Cognitive Therapy and the Narrative Trend: A Bridge Too Far?

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In his article on the possible integration of cognitive and narrative therapies, Ramsay argues that (1) the evolution of traditional cognitive approaches has moved them in a constructivist direction, (2) remaining metatheoretical differences need not impede attempts at integration of the models, and (3) the incorporation of narrative concepts and procedures holds considerable prospects for the further sophistication of cognitive therapy. In response, I share reservations about each of these propositions, based on a concern about deep-going differences between cognitive and constructivist approaches at the level of their preferred epistemologies, values, and procedures. Ultimately, I contend that genuinely progressive integration of cognitive and narrative models can only proceed if attention is given to these divergences, and if cognitive therapists accommodate their traditional theories to enhance their congruence with the novel perspectives they would like to assimilate.

In his paper entitled *Postmodern cognitive therapy*, Ramsay (1998) advances a persuasive argument that cognitive-behavioral and constructivist-narrative approaches to psychotherapy can be conceptually married (or at least reconciled) to the mutual advantage of both. Without wanting to appear curmudgeonly, my goal in this brief paper is to slow the rush toward a mutual embrace of these perspectives long enough to question the long-term viability of the resulting union. Thus, like a premarital counselor, I hope to bring to light both points of convergence and divergence of cognitive and constructivist therapies at the level of their basic attitudes or values, and consider the implications for their harmonious coexistence. However, also like a premarital counselor, I acknowledge at the outset that the decision to wed the two perspectives in a formal way, to explore some less committed form of relationship between them, or to have them part company altogether remains their own. Indeed, as Ramsay insinuates, the relationship...
between the two approaches has in some respects already progressed well beyond the flirting stage, so that vaguely parental admonishments to practice restraint may be about as effective as a sexual abstinence program for curious adolescents!

Whatever level of commingling of cognitive and constructivist therapies eventually comes about, it behooves us to consider whether they enjoy sufficient similarity at core levels to sustain their mutual attraction. In pursuit of this goal, I will consider each of several claims put forward by Ramsay in roughly the order he presents them, and share a few reflections and reservations in connection with each.

1. **Cognitive therapy has evolved considerably, assimilating a number of constructivist and narrative themes in the process.** Only the most cynical observer of psychotherapeutic trends could fail to be impressed by the remarkable recent proliferation of cognitive treatments for various disorders, a trend that has been matched in the history of psychology only by innovative extensions of psychodynamic treatments in the 1940s and '50s, and the explosion of behavior therapies in the 1960s and '70s. As Ramsay notes, cognitive or cognitive-behavioral therapy (CBT) now often claims pride of place as a preferred psychological treatment for problems as varied as depression, generalized anxiety disorder, eating disorders, panic, hypochondriasis, borderline personality, and substance abuse (Beck, 1993). And yet, the basic CBT paradigm of therapist-directed correction of self-defeating cognitions and augmentation of coping skills has more often been extended along a dimension of *breadth* (assimilating an ever wider array of problems into the CBT model) rather than *depth* (accommodating CBT theory to the more complex (inter)personal processes that shape and constrain our construction systems). Some observers have argued that it is precisely their contribution of a depth dimension that makes constructivist approaches (Neimeyer & Mahoney, 1995) an attractive complement to traditional cognitive formulations (Dobson & Pusch, 1993; Meichenbaum, 1995), but this begs the question of whether they can be meaningfully integrated without sacrificing core epistemological commitments of one or both perspectives, an issue to which I will return below.

In general, Ramsay is more impressed with the extent to which traditional (e.g., Beckian) cognitive therapy has moved in a constructivist direction than I would be. For example, while the identification of "idiosyncratic" meanings may figure prominently in the work of both Beck (1991) and Kelly (1955), close inspection suggests that the term is being used as a synonym for "problematic" or "non-normative" by the former, but as implying "deeply personal" or "unique" for the latter. This semantic difference reveals a striking divergence in the central tendency of cognitive and constructivist therapies, which adopt corrective and exhortatory vs. creative and exploratory stances toward such idiosyncratic meaning systems, respectively (Neimeyer, 1993a; 1995).

Still, I concur with Ramsay's contention that at least some prominent cognitive therapists have adopted genuinely constructivist views, as exemplified by work on the development of early maladaptive schemes by such theorists as Young (Bricker, Young, & Flanagan, 1993) and Freeman (1993). Like Mahoney (1991), Guidano
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(1991) and other avowed constructivists, these "neo-Beckians" show greater appreciation for the extent to which current adjustment is constrained by "core ordering processes" first given shape in childhood, and which serve as affectively powerful anchors for personal identity throughout life. Furthermore, they typically edge away from the straightforward rational and empirical disputation strategies favored by Beck (Beck, Rush, Shaw, & Emery, 1979), and Ellis (1993), and toward more experiential and relational interventions that at least partially acknowledge the adaptiveness and viability of modified versions of these basic identity structures. Approaches to cognitive case formulations that posit "core maladaptive beliefs" responsible for a range of symptomatic thoughts, behaviors, emotions, and complaints (Persons, 1989) incline in this same direction, although they tend to retain the uncritical distinction between cognition and affect, the focus on pathology, and the extraordinarily simple models of cognitive structure that typify traditional cognitive therapy.

In acknowledging the blurred boundaries between rationalistic cognitive and constructivist therapies, I want to reinforce the view that rationalism vs. constructivism represents not so much a dividing line between separate and opposed camps, as a dimension along which theoretical concepts and therapeutic strategies can be placed, regardless of their parentage. For example, the "downward arrow" technique originating in cognitive therapy (Burns, 1980) resonates with a constructivist view of personal meaning systems as essentially a network of implications (Neimeyer, 1993c), whereas some adaptations of repertory grid technique have a rationalistic flavor to the extent that they identify construct systems that are logically inconsistent or conflictual (Bassler, Krauthaver, & Hoffmann, 1992). Thus, I am ultimately less concerned with labeling any given "school" as rationalist or constructivist than I am with promoting a coherent psychotherapeutic practice, whether configured along cognitive or constructivist lines.

2. Metatheoretical differences need not impede psychotherapy integration. In discussing possible impediments to the synthesis of cognitive and constructivist therapies, Ramsay borrows from my earlier discussion of theoretically progressive integration (TPI), according to which the convergence of any two models of therapy can be assessed on the levels of (1) therapeutic strategy or technique, (2) clinical theory, (3) formal theory, and (4) metatheory (Neimeyer, 1993b). Like Goldfried (1995), Ramsay prefers to sidestep difficult contradictions that may arise at metatheoretical levels (e.g., concerning the ability of human beings to objectively perceive a reality beyond their constructions), and argue that integration is indeed feasible if it focuses on low-level clinical theory and basic techniques. Moreover, he proposes that important similarities exist at a theoretical level (e.g., in the concern of both approaches with "personal meaning making"), and that these similarities further create a propitious environment for attempts at integration of the two models.

The problem with this argument, in my view, is precisely its tendency to ignore deep-going metatheoretical tensions between rationalistic and constructivist
therapies which frustrate any attempt at a facile integration. If abstract philosophic commitments were somehow insulated from one's clinical stance, then a "low-level" synthesis of models might indeed be possible. But the problem is that core epistemological and ontological values infuse every therapy, whether they operate explicitly or implicitly. In the case of cognitive and constructivist therapies, of course, these commitments are fairly explicit and carry concrete implications for the practicing therapist. If I adopt an essentially objectivist epistemology, according to which reality exists independently of the knower, can be perceived accurately by a dispassionate observer, and can be agreed upon by rational agents willing to subject their beliefs to experimental tests, then I am drawn almost inexorably toward authoritative, literal, directive forms of therapy, targeting the identification and eradication of cognitive distortions and the dysfunctional emotions to which they supposedly give rise, through the use of Socratic, disputative, and empirical strategies. If, on the other hand, I adopt a nonjustificationist epistemology like constructivism, according to which reality is constituted differently by different individuals, communities, and cultures, with no assumption that a single preferred view can be identified, then I am drawn toward more process-oriented, metaphoric, and exploratory forms of therapy, whose goal is to tease out the entailments of any given belief system, help its adherents extend the range of "possible worlds" they might inhabit, and articulate them with the worlds of others who occupy different positions (Neimeyer, 1993a; 1995). Existing research suggests that such differences in therapeutic style are quite evident to even theoretically and philosophically unsophisticated observers of both therapies, and carry important implications for the acceptability of the treatments to their prospective users (Vincent & LeBow, 1995). Thus, to argue that cognitive and constructivist therapies are similar because both have an interest in personal meanings is like arguing that *International Paper* and the *Sierra Club* are similar because they both have an interest in old-growth forests. In both cases, a superficial commonality in focus is belied by far-reaching contrasts in goals and values, which in turn shape concrete practices. A similar problem emerges in the specific case of narrative, which is perhaps the primary focus of Ramsay's argument.

3. Attention to personal narratives offers an excellent prospect for the integration of cognitive and constructivist therapies. Ramsay provides a cogent and inviting summary of some of the more important trends in narrative psychology, with a special focus on the way in which personal experience, identity, and "reality" are constructed in a storied form. Moreover, by hinting at a performative view of stories-as-scripts, Ramsay moves beyond a conception of narratives as merely interpretive templates, to an active and potentially more social view than is typical for a cognitive theorist. Still, the reader does not advance far into this argument before she again encounters the familiar objectivist obsession with "cognitive distortions" in the form of "systematic biases in reasoning and information processing," which is alien to those forms of narrative psychology of greatest interest to therapists with constructivist leanings. Thus, while it may be true, as Ramsay
suggests, that both cognitive and narrative therapists emphasize the importance of a collaborative relationship, defining the presenting problem, and looking for the meaning ascribed to symptoms, it in no way follows that the form of this collaboration, the approach to problem definition, or whose meanings are privileged are also congruent in the two approaches.

A closer look at the process of “narrative repair” as seen through cognitive versus constructivist eyes will suffice to illustrate the basic distinctions between the two perspectives. Consider the case of a young counselor who presents with a general feeling of malaise, and when prompted to give a recent example of when he experienced this problem acutely, described feeling “uncomfortable” and “insufficient” at the end of a recent therapy session when he smiled and said to the client, “It was good to visit with you.” Presented with this complaint, an orthodox cognitive therapist might reasonably ask the counselor to identify what he was feeling (anxiety), to rate its intensity (say, 70 on a scale of 100), to state “what was going through his head” at that moment (“The client thinks I don’t really mean this. I feel like a phony.”), and to rate his degree of belief in each of the resulting self-statements. The therapist might then guide him toward a consideration of cognitive distortions implied in his self-talk (e.g., mind-reading, labeling) and prompt cognitive restructuring by engaging in various forms of rational disputation (e.g., “I generally have a pretty good relationship with my client,” “Just because I’m anxious doesn’t mean I’m a phony, and it might even help me pay closer attention to my client.”). Moreover, the therapist might coach the counselor toward adaptive behaviors to control both disruptive emotional components of the presenting problem (e.g., relaxation training to manage in-session anxiety) and directly target problematic automatic thoughts (e.g., empirically testing beliefs about the client’s reactions by consulting post-session client satisfaction questionnaires used in the clinic). As a result of these interventions and similar self-monitoring and self-change homework assigned at the end of the session, the young counselor might become better able to control the “catastrophic” thinking that escalates his level of anxiety, and to accept the slight nervousness that could reasonably be expected to attend his first excursions into clinical work. Throughout such interventions, the traditional cognitive therapist would be employing “deconstructive rules” borrowed almost exclusively from the discourse of science as construed by logical empiricists (Radnitsky, 1973), a discourse that privileges explicit language, rationality, experimentation, the elimination of error, and control. In terms of the TPI model mentioned above (Neimeyer, 1993b), this approach to therapy would therefore display coherence at metatheoretical, formal theoretical, clinical, and technical levels.

Faced with this same presenting problem, a constructivist narrative therapist would tend to use quite different deconstructive procedures. Displaying a dual sensitivity to both the tacit and discursive grounding of the client’s situated interpretive activity (Mascolo, Craig-Bray, & Neimeyer, 1998), the therapist might attend first to subtle coveral “markers,” suggesting a growing edge of
self-awareness requiring deeper emotional processing (Elliott & Greenberg, 1995). In the above (actual) example, this took the form of noticing a slight trembling in the young counselor's jaw when he related "It's been good visiting with you," which was gently brought to the client's attention. Asking the client to close his eyes, the therapist then asked him to attend to any associated "felt sense" in his body (Gendlin, 1996), and to describe it in an appropriate image (in this case, as an "anxious, tight ball in my chest"). Cueing on the tightness, the therapist softly asked what might happen if he allowed the ball to "loosen," an invitation that brought tears to the client's eyes, and a quiet acknowledgment of the "guilt" contained within its tangled mass. Further processing this tacit meaning, the client placed it within a larger narrative whose central theme was his lack of genuineness in relationships, and the way in which this was painfully accentuated for him in his early attempts to conduct psychotherapy.

As client and therapist jointly pursued the especially poignant sense of "insufficient genuineness" in the this area, they related it to stern injunctions delivered during graduate training to maintain professional distance and control over the counselor's own disclosure, which in turn replicated broader disciplinary and cultural discourses of psychotherapy as a scientific procedure delivered with a minimum of personal involvement. With their own emotionally intimate encounter as a salient counter-example, both client and therapist began to critique the "dominant narrative" of psychotherapy as an impersonal technical intervention, and explore the hopeful possibility that the experience as a counselor might become not a context for replication and exacerbation of the client's problematic sense of falseness, but a setting in which he might liberate himself to relate more closely and genuinely to others. Thus, the client's initially vague awareness of an anxious discrepancy between who he wanted to be as a therapist and the identity he felt compelled to present was acknowledged as an important precursor to personal change, a "unique outcome" representing the emergence of "resistance" against a dominant narrative of professional distance and restraint (White & Epston, 1990). In contrast to the logical-empiricist discourse informing orthodox cognitive therapy, this more hermeneutic-dialectical approach (Radnitsky, 1973) to deconstructing the presenting complaint is less restrictive, drawing freely on literary, rhetorical, and political ways of "linguaging" about the problem (Neimeyer, 1998). Nonetheless, the congruence between its nonjustificationist epistemology, its formal theory centering on the storied structure of identity, its clinical heuristics for understanding dominant narratives at personal and cultural levels, and its specific strategies for identifying and supporting more hopeful alternatives suggests that it is also coherent according to the criteria identified by the TPI model. What would be problematic from the standpoint of a theoretically progressive integration of psychotherapy would be an indiscriminate gallimaufry of deconstructive rules deriving from incompatible metatheories, leaving the therapist eliciting a fragile and almost inarticulate self-awareness on the part of the client at one moment, only to critique its logical or empirical warrant the next. Simply put, the affirmative,
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respectful, and celebratory spirit of constructivist therapists in relation to client narratives (Monk, Winslade, Crocket, & Epston, 1996) clashes at fundamental levels with the more critical, suspicious, and editorial attitude of traditional cognitive therapists and researchers toward the same material. A perspective that promotes the aggregation of strategies deriving from both perspectives may increase the gross number of techniques available to the therapist, but only at the expense of coherence in case conceptualization and guiding principles.

Cognitive therapy poses other obstacles to integration with a narrative perspective as well, or at least with the work of narrative theorists like White and Epston (1990) who attempt to reconstruct the individualizing, pathologizing discourse upon which western therapy has traditionally been based (Foucault, 1970), and on which cognitive therapy uncritically relies. If problems are more usefully "externalized," and viewed as inscribed in social systems rather than individuals (as White argues), then the attempt to identify "cognitive distortions" as the source of emotional distress, and their "rational reconstruction" as the cure, is problematic on several accounts. Not only does this traditional perspective artificially situate problems within people, thereby encouraging them to adopt a distrustful attitude toward themselves, but it extends the general western preoccupation with the control of deviance by external regulatory agencies to a pattern of self-monitoring and self-control which in essence represents the most pernicious form of internalized totalitarianism (White & Epston, 1990). However objectionable such a characterization of their work might be to orthodox cognitive therapists, it nonetheless helps to account for the fact that the newfound enthusiasm of cognitive therapists for the ideas of narrative theorists is rarely reciprocated.

SUMMARY AND CONCLUSIONS

In some respects, this has been a difficult position paper to write. This is because I suspect that Ramsay and I actually agree at many points in our implied critique of orthodox cognitive therapy as well as in our shared excitement for constructivist and narrative alternatives. Where we differ is over his well-intentioned and enthusiastic proposal for a conceptual marriage of the two perspectives. My most fundamental reservation about such a union is that superficial similarities in interests mask deeper-going differences in fundamental goals and values, making a romantic leap into a closer bonding of cognitive and narrative perspectives premature. At a minimum, I would urge attention to the metatheoretical commitments of both approaches and the practices that flow from them, so that the essential tensions embodied in these differences could be dealt with through negotiation rather than neglect. If the resulting dialogue could trigger serious reappraisal of the epistemology underpinning cognitive therapy, then I would share Ramsay's optimism that it might yet be enlivened and deepened through a closer relationship to narrative theory.
NOTES

1I will resist the temptation to extend this metaphor of risky intimacy through warning of the dangers of STDs (Serious Theoretical Discrepancies) or cautioning about the viability of conceptual offspring resulting from a cross fertilization of cognitive and constructivist approaches. However, less metaphoric considerations of such issues will be woven through the critical reflections that follow.

2Vincent & LeBow's (1995) study investigated the acceptability of behavioral, cognitive-rationalist, and cognitive-constructivist approaches to the treatment of body image disturbance, given its prevalence in the college undergraduate population that was the focus of the study. Nearly 400 participants watched videotaped “therapy” sessions briefly outlining the theory behind each approach and its associated interventions, with the same “client” and “therapist” enacting all three treatment approaches. Results indicated that the three treatments were clearly distinct in the eyes of the viewers, with the constructivist approach being perceived more favorably overall than either of the other two models. However, after controlling for degree of subject identification with the presenting problem, those subjects with a more external locus of control were found to respond more favorably to the behavioral and cognitive-rationalist therapies, whereas those with a more internal locus of control responded more positively to the constructivist condition. Such results suggest that therapies embodying different epistemological stances may be matched to the styles of particular clients, and hence reinforce the value of conceptual pluralism in the development of psychotherapy.

3This clinical vignette is modeled closely on an actual therapeutic conversation conducted along the constructivist lines indicated in the second version of the exchange. It is used here with permission of the young counselor whose experience it presents.

REFERENCES


Offprints. Requests for offprints should be directed to Robert A. Neimeyer, PhD, University of Memphis, Memphis, TN 38152.