

Belief change in cognitive therapy: Changing beliefs or changing relationships toward beliefs?

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This article explores how the notion of belief is constructed and used within the cognitive therapy domain. From looking at the linguistic resources and practices therapists had available and used in constructing and deploying different notions of belief, two main constructions of belief became evident; these were of 'a belief itself' and of 'a believing person'. These constructions were achieved by therapists selectively drawing on various repertoires and by using a range of discursive strategies. Throughout this paper I highlight some of the positive and negative therapeutic implications of such constructions, and conclude by discussing some further tensions that were detected within and between these two main constructions.

Note: Due to space restrictions, this article merely outlines general findings from a larger research project. It does not attempt to furnish the evidence necessary to justify the subsequent interpretations, and as such, no examples of discourse or text have been provided. However, the interested reader is welcome to request a fuller version with examples of segments of text that justify such conclusions. As a compromise, words in parentheses (e.g., 'it', 'belief') have been selected from these texts and included.

DISCOURSE ANALYSIS.

As an approach to research, discourse analysis takes discourse itself as the focus of research interest (Gee, 1999; Smith *et al.*, 1995; Potter & Wetherell, 1987). Discourse analysts are interested in the content and organisation of talk and texts themselves, with the actual detail of the passages of discourse, with what is said and written, and with the resources that are drawn upon to enable that talk and text (Potter & Wetherell, 1987).

The particular type of discursive approach adopted for this research project was that of Potter, Edwards and Wetherell, and involves two overarching and interconnected components and three key elements for identifying these two components (see: Potter & Wetherell, 1987; Edwards, 1997). The two broad components are the discursive *practices* people perform and the discursive *resources* people draw on in performing those practices. The three key elements that help highlight these two components are examining the talk and text for *function*, noticing the *variation* and consistency in the talk and text, and exploring the talk and text to see how it is *constructed*. In addition, the variation, consistency and construction employed in the talk or text help clarify the interpretative repertoires (i.e., resources), whilst the wider context and cultural backdrop helps clarify the discursive functions (i.e., practices). Thus, under this discursive approach, the researcher explores the variability and consistency within and across the talk or text, investigates how the talk or text was constructed, and examines the functions and consequences the talk or text serves. By analysing accounts in this way, the assumptions and underpinning social aspects of the talk or text are made explicit (Potter & Wetherell, 1987).

METHODOLOGY.

The multi-media approach of this research involved obtaining three distinctly different types of talk and text from within the cognitive therapy domain. These consisted of cognitive therapy instructional books, cognitive therapy demonstration videos, and interviews with practicing cognitive therapists.

Theoretically and practically this translated into a better understanding of how discourse was being used and constructed within and across the cognitive therapy domain. In other words, by strategically employing a multi-media approach from the outset I was able to gain a much wider exploratory scope of the discursive resources and practices utilised.

OVERVIEW.

Cognitive therapists seemed to consistently mobilise two distinct constructions in their 'belief talk'; firstly a 'belief' was a discrete object ('the belief itself'), which could secondly be possessed or held by an individual ('the believing person'), and once possessed had varying consequence. These two different constructions involving the notion of belief produced various tensions.

THE BELIEF ITSELF.

Therapists constructed a belief as a discrete, malleable and legitimate object. They accomplished this by drawing on a number of interconnecting and supporting repertoires, which included an objectification repertoire,

a malleable repertoire and a scientific repertoire. The objectification repertoire was drawn on to work up a belief as a discrete and separate object. The malleable repertoire was drawn on to make belief a mouldable and changeable object. The scientific repertoire was drawn on to then legitimise the status of the belief itself. These repertoires combined to portray a picture of beliefs as discrete, malleable and legitimate objects from which the therapist could utilise to effect therapeutic improvement in their clients.

An objectification repertoire.

In this repertoire beliefs were portrayed as discrete objects, and a boundary was drawn around the notion of belief. Here the belief was individualised so that the therapist could work with 'it', enabling the theoretical objective of belief change for therapeutic improvement. Here talk emphasised that the client's belief was a discrete and separate object. Supporting this individuation, beliefs were talked of as being of a certain 'kind', which fell into a specific 'category', and were part of a 'set' which interconnected with a larger belief 'system'.

This taxonomic talk made a belief a discrete and separate object, and served a number of particular functions for the therapists. The first was that the foundations of the person's problem (i.e., their beliefs) were labelled and categorised. This perspective lessened ownership of the problem, provided the client with distance from their problem, and thus bestowed partial therapeutic relief. This technique is in line with research which suggests that clients are relieved by receiving a label (or 'handle') for their problems (e.g., see Fodor, 1987).

A second function was that the client was furnished with a sense of confidence in their therapist and the therapeutic process they were undertaking. By the therapist individualising a belief and conveying that it is an object, of a certain 'kind' which fits into a 'category' and is part of a 'set' and larger 'system', an assisting framework was alluded to. This framework allowed the therapist to assess, measure, and manipulate a client's beliefs in order to provide therapeutic relief. By alluding to this framework, and by the client's subsequent realisation that the therapist had access to and knowledge of this framework, confidence and faith in the therapist and therapy process were fostered and strengthened. In addition to the confidence cultivated, credibility was drawn by the type of framework that was conveyed, as many other highly creditable professions use a similar framework. In no instance did the clients seem to question the therapists' framework, and thus credibility came through in their acceptance of this framework.

A malleability repertoire.

In this repertoire, beliefs were portrayed as malleable and modifiable objects. This is perhaps unsurprising given that modification of unhelpful beliefs is one of the most important goals of cognitive therapy (Beck, 1995). This depiction of beliefs as malleable was in contrast to their portrayal as fixed and stable, where beliefs were objects that were 'fixed', 'strong', 'rigid', 'maintained' and part of a 'closed system'. This depiction as fixed and stable occurred towards the beginning of the transcripts and usually portrayed the current state of their client's beliefs.

Contrasting against this stability depiction, beliefs were constructed as malleable and modifiable objects by the therapists. This involved talk of 'modifying', 'altering' or 'changing' the beliefs themselves so that it becomes a different entity. Supporting this more direct reference to the malleability of beliefs, therapists also corroborated this construction by frequently highlighting the temporality of beliefs. Here beliefs were portrayed as being either 'old' or 'new', suggesting and reinforcing temporal change. These references functioned to reinforce both the possibility and normalcy of the beliefs themselves changing.

An interesting discovery was the particular way therapists orchestrated their discourse to construct a more malleable form of belief, paving the way for the beliefs themselves to change. In this regard, a frequent pattern of discourse organisation in the transcripts referred to belief and then subsequently referred to a more malleable concept associated with, or instead of, the belief. These concepts included shifting the use of 'belief' to an 'idea', a 'notion' or an 'understanding'. This semantic shift which portrayed beliefs in less stable and more malleable terms, assisted in the process of portraying beliefs themselves as changeable. By associating a belief with the concepts of an 'idea', a 'notion', and an 'understanding', this association functioned to break beliefs down into a more malleable form. This was because these particular concepts can be easily changed or modified, as they are not certain or known, but are instead only regarded or considered by an individual. By associating belief with these concepts, if a person was able to easily change their ideas, understandings or notions, they should also be able to change their beliefs because the objects themselves are malleable. This is also the case in cognitive therapy theory where 'intermediate beliefs' are also commonly referred to as 'underlying assumptions'; the term 'assumption' also highlighting a more malleable concept.

A scientific repertoire.

This involved legitimising and giving a status to a belief as an object. This was achieved by therapists expressing a scientific account of the process engaged in for a belief to be legitimate. Here beliefs came to be 'accurate' by being 'formulated' into 'hypotheses' which were 'evaluated' and 'examined' by standard 'procedures'. Beliefs were 'supported' by 'evidence' and 'data' which 'proved' the beliefs when 'tested'. This scientific process of gathering 'evidence' and 'data' which 'supports' the belief, and 'evaluating', 'examining' and

'testing' it, then led to a judgment about the 'accuracy' of the belief. This accuracy notion in turn gave the belief a legitimate status.

Although it is generally acknowledged in theory that the therapist is to "evaluate beliefs through the systematic accumulation of evidence" (Gluhoski, 1994, p. 597), the warranting effects entailed by such a scientific justification process are not known or so obvious. The main function this scientific process provided was credibility for the therapeutic process from which the therapist worked. For example, by drawing on scientific notions to increase the object status of belief, these notions worked in a similar way to a doctor's scientific search for evidence in a patient's medical exam to support their diagnosis or prognosis. In such a case, the evidence works to support and hold together the doctors diagnosis or prognosis, as well as to give it a legitimate status. Analogously, here the therapist's hypothesised and formulated beliefs were supported and legitimated by a similar scientific and evidence based approach. The effect of portraying this scientific process through their talk was that the legitimacy of the belief itself as a discrete and malleable object was substantiated. The belief itself was given a higher and more valid perceived status by the client, which in turn increased their confidence in therapy and aided in the therapeutic and belief change process.

Summary.

Therapists constructed a belief as a discrete, malleable and legitimate object. This was achieved by drawing on a number of repertoires, which included an objectification repertoire which worked up a belief as a discrete and separate object, a malleable repertoire which made a belief modifiable and changeable, and a scientific repertoire which legitimised and gave a high status to a belief. These ways of talking about beliefs served various functions. Foremost amongst these were the enabling of the theoretical objective of belief change, providing therapeutic relief by labelling the problem, instilling confidence in the client, and giving credibility to the therapy process and therapist.

THE BELIEVING PERSON.

Therapists portrayed the person holding or possessing a particular belief as a defective, yet changeable, patient. They accomplished this by drawing on a number of interconnecting and supporting repertoires, which included a medical repertoire, a defective repertoire and a changeable repertoire. The medical repertoire was drawn on to work up the believing person as a patient. In conjunction with the medical repertoire, the defective repertoire was drawn on to depict the patient as flawed or damaged. The changeable repertoire was drawn on to suggest the necessity of the patient changing the beliefs they held. These ways of talking combined to sketch a picture of the believing person as a defective, yet changeable, patient.

A medical repertoire.

This repertoire involved the use of various medical notions, terminology and images to depict the believing person as a patient. The most evident use of this medical repertoire was the extensive direct referencing of the client as a 'patient'. In contrast, other possible more neutral descriptive terms such as 'client', 'person', 'individual', 'consumer', 'customer', 'subject' or any other referential term did not appear in the selected texts. Supporting this more direct referencing of the believing person as a patient, therapists organised their discourse to assist this depiction in a number of medicalised ways. These included utilising the notions of their clients being 'examined', receiving a 'prognosis' and obtaining 'treatment' from the therapists.

With regard to being examined, a particular part of the patient (i.e., their beliefs) was examined by the therapists. This happened in a similar fashion to the way a doctor examines their patient for an illness. With the therapists, the examination process involved the person's beliefs being 'identified' or 'hypothesised', and then 'evaluated', 'tested' and 'monitored'; all elements of a medical examination and diagnostic process. From the examination of the person's beliefs, the therapists then made a prognosis based on their examination. This was achieved by talking about 'good and bad news', 'improvement', and 'getting better'; all elements of a medical prognosis. Following on from the notion of 'prognosis' was the portrayal of the patient obtaining 'treatment' from the therapist for their beliefs. Here the patient improves and gets better provided they follow the therapist's 'treatment'. These three medical notions of being 'examined', receiving a 'prognosis' and obtaining 'treatment' interconnected to support the more direct reference of the person as a 'patient'. In addition, although not directly related to 'belief talk', therapists frequently utilised the medical notion of a 'symptom' to describe their client's troubles.

A defective repertoire.

This repertoire built on the depiction of the client as a patient and involved depicting the patient as 'defective', with a diminished status. By 'defective' I mean the client was portrayed as flawed or damaged, with a diminished status and thus in need of change. There were three distinct facets to this defective depiction, which included portraying the patient as being 'ignorant' of their beliefs and in need of 'education', having to 'cope' with their 'painful' beliefs, and lastly being in a 'dysfunctional' state as a result of their beliefs.

In the first facet, the believing person was portrayed as ignorant of the beliefs they held and in need of education about their beliefs. Here the patient's beliefs were to be 'identified', 'articulated' and made known by the therapist. Interconnecting with the medical repertoire, this ignorance seemed analogous to a doctor's patient being ignorant about their specific illness when they first seek medical treatment. Here the process of a doctor linking symptoms to known causes and categories of pathogens or illness, and educating their patient about their particular illness, was similar to the therapist educating their patient about their particular beliefs and how their symptoms were linked to their beliefs. As the belief ignorance was not bliss, therapists revamped and patched up this ignorance by 'educating' and 'teaching' their patients about the beliefs they held, which they in turn 'learned'.

The second facet of this defective construction involved the patient being portrayed as 'coping' with their 'painful' beliefs. Alternatively, the therapist could have described the person as handling, managing, grappling or dealing with their beliefs. However, the notion of coping, and the context it was used in, entailed and portrayed an extra effort; an effort beyond that required if one was handling or dealing with the possession of a certain belief. Instead the activity of coping was represented analogously to the way a doctor's patient copes with their illness, and implied a diminished capacity. Closely tied with the notion of coping was the associated notion that the beliefs that the patients were coping with had 'painful' effects and consequences. The notion of pain, like coping, is also a concept highly associated with a medical context. This is because the generally perceived role of the medical profession is to relieve pain. However, the impression of a person in pain also conjured up a 'damaged' image in the context in which it was used.

The last facet of this construction directly portrayed the patient as 'dysfunctional', as a result of their painful beliefs. This representation was in contrast to a portrayal of an ideal person as functional. In other words, on the one hand a person's beliefs could 'function adaptively' giving them a 'normal and healthy' status, and on the other hand the beliefs could be 'dysfunctional' giving them a 'flawed and unhealthy' status. Here the patient's dysfunctional beliefs worked analogously to the way that 'disease' functions to give a doctor's patient the status of 'ill' or 'sick'. Because the belief made the patient dysfunctional or had dysfunctional consequences, the patient was constructed as 'flawed', 'damaged' or 'unhealthy', and attained a dysfunctional patient status. From here, the role of the therapist was to advance the patient from having 'painful' and 'dysfunctional' beliefs, which entailed a 'defective status', to obtaining more functional beliefs, which would furnish a normal and healthy status.

In all, the patients were depicted as incapacitated, passive, in need of help, and having a lesser degree of responsibility for their health.

A changeability repertoire.

This repertoire involved portraying the defective patient themselves as changeable. Here various changeability notions were used to depict the believing person as possible of changing, necessitating a change, and having changed. In contrast to the malleability repertoire of 'the belief itself' construction where the beliefs themselves changed, here it was the person that changed in relation to the beliefs.

To accomplish such a relationship change between the person and the belief, therapists utilised a number of different notions, including the person 'learning' and 'developing' different beliefs, which were then 'activated', 'operated' or 'arose'. These notions highlighted the transforming relationship between the belief itself and the person who held or possessed the belief. This way of talking emphasised that it was the person's relationship to the beliefs that changed and not the beliefs themselves. For instance, when a belief was 'learned' or 'developed', this belief was 'taken on board' or 'possessed' by the person as it was. When the belief was 'activated' or 'arose', the person's relationship with this belief changed as it became more predominant or apparent to them. In both cases the person's relationship with the belief had changed, rather than the belief itself changing in any content or form. Supporting this relationship change were various temporal notions that further suggested that the person, rather than the belief, had or was changing.

Once the appropriate relationship change had occurred between the person and the belief, the ways of talking shifted to segment this change and stabilise the person and the belief that was taken on board. It was now appropriate for the patients to be described as possessing or 'holding' certain beliefs. Here, holding a belief implied that both the person and the object were in a relatively stable relationship, either pre or post relationship change. Thus, there appeared to be a progression ranging from stable to fluid to stable in which the notion of the believing person was constructed; in some instances the relationship was stable and in others it was changing. In other words, through the use of various indirect notions, a believing person was constructed as stable, moved through a fluid phase, and then returned and segmented a stable position. The main function of this talk was to open the client up to the possibility of changing their relationship with certain beliefs, and to assist with this relationship change. Both of these aspects enabled therapeutic improvement.

Summary.

Therapists constructed 'the believing person' as a defective, yet changeable, patient. This was achieved by drawing on a number of repertoires, which included a medical repertoire that depicted the believing person as a patient, a defective repertoire that depicted the patient as flawed and damaged, and a changeable repertoire that

portrayed the patient as needing or having changed. These ways of talking about the believing person served various functions. Foremost amongst these were to reduce the status of the patient, open up the possibility for and necessity of changing, and allow for and enable the enactment of therapeutic improvement.

THE TENSIONS WITHIN AND BETWEEN THE TWO CONSTRUCTIONS.

Given the two constructions, as well as the repertoires and strategies that enabled and supported these constructions, there remained a number of interesting unresolved tensions detected in therapists' talk.

What changed?

Perhaps the most evident tension was between talk which mobilised a change in the belief itself as opposed to talk which mobilised a change in the person. In some instances the talk was around changing the beliefs themselves, whereas in other instances it was around changing the person by changing their relationship with certain beliefs. With both of these elements in sections of talk, there was confusion as to what exactly the therapists' talk was endeavouring to change; change the belief or change the person? This produced a clear tension between the different objectives of change.

This discovery was unanticipated and constitutes one of the most interesting aspects of this study. This is because the ramification of such a tension throws considerable doubt onto the whole belief change process in cognitive therapy. The evident implication is that cognitive therapy needs to make clearer the distinction between changing a belief and changing a person's relationship to a belief, and perhaps more importantly, which of these (if not both) the therapist should be trying to accomplish. Although perhaps the former was favoured in the texts, a recent research study (Teasdale *et al.*, 2001) suggests the latter type of talk may be more beneficial. For example, in this study they concluded that, "interventions that focus on changing patients' relationship to their dysfunctional thoughts and feelings, rather than attempting to modify thought content or belief, would be more useful" (p. 355).

How are the beliefs changing?

A second evident tension was that between talk which mobilised different ways of changing beliefs. From the therapists' talk there seemed three distinct ways; *deactivating* them, *modifying* their structure and content, or *constructing* more adaptive beliefs to neutralise and replace the dysfunctional beliefs.

However, neither the therapists' talk, nor cognitive therapy theory, suggests guidelines as to which particular approach is appropriate. At times, some of the talk indicated various combinations of strategies. Given research which suggests that people are confirming rather than disconfirming (Rokeach & Rothman, 1965; Mahoney, 1974), this meaning that clients are more responsive to evidence which supports beliefs rather than to evidence which disconfirms them, constructionist talk (in the above sense) may be a more fruitful path.

Talks' influence on change.

A third evident tension involved the therapists drawing on the medical and scientific repertoires. In doing so, they drew on the associated attributes of 'certainty' and 'stability' which were, at times, in stark contrast to the portrayal of beliefs as fluid and non-ridged objects. Thus, this talk restricted and hindered the belief change process. In other words, by the very nature of the repertoires drawn on, the therapists' talk lent towards a stable notion of belief, whereas talk which lent towards a fluid and non-ridged notion of belief might have been more therapeutically efficacious in various contexts.

Interestingly, supporting this view, a growing number of clinicians have openly acknowledged the unhelpful medical and scientific influences in cognitive therapy, and have taken proactive steps to alleviate such an influence. For example, a recent paper by Dvorak (2002) redesigned some of the popular cognitive therapy tools (e.g., thought record, core belief worksheet) to 'combat' their scientific and medical 'slant'. In their original formats, clients commented that they appeared 'cold', 'mechanical', 'clinical' and 'medical', which was deemed to hinder therapeutic progress.

Ownership of change.

A fourth evident tension concerned where the locus of change originated from. The therapists talked as if therapeutic enhancement came from themselves, rather than from the client's volition. However, when confronted, clients resisted this talk, claiming ownership for their own efforts to change.

This was a surprising tension given the claimed collaborative nature of cognitive therapy. The implication is that therapeutic efficacy may be enhanced by therapists emphasising the focus of change on the client, rather than themselves. For example, Garfield comments, "when individuals are allowed to examine and evaluate the rationality and coherence of their own beliefs, resulting cognitive changes are often more dramatic and enduring than when a didactic strategy is applied" (1988, p. 78). In other words, belief change may be more

straightforward and have more effect when client directed, rather than therapist mediated, and could easily be reinforced by shifting the focus of the talk.

CONCLUSION.

By focusing on what 'belief' was actually doing in the cognitive therapy domain, a picture of how beliefs were constructed and what they accomplished emerged. The findings tend to support the view that there are specific idiosyncratic aspects to belief, which are constructed and constituted in multiple repertoires and by various discursive strategies. This suggests a need for cognitive therapy to re-evaluate the notion of belief and its various uses. Hopefully, my insights and comments provide a better understanding of how belief is constructed in the various interactions within the cognitive therapy domain.

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