Cognitive Therapies Do Not Ignore Affect

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Résumé

On propose ici de défendre la vue selon laquelle les thérapies cognitives s'intéressent aujourd'hui, comme il en fut toujours le cas, à l'expérience affective humaine et, que ces thérapies ne se limitent pas aux questions et difficultés conscientes, rationnelles ou affectives-neutres. On y cite des exemples de programmes vitaux de recherche et de développement théorique en psychologie cognitive, qui donnent à la fois appui et direction aux thérapies cognitives contemporaines. Il est important de clarifier certains malentendus au sujet des thérapies cognitives, étant donné les promesses qu'elles représentent quant à l'intégration des domaines théoriques et empiriques en psychologie académique-expérimentale et appliquée.

Abstract

Arguments are offered to support the claims that cognitive therapies are now, and always have been, concerned with human affective experience, and that these therapies are not limited to conscious, rational, affectively-neutral concerns or difficulties. Examples are cited of healthy programs of research and theoretical development in cognitive psychology that provide support and direction to contemporary cognitive therapies. Clarification of misconceptions about the cognitive therapies is important because of the promise these therapies hold for integrating theoretical and empirical work in academic-experimental and applied areas of psychology.

In this article, I wish to do three things. First, I want to supply evidence that many cognitive therapists are now, and always have been, concerned intimately with human affect. I will argue that concern with affect has been a primary motivating factor in the development of cognitive therapies. Secondly, I will attempt to demonstrate that there are healthy programs of research and theory in cognitive psychology that are concerned with understanding human emotion, and that these provide both support and direction to the development of the cognitive therapies. Finally, I will show that cognition often is anything but conscious, rational, and affectively neutral.

COGNITIVE THERAPISTS ARE CONCERNED WITH AFFECT

The fact that generations of cognitive therapists from Adler and Sullivan, through Beck and Ellis, to Mahoney and Guidano and Liotti have been doggedly critical of many aspects of abreactive therapies should not be interpreted to imply that they have been unconcerned with emotional upset and its alleviation. On the contrary, many cognitive therapists view the amelioration of affective disorders as a primary goal of therapy. They also believe that this goal is best achieved through a focus on client beliefs, thinking patterns, and cognitive-perceptual processes,

possibly because they consider cognitive and affective systems as highly interdependent or as a single indivisible system. Dealing directly with a client's cognition is thought to be the most efficient and feasible way of rendering affective relief.

Adler, while recognizing a close integration of thought and affect in the striving for perfection or completion, believed that cognitive abilities in humans were developed more fully than in any other animal, and that human thought, therefore, could be expected to exert great influence on human emotion and behaviour (cf. Shulman, 1985). Echoing a similar sentiment and reminding us explicitly of the interdependence of cognition and affect, Sullivan wrote in 1925:

> Cognitive elements must be dealt with before the conative and affective aspects of mental situations can be elucidated. At the same time it is unduly easy to lose appreciation of the artificial abstraction by which we come to speak of cognition as if it were in itself some independent faculty of mind. (Sullivan, 1962, p. 28 note)

Moving ahead one generation, we see similar views expressed by cognitive therapists like Aaron Beck and Albert Ellis. Ellis' views on the interdependence of affect and cognition are well known and equally well advertised in the rubric, *rational-emotive* therapy. These views are emphatically summarized in two little-known articles (Ellis, 1970, 1974) in which he argues that the active therapeutic ingredients in abreactive, experiential, and relationship therapies are cognitive, both in nature and of necessity.

> . . . the client's changing his felt meaning and making a significant conceptual shift are integrally related and are essectially *the same thing*! . . . Thinking-feeling is the essence of being human and probably cannot be separated into two distinct processes. (Ellis, 1970, p. 49)

More recently, Beck (1985) has summarized his essential agreement with Ellis in this respect by arguing that cognitive change is basic to the change processes active in all psychotherapies.

> A common denominator of the various systems is the ascription of cognitive mechanisms to the process of therapeutic change . . . Changes in the cognitive processes play an essential therapeutic role with each type of treatment. (p. 345)

A new generation of cognitive therapists are perhaps even more concerned that deeper aspects of human emotional experience be probed for their potential in elucidating and developing constructive personal epistemologies and ontologies that undergird the total adjustment of the client. Mahoney (1985) puts it this way:

> When clients request our assistance in reducing and controlling the pain and debilitation of their personal struggles, I believe our most humane intentions lie in the direction of that assistance . . . In our attempts rapidly to reduce emo-

tional turbulence, I sometimes wonder if we are not rushing to quiet the messenger long before we have comprehended the message. The bulk of our specifiable techniques for helping seems to be aimed at achieving emotional satisfaction, directly or indirectly, without our more fully examining the role of contrasts and feelings in our personal experience. (p. 27)

Similar views are expressed by therapists such as Guidano and Liotti (1983, 1985) and Joyce-Moniz (1985) who see cognitive therapy as a deeply personal struggle with affectively-laden issues of constructed meaning and personal philosophy. It is my distinct impression that rather than eschewing affective issues in therapy, cognitive therapists' deep concern with such matters has been a consistent prod in their efforts to elucidate the functioning of the human mind with its as yet little-understood powers to create and maintain emotional disturbance, and growth, and synthesize systems of highly-personal meaning.

COGNITIVE THEORIES OF EMOTION

Many may agree that leading cognitive therapists themselves have been duly attentive to affect. However, it may be alleged that the cognitive theories from which cognitive therapists draw their more academic ideas are especially impoverished when it comes to questions of affective experience. There is a good deal of truth to this suspicion, but I believe that there are notable exceptions. I want very briefly to mention three.

Leventhal (1979) has developed a perceptual motor processing model of emotion, based on his laboratory work in social psychology studying the role of emotion in pain, humour, and attitude change. His overall model contains two highly interactive stages: an initial perceptual-motor stage and a second planning-action stage. Emotion is most directly active in the perceptual-motor phase, during which it is generated by combining the intitial perception of a stimulus with a resulting expressive motor reaction. The three separate mechanisms operative here are a facial-motor mechanism, a schematic or emotional memory, and a conceptual system that stores beliefs about emotional experience. The facial-motor mechanism is largely innate or "built in," and consists of a variety of automatic expressive motor codes. The schematic emotional mechanism consists of more acquired motor codes together with image and feeling codes that represent particular experiences and are concrete and episodic in nature (cf. Tulving, 1972, 1985). Both the facial-motor and schematic emotional mechanisms operate at a pre-attentive, synthetic level. The components that are sythesized (the eliciting event, the expressive reaction, schematic memories) are outside of focal awareness. It is only the product of the synthesis that is experienced consciously, primarily as a result of construction that occurs through the actions of the abstract conceptual system. This system contains higher-order conceptual meanings and makes possible the

conscious interpretation of lower levels of processing. All three mechanisms active during the perceptual-motor phase are arranged hierarchically and operate in an integrated fashion.

Implications of Leventhal's model for working with affect in cognitive therapy have been examined by Greenberg and Safran (1983). These scholar-therapists have elaborated the therapeutic relevance of several key aspects of the Leventhal model, especially the distinction between conceptual and perceptual aspects of cognition (Greenberg & Safran, 1980; Safran & Greenberg, 1982a, 1982b). Leventhal's ideas about affective processing also have been incorporated into the cognitive therapeutic theorizing of Guidano and Liotti (1983, 1985).

A second, cognitively-based theory of emotion is developed extensively by George Mandler (1975). This theory has been adapted as a framework for a program of research and theoretical development on emotion in close relationships (an area with obvious therapeutic ties) being conducted by Berscheid and her associates (see Berscheid, Gangestad, & Kulakowski, 1984).

Emotion is conceived by Mandler to be integrally related to the functioning of the mind. In Mandler's theory, both autonomic nervous arousal (ANS) and the cognitive-interpretive system play major roles. ANS discharge is assumed to be a necessary condition for emotional experience. Physiological accompaniments to the experience of emotion (e.g., sweating palms, pounding heart, "butterflies," and so forth) are the direct results of ANS discharge. A sufficient, and possibly necessary, condition for ANS arousal is the interruption of some on-going activity or plan. This is particularly true if it is a highly organized behaviour sequence in the process of execution that is interrupted. Thus, in Mandler's view, the subjective experience of emotion, together with its physiological accompaniment, occurs when a highly organized response sequence or plan is interrupted. This subjective experience, perhaps leading to displays of emotional behaviour, will continue until either the interrupting stimulus is removed, or an available substitute response is conceived and executed to complete the sequence or plan.

The degree or extent of one's emotional experience is correlated with the degree of organization in the plans that are interrupted, and with the difficulty of locating alternative ways of completing the plans. Negative emotions are associated with interruptions that appear to hinder the completion of plans. Positive emotions are associated with interruptions that unexpectedly advance plan completion or that contain events over which individuals believe they have control and can be seen to promote other desired plan sequences (Berscheid, 1983).

Berscheid's studies of emotion in close relationships (Berscheid, 1983; Berscheid, Gangestad, & Kulakowski, 1984) suggest numerous ways of incorporating the Mandler-Berscheid concepts into frameworks that counsellors and therapists use to conceptualize and intervene in client

problems, particularly those that involve difficulties with intense emotions originating in interpersonal contexts. In particular, Berscheid, Gangestad, and Kulakowski (1984) suggest that the rational-emotive methods advocated by Ellis are particularly well suited to the therapeutic alleviation of emotional disturbances because of their potential in helping clients to restructure plans and to reinterpret interrupting stimuli in more benign ways.

My final example of a healthy program of cognitive theory and research of potential relevance to cognitive therapies targeted at emotional issues is found in the recent work of Bower (1981). Bower proposes an associative network theory of memory and emotion, based on an extensive series of studies conducted by himself and his associates (e.g., Bower, Gilligan, & Monteiro, 1978). Human memory is modelled in terms of complex hierarchical tangles of associative networks composed of semantic concepts, propositions, and schemata (Anderson & Bower, 1973). Events are represented in memory by clusters of descriptive propositions.

Bower's (1981) semantic network approach assumes that each separate emotion has a specific node or unit in memory that organizes other aspects or components of the emotion connected to it by associative pointers. Such components consist of memorial codes for associated autonomic reactions, expressive behaviour, verbal labels commonly assigned to the emotion, and situations that when appraised lead to the experience of the emotion in question. Memorial coding, and association with a particular emotion node, of past life events during which the emotion was experienced are of particular importance in Bower's theory. This is so because such coding and association help to explain laboratory results that support the notion of mood-state-dependent retrieval. This phenomenon references the facilitation of recall of memorial information, that was originally encoded during an emotional experience, by re-experience of the same emotion at recall. The flip-side of this phenomenon is, of course, the difficulty of retrieving memorial information previously associated with a particular emotional experience in the absence of that emotion, or while a very different emotion is being experienced.

An example of how Bower's theoretical notions might be directly relevant to therapeutic work on emotional issues appears in an article by Martin (1985). In a case study reported in this paper, associative networks of a client's memorial organization of information about her problems are presented. Of particular interest, is the incorporation of emotion nodes in these networks and the manner in which these emotion nodes appear to change during the course of therapy.

There are other examples of close working relationships between cognitive theorists/researchers and therapists (see, for example, the incorporation of Arnold's, 1960, 1970 cognitive appraisal theory of

emotion in the therapeutic notions advocated by Safran & Greenberg, 1982a). However, I believe the three examples provided are sufficient to substantiate my claims that cognitive psychology has been concerned with affective factors, and that this concern has implications for the ongoing development of contemporary cognitive therapies. I turn now to the third objective I set in my introductory remarks.

CONSCIOUS, RATIONAL, AND AFFECTIVELY NEUTRAL?

Popular connotations of the term, cognitive, suggest that it is limited to conscious, rational, deliberate activity that is devoid of motivational and emotional colour. I find little evidence to suggest that leading figures in the fields of cognitive psychology and cognitive therapy have embraced these popular connotations. I wish to focus on three issues, the myths that cognitive therapy and theory are restricted to (1) conscious, (2) rational, and (3) affectively-neutral phenomena.

Perhaps the most difficult misunderstanding to fathom is the idea that cognitive psychology and cognitive therapy are concerned only with conscious material. Experimental cognitive psychology long has recognized that a great many memorial processes and structures occur and exist outside of conscious awareness. Most experimental work on perception, recognition, encoding, and recall has proceeded on this assumption (see Ericsson & Simon, 1984 for an information processing model that predicts the extent to which such processes will be unavailable for conscious analysis and report). Major cognitive theorists (Bower, 1981; Fodor, 1983; Pylyshyn, 1984) are unanimous in holding that much, perhaps the vast majority of, cognitive activity is not consciously accessible.

Cognitive therapists like Beck, Ellis, Guidano and Liotti, and Mahoney (particularly in his most recent writings) are unanimous in the view that many of the most insidious components of human belief systems are unavailable to facile, immediate conscious probing. Guidano and Liotti (1982, 1985) and Mahoney (1985) talk extensively about deep, tacit personal knowledge structures that house idiosyncratic systems of ontology and epistemology—systems that often underlie and support client difficulties, but which are extremely difficult to penetrate and to bring into awareness. Ellis' (1979) distinction between elegant and inelegant cognitive therapy also rests upon the existence of deeper levels of belief that cannot be explored through surface analyses of readily-available internal self-statements alone. While most cognitive therapists desire to help clients become more aware of influential, tacit belief systems, they certainly do not assume, any more than do experimental cognitive psychologists, that all cognition (or even the most important or greater portion of it) is conscious.

A myth closely related to that of consciousness, is the idea that

cognition is rational; and that, by implication, cognitive psychology and therapy only are concerned with rational processes. While, once again, it is true that some forms of cognitive therapy attempt to encourage rational reflection, acceptance of the largely irrational character of human cognition is a major plank in the therapeutic platforms of most cognitive therapists, and of a growing number of cognitive psychologists and scientists (see Gardner, 1985). Indeed, if cognitions were restricted to logical, deliberate, rational processes, therapists like Ellis and Beck presumably would spend much less time and energy combatting the irrational and erroneous beliefs that they find undergirding and supporting so much personal anguish in their clients.

Confusions leading to the equation of cognition with deliberate rationality have been addressed by a number of cognitive therapists, including Lazarus (1982, 1984), Greenberg and Safran (1983), and Guidano and Liotti (1985). Lazarus (1982, 1984) has been particularly eloquent in this regard during his ongoing debate with Zajonc (1980, 1984) over the primacy of cognition or affect.

> The point is that cognition cannot be equated with rationality. The cognitive appraisals that shape our emotional reactions can distort reality as well as reflect it realistically. (Lazarus, 1982, p. 1022)

In the same vein, Gardner (1985), in his masterful review of the cognitive revolution, concludes that one of the major results of the first decades of work in cognitive science has been the demonstration that a highly rationalistic view of human thought cannot be supported. Unlike many programs of cognitive science, cognitive therapies have long been built on the knowledge that human thought is often anything but rational.

Yet another common myth is that cognitive therapy is affectively neutral, in the sense of advocating a rigid subjugation of affect to cognition. Indeed, the degree of independence of affective and cognitive systems and the temporal and causal patterns linking them are much debated (see, for example, Lazarus, 1982, 1984; Rachman, 1981; Zajonc, 1980, 1984). However, few cognitively-oriented scholars or therapists really believe that cognition is impoverished of affect (although some scholars may, for convenience, ignore affective content in their empirical work). Cognitive models such as those of Bower (1981), Leventhal (1979), and Mandler (1975) are primarily concerned with affect and its representation in the cognitive systems. Therapists such as Beck, Ellis, Greenberg and Safran, Guidano and Liotti, and Mahoney are primarily concerned with alleviation of human emotional suffering, seeing cognitive change and restructuring as efficient means to this end.

In addition to cognitive persepctives reviewed earlier in this article, an influential set of cognitively-oriented theorists has developed elaborate theories of human motivation that have obvious relevance to

affective concerns and their therapeutic amelioration. Well-known examples here include Bandura's social cognitive theory of self-efficacy (Bandura, 1977a, 1977b, 1986) and Abramson, Seligman, and Teasdale's (1978) attributional reformulation theory of learned helplessness.

CONCLUSIONS

It is my contention that most cognitive therapies have been, and continue to be, directed at the alleviation of emotional disturbance. I believe that contemporary cognitive therapies are not limited in their theoretical or practical development by an exclusive focus on conscious, rational, affectively-neutral phenomena. It is understandable that lay connotations of the term, cognitive, might result in misunderstandings about cognitive therapy, its objectives, and its limitations. It is, however, less clear why similar confusions seem to exist in the minds of some academic and applied psychologists and therapists (cf. Lazarus', 1982, response to Zajonc, 1980).

Perhaps one reason is that psychology and psychotherapy are far from being unified disciplines. Concepts and terms often show little semantic generalization across different branches of psychology or across different therapeutic orientations. Scholars/practitioners in one camp may have only fleeting familiarity with positions advocated in others. Given this state of affairs, rubrics become all-important. Cognitive therapies become "cognitive only" therapies, and questions of "primacy" (cf. Lazarus, 1984; Zajonc, 1984) are pursued within a "win-lose" framework.

Perhaps the most important reason for attempting to clarify and correct misconceptions about the nature of cognitive therapy is that such therapies currently represent one of psychology's most concerted attempts to link its academic-experimental tradition to real-life events. Most therapeutic schools have developed outside of mainstream, academic psychology. However, many contemporary cognitive therapists have knowledge of experimental work in cognitive, social, and educational psychology, and attempt to conceptualize and examine their therapeutic interventions in terms common to these disciplines. I believe that this pattern of development holds promise for the eventual design of a rigorous, experimental, ecologically-valid psychology that advances itself through field-relevant thinking and inquiry (e.g., Kraft, Glover, Dixon, Claiborn, & Ronning, 1985; Martin, 1984).

References

Abramson, L., Seligman, M., & Teasdale, J. (1978). Learned helplessness in humans. *Journal of Abnormal Psychology, 87*, 49-74.

Anderson, J. R., & Bower, G. (1973). *Human associative memory*. Washington: Winston and Sons.

Arnold, M. B. (1960). *Emotion and personality.* New York: Columbia University Press.

Arnold, M. B. (1970). *Feelings and emotions: The Loyola Symposium.* New York: Academic Press.

Bandura, A. (1977a). *Social learning theory.* Englewood Cliffs, NJ: Prentice-Hall.

Bandura, A. (1977b). Self-efficacy: Toward a unifying theory of behavioral change. *Psychological Review, 84,* 191-215.

Bandura, A. (1986). *Social foundations of thought and action: A social cognitive theory.* Englewood Cliffs, NJ: Prentice-Hall.

Beck, A. T. (1985). Cognitive therapy, behavior therapy, psychoanalysis, and pharmacotherapy: A cognitive continuum. In M. J. Mahoney & A. Freeman (Eds.), *Cognition and psychotherapy* (pp. 325-347). New York: Plenum.

Berscheid, E. (1983). Emotion. In H. H. Kelley, E. Berscheid, A. Christensen, J. Harvey, T. L. Huston, G. Levinger, E. McClintock, P. Peplau, & D. R. Peterson (Eds.), *Close relationships.* San Francisco: W. H. Freeman.

Berscheid, E., Gangestad, S. W., & Kulakowski, D. (1984). Emotion in close relationships: Implications for relationship counseling. In S. D. Brown & R. W. Lent (Eds.), *Handbook of Counseling Psychology* (pp. 435-476). New York: Wiley.

Bower, G. H. (1981). Mood and memory. *American Psychologist, 36,* 129-148.

Bower, G. H., Gilligan, S. G., & Monteiro, K. P. (1978). Emotional mood as a context of learning and recall. *Journal of Verbal Learning and Verbal Behavior, 17,* 573-585.

Ellis, A. (1970). The cognitive element in experiential and relationship psychotherapy. *Existential Psychiatry, 7,* 35-52.

Ellis, A. (1974). Cognitive aspects of abreactive therapy. *Voices: The art and science of psychotherapy, 10,* 48-56.

Ellis, A. (1979). Rejoinder: Elegant and inelegant RET. In A. Ellis & J. M. Whiteley (Eds.), *Theoretical and empirical foundations of rational-emotive therapy* (pp. 240-267). Monterey, CA: Brooks/Cole.

Ericsson, K. A., & Simon, H. A. (1984). *Protocal analysis.* Cambridge, MA: The MIT Press.

Fodor, J. A. (1983). *The modularity of mind.* Cambridge, MA: MIT Press.

Gardner, H. (1985). *The mind's new science: A history of the cognitive revolution.* New York: Basic.

Greenberg, L. S., & Safran, J. D. (1980). Encoding, information processing, and cognitive behaviour therapy. *Canadian Psychologist, 21,* 59-66.

Greenberg, L. S., & Safran, J. D. (1983). *Integrating affect and cognition: A perspective on the process of therapeutic change.* Unpublished manuscript, The University of British Columbia, Vancouver.

Guidano, V. F., & Liotti, G. (1983). *Cognitive processes and emotional disorders.* New York: Guilford.

Guidano, V. F., & Liotti, G. (1985). Constructivistic foundation for cognitive therapy. In M. J. Mahoney & A. Freeman (Eds.), *Cognition and Psychotherapy* (pp. 101-142). New York: Plenum.

Joyce-Moniz, L. (1985). Epistemological therapy and constructivism. In M. J. Mahoney & A. Freeman (Eds.), *Cognition and Psychotherapy* (pp. 143-180). New York: Plenum.

Kraft, R. G., Glover, J. A., Dixon, D. N., Clairborn, C. D., & Ronning, R. R. (1985). Memory research in counseling: A perspective and some hypotheses. *Counselor Education and Supervision, 25,* 122-133.

Lazarus, R. S. (1982). Thoughts on the relations between emotion and cognition. *American Psychologist, 37,* 1019-1024.

Lazarus, R. S. (1984). On the primacy of cognition. *American Psychologist, 39,* 124-129.

Leventhal, H. (1979). A perceptual motor processing model of emotion. In P. Plines, K. R. Blankstein, & I. M. Spigel (Eds.), *Perception of emotion in self and others.* New York: Plenum.

Mahoney, M. J. (1985). Psychotherapy and human change processes. In M. J. Mahoney & A. Freeman (Eds.), *Cognition and Psychotherapy* (pp. 3-48). New York: Plenum.

Mandler, G. (1975). *Mind and emotion,* New York: Wiley.

Martin, J. (1984). The cognitive mediational paradigm for research on counseling. *Journal of Counseling Psyhology, 31,* 159-172.

Martin, J. (1985). Measuring clients' cognitive competence in research on counseling. *Journal of Counseling and Development, 63*, 556-560.

Pylyshyn, Z. (1984). *Computation and cognition.* Cambridge, MA: The MIT Press.

Rachman, S. (1981). The primacy of affect: Some theoretical implications: *Behavior Research and Therapy, 19*, 279-290.

Safran, J. D., & Greenberg, L. S. (1982a). Cognitive appraisal and reappraisal: Implications for clinical practice. *Cognitive therapy and research, 6*, 251-258.

Safran, J. D., & Greenberg, L. S. (1982b). Eliciting "hot cognitions" in cognitive therapy. *Canadian Psychology, 23*, 83-87.

Shulman, B. H. (1985). Cognitive therapy and the individual psychology of Alfred Adler. In M. J. Mahoney & A. Freeman (Eds.), *Cognition and Psychotherapy* (pp. 243-258). New York: Plenum.

Sullivan, H. S. (1962). *Schizophrenia as a human process.* New York: Norton.

Tulving, E. (1972). Episodic and semantic memory. In E. Tulving & W. Donaldson (Eds.), *Organization of memory.* New York: Academic Press.

Tulving, E. (1985). How many memory systems are there? *American Psychologist, 40*, 385-398.

Zajonc, R. B. (1980). Feeling and thinking: Preferences need no inferences. *American Psychologist, 35*, 151-175.

Zajonc, R. B. (1984). On the primacy of affect. *American Psychologist, 39*, 117-123.

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