is hypothesized that the impact of the therapist’s intervention is mediated by the client’s perception of the meaning of that intervention. This, in turn, is mediated by the interpersonal schema that the client brings to bear upon the interaction. This leads to the hypothesis that the positive impact of a specific cognitive intervention will be mitigated if the client perceives the therapist’s action in a way which confirms his or her dysfunctional interpersonal schema. This hypothesis could be evaluated by having independent raters evaluate the degree of cognitive change taking place following every challenging intervention and then rating the extent to which these interventions are schema confirming or disconfirming using an adaptation of Weiss et al.’s (1987) methodology.

A final research direction would involve evaluating the hypothesis that clients’ interpersonal schemas change as a result of the therapeutic approach described in the present article. This could be accomplished by administering the type of
interpersonal schema questionnaire (Safran, Hill, & Ford 1988) described in Safran (1990) to clients before and after treatment and evaluating whether change on other outcome measures is associated with change on this measure. A related investigation would involve evaluating whether change on an interpersonal schema measure of this type is related to maintenance of treatment gains at follow-up. If a questionnaire of this type provides a valid operationalization of an enduring cognitive structure which shapes information processing and interpersonal patterns, then those subjects who show significant changes on this measure should show more enduring changes in other areas than those who do not.

CONCLUSION

There has been a tendency in the cognitive behavioral literature to consider the therapeutic relationship to be less important than specific cognitive techniques. This is beginning to change as cognitive therapists increasingly recognize the importance of the relationship. There still, however, remains a tendency to view a good therapeutic relationship as more of a necessary condition for change than a mechanism of change. The current perspective, however, suggests that this view of things fails to recognize the inseparable nature of technical and relationship factors in the change process. By “unpacking” the concept of the therapeutic relationship, my intention has been to show how every cognitive intervention inevitably impacts on the therapeutic relationship and how any “relationship act” is ultimately a cognitive intervention. This type of clarification will hopefully help cognitive therapists explore the more subtle interpersonal aspects of the change process with the same type of conceptual rigor that has been applied to the cognitive realm.

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