

THEORY AND PRACTICE IN THE COGNITIVE PSYCHOTHERAPIES: CONVERGENCE AND DIVERGENCE

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Cognitive therapy, linguistic therapy of evaluation, and constructivist psychotherapy display prominent points of both convergence and divergence at conceptual and practical levels. This article considers these comparisons and contrasts, focusing on their respective positions regarding their meta-theoretical models of human beings, science, and epistemology, as well as key aspects of their therapeutic stance, style, and strategic preferences. The resulting analysis suggests that these three contemporary approaches to cognitive therapy make distinctive contributions to clinical practice, adding to the richness of the field in different ways.

As the number of distinctive psychotherapies falling under the broadly “cognitive” rubric burgeons (c.f. Dobson, 2001), both the bewildered student and jaded veteran therapist might well ask, “How different are the nominally distinguishable forms of cognitive therapy *really*, at the level of actual clinical practice?” Beneath such a question may lie the hope or suspicion that the multiple variants on the cognitive theme actually offer mainly “old wine in new bottles,” repackaging familiar techniques by redesigning their labels more than their basic products. From a rather different vantage point, the cognitive therapy practitioner might seek sufficient differentiation at conceptual and practical levels to make some form of systematic eclecticism worth pursuing by

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borrowing from the novel insights and procedures of the various theories. Our goal in this closing commentary is to highlight points of both convergence and divergence in the three approaches to cognitively oriented therapy examined in the foregoing articles, as reflected in their respective approaches to the treatment of Gabriel. Supplementing earlier analyses of epistemological, philosophical, theoretical, and technical features of “rationalist” or “objectivist” cognitive therapies versus constructivist variants (Mahoney, 1991; Neimeyer, 1995), we will offer a few observations of a theoretical kind, and then concentrate principally on practical comparisons and contrasts among the three models. In this way we hope to extend similar case-based analyses of the distinctive contributions of various approaches to psychotherapy in general (Farber, Brink, & Raskin, 1998; Shostrom, 1966), as well as different cognitive psychotherapies specifically (Caro Gabalda, 2001; Cecero & Young, 2001; Nezu & Nezu, 2001; Wessler, 2001). Here we will comment briefly on several dimensions of comparison among our three approaches, providing a convenient summary of them in Table 1.

TABLE 1 A Brief Summary of the Main Points of Convergence and Divergence Among Cognitive Therapy (CT), Linguistic Therapy of Evaluation (LTE), and Constructivist Psychotherapy (CPT)

Position	CT	LTE	CPT
Theoretical Commitments			
The person as scientist	++	+	+
Logical empiricist philosophy of science	++	+	--
Use of map vs. territory distinction	+	++	--
Focus on language use as source of negative emotion	+	++	--
Practical Procedures			
Explicit socialization to therapy	++	-	--
Directive therapeutic stance	++	++	-
Self-monitoring via questionnaires	++	-	-
Intellectual style of intervention	+	++	--
Specificity of intervention	++	++	+
Use of homework in therapy	++	+	+
Efficient termination of therapy	++	++	+

NOTE: ++ = Agree strongly, + = Agree somewhat, - = Disagree somewhat, -- = Disagree strongly.

Theoretical Commitments

The Person as Scientist

One touchstone of commonality joining the three cognitive models featured in this series is their shared metaphor of the person as scientist, such that each focuses on Gabriel's attempts to interpret reality in order to try to make sense of it. A corollary of this stance, dating back to Kelly (1955), is that different individuals commonly impose quite different meanings on the same event, meanings that say as much about them as about the reality they hope to construe. Thus, Gabriel can be viewed as formulating an informal "theory" about the world—especially the social world—and his place in it. In each of the approaches it is these constructs and their emotional and behavioral implications that ultimately are the focus of intervention.

Logical-Empiricist Philosophy of Science

This conceptual convergence, however, masks important points of divergence among the three perspectives. First, Beckian cognitive therapy (CT) draws on the personal scientist model principally to sharpen the focus on the context of theory *testing*, whereas constructivist psychotherapy (CPT) emphasizes the process of theory *generation*, a distinction that has in other arenas been described as the "context of justification" versus the "context of discovery." Accordingly, a CT perspective marshals a host of procedures to pinpoint specific faulty thinking patterns to be tested and changed by an array of cognitive and behavioral techniques. In contrast, this rational and disputative stance is almost wholly alien to CPT, which would concentrate instead on both a broader survey of the structure and implications of Gabriel's primary role constructs (the Kellian emphasis) and a focal attempt to reveal the unconscious emotional truth of the meanings of his symptoms, with no attempt to invalidate them (the coherence orientation). In the terminology of the philosophy of science, CT seems to embody a positivist, logical-empiricist understanding of science in the first instance, as opposed to a more postmodern, hermeneutic one in CPT (Radnitsky, 1973). It is therefore not surprising that CPT has evolved in the direction of supplementing or supplanting the

person as *scientist* model with the metaphor of the person as *narrator*, drawing on personal, social, and cultural stories to organize life events and position the self as a protagonist relative to them (Neimeyer, 2004, 2006). This focus on the client's personal theory as a literary text to be deconstructed lends itself far less easily to techniques designed to correct distorted or unrealistic thinking than the belief-modification orientation that animates CT.

In relation to the philosophy of science, LTE (developed from general semantics within the field of cognitive therapy and therefore influenced by logical empiricism) could be placed mid-way between CPT and CT. For LTE (as for general semantics, described below) there is not a fixed, "objective reality." As with other cognitive models, LTE focuses on the process of knowing. In this sense, human beings know through evaluations ("emotion"—"reason"). As knowledge is related to abstraction and to language use, knowledge is seen as incomplete, inferential, private, and collective, never final or "valid" (Caro Gabalda, 2002a). Therefore, in LTE theories are not tested or validated empirically. LTE aims to effect a change on the patient's language or discourse. The goal is not the correspondence of what is said with an "objective," external "reality," but rather the recognition of the differences, and the establishment of a structural relationship between language and reality, between our "theories" and our "experiences." For LTE the work with patients' theories is deeply related to the structural difference between maps and territory.

Map vs. Territory Distinction

A further epistemological comparison that both bridges and distinguishes the three models is the explicit grounding of both LTE and CPT in the theory of general semantics (Korzybski, 1921, 1933) and its assumption that human beings live in a neuro-linguistic and neuro-semantic environment that clearly does not map onto the "real" world. Interestingly, however, the two approaches draw sharply different practice implications from this insight.

The map vs. territory distinction is fundamental to LTE. From one side, language (our map) tends to be a static, elementalistic tool, with a smaller degree of differentiation than the world of "events," or *what is going on* (WIGO; Bois, 1966), from which we

abstract what we call our “realities” and “facts.” That is, we interact and live in a world in process, with ongoing change, having a high degree of differentiation and variability. In therapy, patients are trained in being conscious of such differences and encouraged to understand their emotional problems as problems of knowledge that could be improved. As there are no “facts” free from doctrine (Korzybski, 1924), the existence of an objective knowable-as-is external “reality” independent of our “knowing” is not postulated (Caro Gabalda, 2002b).

Applying these assumptions to a therapeutic setting involves training patients in developing an extensional orientation that helps them to recognize the structural differences between the world of “facts” and the world of words. When we know a “fact,” we know it through our “theories,” abstracting processes, inferences, nervous system limits, and so on. The access to our “territories” is through our constructed maps. Therefore, the therapist repeatedly educates Gabriel about the structural distinction between the map and the territory to which it presumably refers. The therapist then engages him in a “general semantics debate,” different processes of abstraction, and an extensional discourse, to help him “evaluate properly” what is going on, rather than jumping to conclusions, labeling, or committing other forms of linguistic constructions not structurally adjusted to “facts.”

Although a Beckian approach to CT does not so explicitly draw on Korzybski as it is deduced from the conceptualization of the case, CT focuses on Gabriel’s faulty thinking patterns (such as his all-or-none thinking), to be detected and changed by different cognitive and behavioral techniques. Especially relevant for this conceptualization are beliefs such as, “I cannot tolerate discomfort” (measured through the Personality Beliefs Questionnaire; Beck et al., 2001). As part of the *socialization* to treatment, Gabriel learns that his thoughts and beliefs play a significant role in his suffering and avoidance patterns (Newman, 2010/this issue). Although CT does not typically talk about maps vs. territory, some explanations of Gabriel’s problems bring them closer to the other two perspectives. For instance, Newman will try to show Gabriel that his belief “I cannot do my work unless I am comfortable and I am certain that I will succeed” is not a fact (Newman, 2010/this issue). That is, the CT therapist teaches Gabriel that subjective beliefs are not synonymous with facts (Newman, 2010/this issue).

In contrast, CPT draws a different lesson from Korzybski—namely, that we have access *only* to our maps, not the territory itself, and accordingly we have no simple way of contacting a reality beyond our symbol systems to use as the guarantor of their validity. Rejecting the latter “doctrine of immaculate perception” (Mahoney, 1991), constructivists would argue that all human beings are ultimately cartographers, and that at best we can compare the features of our respective maps and where they tend to lead us. Thus, with Gabriel constructivist therapists would not so much look to correct the map of his subjective reality as to expand it and bring it into contact with other pages of his own atlas and those of other people. Stylistically, this tends to foster a therapeutic style that is much more exploratory than educational, as the therapist cannot make the assumption that he or she has the appropriate “lesson plan” to guide the interaction. If anything, the client is viewed as having the relevant expertise regarding the content of his or her meaning system, whereas the therapist simply brings to bear on this effort a hard-won expertise in the processes of change (Neimeyer, 2010/*this issue*). The result is a therapy that is less agenda-driven than responsive to often surprising discoveries that arise moment to moment in the therapeutic interaction.

Focus on Language Use as Generating Negative Emotion

Although all three orientations pay close attention to the client’s use of language, LTE is distinguished from the others by its strong emphasis on basic linguistic orientations as the source of problematic emotion. Specifically, in Gabriel’s case the client’s heavy use of an *intensional orientation* is the focus of treatment. For instance, in the case of Gabriel, anticipations (“I am going to fail”) and intensionalizations (“I must study without suffering”) were especially relevant and exemplify the main LTE tenet: We construe our experiences through language. For LTE, *anxiety* is specifically related to anticipating and to relying more on words/maps than on facts/territories.

In comparison, CT would understand Gabriel’s anxiety as less essentially bound to his use of language per se than to a repetitive cycle of negative thoughts plus corresponding avoidance coping, in an ongoing process of faulty thinking and behaving. Thoughts such as “I cannot do my work unless I am comfortable and I am

certain that I will succeed” inhibit Gabriel’s work, exacerbating his avoidance and interfering with his goals. Gabriel should be aware of some other faulty thinking, especially of the type of “I cannot do ‘x’ because of ‘y,’” as in, “I cannot tell my parents about my difficulties because it will be a disaster. I cannot study for my exam because I am tired and my heart is racing.” It could be inferred that a cognitive therapist would target many of the same verbalized self-statements identified by LTE, described in more common language terms (e.g., catastrophizing, all-or-nothing thinking). This could be misleading, as these kinds of evaluations are conveyed to patients in LTE as an explicit way of helping them to realize how they are using language to construe the world of “facts” rather than as correction of discrete “cognitive errors.”

Finally, classical CPT borrows from Kelly (1955) its conceptualization of negative emotion as a sign of pending or actual invalidation of one’s personal construct system. *Anxiety* is experienced when someone faces an event whose implications go beyond anything he or she can meaningfully anticipate or control. *Threat* poses the paralyzing perception of looming invalidation of our core sense of who we are. Thus, these emotional or transitional states can be seen as inextricably bound to our sense-making efforts, at levels that often reside beneath the level of public language per se. For example, Gabriel’s anxious anticipation of what is lurking in his vaguely defined future beyond college could be hard to articulate verbally without the therapist’s prompting him to visualize it more precisely. In doing so, Gabriel could also come into contact with some deeply held fears of what movement toward such a future might mean, in a way that reinforces his holding onto his symptomatic self-criticism and avoidance, despite their real costs. Dissolution of this “pro-symptom position” becomes feasible once it is fully conscious and juxtaposed to contradictory living knowledge in Gabriel’s own field of awareness. Although not overtly described in the CT treatment of Gabriel (Newman, 2010/this issue), CT could just as easily have involved the use of imagery exercises of the sort that encourage the client to explore his conceptualization of his future. Such an intervention would assist in formulating and clarifying Gabriel’s goals, stimulate a discussion about his feelings of hopelessness, and serve as a therapeutic exposure to thoughts about his future that Gabriel might otherwise wish to ignore.

In some sense, the three perspectives relate anxiety with the issue of *anticipation*, although they develop it differently. Anticipation was the main focus of Gabriel's linguistic treatment. The whole treatment was devised around problems of anticipation, helping him to focus on the here and now and dealing with life uncertainties (Caro Gabalda, 2010/this issue). Gabriel learned by heart this *nonanticipating orientation*. As he mentioned in his last session, he reached an important conclusion "to focus on the studying and to study. Do not jump to conclusions," an excellent description of this nonanticipating orientation.

Practical Procedures

Explicit Socialization to Therapy

Differences among the three orientations become immediately apparent from the first session, as the therapist conveys to the client directly or indirectly the methods by which they will be working. For CT this *socialization* to the cognitive model is an important issue and is even considered to be a cognitive technique in its own right (Leahy & Holland, 2000). Using a clear exposition of terms and examples, the therapist teaches the client to conceptualize distress in terms of interactions between problematic ways of thinking, feeling, and acting, patterns that are made explicit to the client as a part of standard treatment. For LTE, on the other hand, such explicit socialization to treatment is less common, and it rarely occurs at all in CPT. Instead, both consider the orientation to treatment to be part and parcel of the construction of the therapeutic relationship, such that mutual goal setting occurs naturally as the therapy progresses.

Directive Therapeutic Stance

All three therapies are active and collaborative in orientation, but they differ significantly in terms of how they implement this stance. The most evident of these differences is that whereas CT and LTE are directive and corrective therapies, CPT is not. According to Mahoney (1991) "the therapeutic relationship in rationalistic cognitive therapy entails technical instruction and guidance, while in the constructivist view it entails a safe, caring and intense context in and from which the client can explore and

develop different relationships with the self and world” (p. 244). We are not implying that CT and LTE do not provide a safe and caring context, but rather that this context takes the form of structured procedures that are educative and directive, in the sense that the client must come to understand the problem from a specific conceptualization that is communicated by the therapist at the beginning of therapy (see, for example, Newman’s comments and explanations to Gabriel, 2010/this issue). Nevertheless, both therapies insist on setting an appropriate atmosphere in the sense of establishing a good therapeutic alliance. No active and collaborative procedure could be implemented lacking this alliance. Bordin’s (1979) perspective on an alliance based on a bond and on agreement on tasks and means is explicit in LTE (see Caro Galbada, 2010/this issue), but it could be generalized to CT, as well. For instance, the “activity” of the CT treatment is explained to Gabriel with an air of optimism and a tone of genuine support (Newman, 2007). For CPT, the therapeutic relationship is also characterized by high levels of support but is much less oriented around the therapist’s agenda-setting for the session. Instead, a premium is placed on “leading from one step behind” (Ecker & Hulley, 2008), that is, responsively deepening and broadening the client’s attention to themes and issues that are emotionally resonant and relevant to an evolving understanding of the problem. Formulated differently, the CPT therapist may be *process-directive* but rarely *content-directive*, suggesting *how* they might proceed moment by moment while leaving to the client the determination of *what* particular patterns merit their attention. Although CT and LTE put relatively more emphasis on a formal content-driven agenda than does CPT, the process in CT and LTE is collaborative in that the client and therapist share the task of formulating the session’s areas of focus. Further, the agenda is flexible, such that the emergence of a high-priority topic (e.g., the client’s thoughts about dying) will necessarily become the chief topic of exploration regardless of its apparent goodness-of-fit with the heretofore agreed-upon agenda items for the session.

Self-Monitoring via Questionnaires

As a well-substantiated approach to therapy with a deep respect for evidence-based practice, CT commonly relies on a wide range of questionnaires both to identify a therapeutic focus and to

document client improvement over time. In Gabriel's case these could range from familiar measures of anxious and depressive symptomatology to the sorts of faulty thinking patterns assessed by the Personality Beliefs Questionnaire (Beck et al., 2001). Consistent self-monitoring with several of these measures could help Gabriel identify hopeful changes in his symptoms, as well as to detect and challenge cognitive processes that militated against improvement. In contrast, although symptom scales could be used to assess outcome in both CPT and LTE, such assessment is not integral to these approaches, which tend instead to rely on the therapist's reading of the process of therapy in the first instance and the client's use of language in the second to target material of relevance.

Intellectual Style of Intervention

In keeping with their respective positions on the nature of emotion, each of the cognitive models discussed here adopts a characteristic style of intervention marked by greater or lesser reliance on cognitive disputation, reasoning, or Socratic debate as core therapeutic techniques. In general, CT favors this more intellectual stance toward human problems, helping patients to detect their faulty thinking and schemata (such as Gabriel's "entitlement" schema) in order to develop more adaptive cognitions that will promote hopefulness and self-efficacy. Gabriel's therapeutic activities—such as self-monitoring of his automatic thoughts, use of "self-encouraging statements," testing of beliefs via behavioral experiments, and so on—are good examples of this style. It should be noted, however, that CT does favor the exploration and expression of emotions when clients are excessively constricted in identifying and communicating their feelings (see Newman, 1991). It is not clear that such a description fits Gabriel.

The perspective taken on this issue in LTE is somewhat different. LTE, like general semantics, avoids the distinction between "reason vs. emotion." LTE focuses on *evaluation*, a process that integrates both thinking and feeling. For example, LTE helps clients to attend to their nonverbal world of experiences (as in the first level of the *orders of abstraction* technique used with Gabriel; see Caro Garbalda, 2010/this issue) and then to proceed to higher or more verbal levels of abstraction.

Although LTE does not assume that reality is revealed via senses, its therapeutic work does consist of training clients to detect evaluations (verbal and nonverbal) and to develop a different kind of linguistic construction. LTE fosters a basic change in linguistic orientation, and does so using intellectual means, as the main LTE techniques used with Gabriel show (see Caro Garbalda, 2010/this issue).

In contrast, the intellectual style of intervention that features prominently in CT and LTE is eschewed by CPT. Instead, constructivist therapists gravitate strongly toward more experiential and emotion-focused change strategies the goal of which is less to challenge dysfunctional thinking than to broaden and deepen the client's awareness of the issues at hand, so as to "outgrow" the problems engendered by constricted constructions of self and situation. If anything, CPT encourages greater rather than lesser degrees of "abstraction" in the construing of the problem circumstance, contrasting somewhat with LTE, which helps patients follow a circular process of abstraction between nonverbal and verbal levels. For example, constructivists often join clients in elaborating trenchant metaphors that describe their problems and possibilities, as a means of "transcending the obvious" (Kelly, 1969) and approaching life in new and creative ways. The resulting therapy often has an intuitive, spontaneous character, more akin to a jazz improvisation than a music lesson or carefully rehearsed performance (Neimeyer, 2010/this issue). In comparison, cognitive therapists often try to enhance the psychoeducational aspect of therapy via stylistic use of therapist-offered metaphors, analogies, and hypothetical questions (Newman, 2000). The intention is to help clients think in ways that promote creative problem solving, novel and constructive conceptualizations of their problems, and improved memory for the contents of the therapy sessions that facilitate maintenance of therapeutic gains. LTE agrees with this CT emphasis and orientation, whereas CPT would be more apt to extend and explore the client's own metaphors as a therapeutic focus in its own right, rather than as a means of making the therapist's instruction or intervention more effective.

Specificity of Intervention

A common feature of all three approaches is that each adopts a therapeutic focus on specific circumstances in which the problem

is encountered but also intervenes at a more general level in accordance with its own conceptualization of the client's problems. CT focuses on directly reducing Gabriel's avoidance behavior, on decatastrophizing his anticipations regarding academic outcomes, and on boosting his confidence in coping with such symptoms in the future. CT could also pursue more general aims, such as helping Gabriel express himself, improve his relationships, or feel more empowered. Such changes might be conceptualized as moving beyond a focal attention to automatic thoughts cued by engagement with the problem situation to the goal of changing Gabriel's main schemata, such as his sense of *entitlement* or *incompetence*. However, as Newman notes, the goal is not to remove all symptoms.

In somewhat parallel fashion, LTE focuses on helping Gabriel diminish his performance-related anxiety and depressive symptoms while addressing the issue of his orientation toward language. That is, the main aim of LTE is to foster the client's ability to develop different and more extensional kinds of evaluations (Caro Gabalda, 1999). If, it is assumed, this extensional orientation is developed, then symptoms will disappear or diminish. Specific aims with Gabriel, for instance, were to help him to stop anticipating (jumping to conclusions such as, "I am not going to have a good schedule"), resolve his identifications ("I am a lazy person"), and change his absolutistic discourse (intensionalizations, use of words as "always," "never," "must," etc.). The more relevant aim was helping Gabriel to *focus on the here and now*, rather than anticipating.

Finally, CPT's implementation of this stance entails highly specific attention to the client's construction of the meaning of the focal problem—as revealed through radical questioning, focusing, visualization, and other procedures—followed by broadening of attention to other horizons of the client's life in which thematically similar struggles may emerge. For example, Gabriel's tacit assumption that boldly moving into full adulthood would entail exposure to scorn and rejection might prove to have relevance well beyond his relationship with his father, and could be reflected in tendencies to limit communication of vulnerable feelings or other forms of withdrawal in a variety of social arenas. Conversely, the CPT therapist might begin with a broad-based narrative assessment such as the self-characterization or quantitative

assessment such as constructing a map of his relational world using a grid technique, and then use these to focus attention on specific themes or patterns that merit exploration or are of interest to the client. Thus, in unique ways, each of the approaches endorses a flexible focus that situates the initial complaint within a more general concern with the client's system of meaning and language.

Use of Homework in Therapy

A further technical comparison among the three approaches concerns the use of homework, between-session tasks negotiated by therapist and client. In keeping with its active, directive orientation, CT makes extensive use of such assignments, from bibliotherapy to various forms of cognitive and behavioral self-monitoring and self-change techniques. Ultimately, even behavioral tasks serve cognitive goals, as the assignment for Gabriel to monitor his attendance in a difficult class can also produce a clear record of his thinking patterns when confronting this problem situation. However, CT also tends to view mastery of difficult experiences via repeated exposure as itself a curative mechanism of therapy, so that therapy commonly tacks from interventions that have a cognitive to a behavioral focus and back again in a positive feedback loop (Newman & Fingerhut, 2005). In summary, it is fair to claim that homework is considered intrinsic to traditional cognitive behavior therapies (Kazantzis & L'Abate, 2006).

In comparison, LTE typically requires only a record of thoughts and emotions in specific situations with the aim of identifying the main intensional orientation of the client, although linguistic assignments (applying out of session LTE techniques) differentiate somewhat across the course of treatment. This follows from a key assumption of general semantics (Korzybski, 1921), that human beings function as a whole, and accordingly that a fundamental change in linguistic orientation encourages patients to behave in different ways and to resolve previously avoided or difficult situations. Therefore, from the LTE perspective there is no need to involve patients in specific behavioral tasks and role-playing.

CPT is likely to be the least prescriptive in this regard, with fewer expectations regarding the outcome of various assignments.

Instead, as in coaching Gabriel to enact a hypothetical identity in daily life and report what he learns and observes, or in encouraging him to read a written statement of his PSP in the relevant problem context, the constructivist therapist mainly is seeking to enhance the client's awareness of the constraints and entailments of his or her (typically unconscious) constructions of self and situation. These and myriad other homework assignments represent selective embellishments of constructivist psychotherapy, however, rather than essential features (Neimeyer & Winter, 2006).

Efficient Termination of Therapy

When is a patient ready for the end of treatment? CT is very specific about this crucial decision point, using both questions put to the client in therapy and the use of outcome measures to evaluate completion of target goals. LTE accords with this general stance, attending to client comments about the utility of therapy and the achievement of aims, the kinds of extensional evaluations shown and maintained, as well as responses to formal outcome measures. Finally, CPT also endorses a principle of therapeutic sufficiency: doing just enough, but no more than required, to allow the client to move forward again with life in more satisfying ways. Although formal outcome assessment may help confirm this, the more basic evaluation is the client's sense that "enough is enough," an evaluation that is commonly invited at the end of most sessions. That is, just as constructivist therapists may optimistically open a session with a question such as, "What do you feel ready to do today?" or "If this session were to be helpful to you, what would we need to accomplish?" so too they might end a session by asking, "Do you feel that you've achieved what you came in to achieve, or do you think that scheduling another session with me would be helpful?" (Neimeyer, 2010/this issue). Of course, there are cases in which presuming some continuity of therapy is indicated to enhance the client's sense of security to tackle difficult ongoing issues, but CPT would suggest that this be decided on a case-by-case basis, rather than by default. When graduation from therapy is indicated, a celebratory stance that reviews progress and recruits an audience for the client's new learning and achievements is commonly adopted, in keeping with the practices of narrative therapy (Epston & White, 1995).

Convergence and Divergence: The Three Models' Contributions

What, in light of our review, could be emphasized as significant convergences and divergences between these three approaches to cognitive psychotherapy? Each model offers a diversity of concepts and procedures that overlap only partially with those of the others, enticing eclectic practitioners with the prospect of an expanded toolbox by including attractive ideas and techniques derived from each. A close examination of the comparisons in Table 1 suggests remarkable similarities and divergences. That is, all of the approaches share some features, such as mutual reliance on a person-as-scientist model, a flexible focus, an active stance in therapy that finds expression in the use of homework, and a movement toward efficient conclusion of therapy as the work is completed. However, it is equally clear that there are numerous points of divergence, many of them serious and deep, such as the underlying philosophy of science endorsed by the different models of therapy, their acceptance or rejection of realism, and their therapeutic stance and style as revealed by sharply contrasting procedural preferences. On close inspection it seems clear that, whereas CT and LTE display a more general agreement on practical procedures, although with varying levels of endorsement, on most positions CPT frequently dissents on both theoretical and technical grounds from the others, whereas LTE is midway on theoretical commitments between CT and CPT.

What, then, do these observations imply about the further development of these three approaches? First, they suggest that each will likely continue to develop its own tradition of research and practice, diversifying, disseminating, and documenting the efficacy of its own methods in contexts of training and research. As a mature tradition, CT is, of course, far along in such development, with myriad procedures enjoying a strong evidence base and variations on its basic methods being tailored to a vast range of presenting problems (see Butler, Chapman, Forman, & Beck, 2006, for an extensive review of meta-analyses). In comparison, CPT weaves together numerous distinctive traditions of therapy, including not only personal construct and coherence models but also humanistic, experiential, emotion-focused, narrative, social constructionist, and feminist approaches that share a broadly postmodern philosophy (Neimeyer, 2010/*this issue*; Neimeyer &

Mahoney, 1995; Neimeyer & Raskin, 2000). Like CT, CPT has enjoyed several decades of development and refinement, and accordingly also has generated a vast set of methods, which have received general support when evaluated for their efficacy (e.g., Greenberg, Watson, & Lietaer, 1998; Holland et al., 2007).

Gabriel's treatment (Caro Gabalda, 2010/this issue) from the perspective of LTE focuses in this special issue on the *original contribution* of LTE to the field of cognitive therapy. That is, Caro Gabalda's article describes the techniques that (based on general semantics) represent the main linguistic techniques and LTE's special flavor. However, as with the other two perspectives, any therapist using LTE could add other techniques to this model, as general semantics could nicely fit with different therapeutic approaches (Basescu, 1979/2002; Bateson, 1972/2002; Ellis, 2002).

The first LTE publication is dated 1986 (Caro Gabalda, 1986). Since then, LTE has been conveyed primarily at theoretical and practical levels, with group and case studies documenting its unique features, mixing outcome and process studies (i.e., Caro Gabalda, 1992, 1997, 1999, 2001, 2006, 2008). Process studies represent a logical next step toward the documentation and dissemination of this cognitive therapy variant. In summary, the three approaches to cognitive psychotherapy explored and illustrated in this special series reflect enough conceptual commonality to make selective cross-fertilization possible, but also enough divergence to militate against their assimilation into a single therapy. Therefore, it is safe to predict that each approach will continue to attract adherents and make a distinctive contribution to the future practice of cognitive psychotherapy.

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