Disappearing Differences Do Not Always Reflect Healthy Integration: An Analysis of Cognitive Therapy and Rational-Emotive Therapy

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A prominent strategy for psychotherapy integration is the extraction of principles of change commonly represented in therapy systems, on the premise that points of agreement should be especially powerful (Arkowitz & Hannah, 1989; Frank, 1961, 1982; Goldfried, 1980). An earlier review concluded, however, that factors identified to date are not common in a sufficiently meaningful sense to facilitate research (Haaga, 1986). In particular, the common factors approach requires a common language of psychotherapy, which may be attainable only by glossing over different theoretical meanings by using somewhat ambiguous terms (Messer, 1987).

However, some advocates of the common factors position consider identification of commonalities only a first step in devising research priorities (Goldfried & Safran, 1986). A needed second step is the delineation of more specific disagreements. For example, both behavior therapists and client-centered therapists consider providing clients feedback an important factor in therapeutic change. They differ substantially, though, on the main techniques for, and foci of, this feedback (e.g., in vivo self-monitoring of target behaviors vs. in-office reflections of feelings; Goldfried, 1991; Wilson, 1982).

The purpose of this paper is to illustrate the potential value of deriving research questions through emphasis on these specific differences by examining psychotherapy integration in cognitive-behavioral therapy (CBT). Our thesis is that an informal common-factors integration of two major systems of CBT [rational-emotive therapy (RET; Ellis, 1962) and cognitive therapy (CT; Beck, 1964)] is well underway, but that more fruitful would be a reemphasis on distinctions between the approaches.

DISTINCTIONS BETWEEN RET AND CT; A DISAPPEARING ACT

This section summarizes some of the main differences between CT and RET (Dryden, 1984, gives a more exhaustive account). These distinctions have been disappearing, but not as a result of new theoretical understanding nor of empirical tests indicating that one or the other position was correct.

Goals and Expectations

RET distinguished itself by stipulating as a goal self-acceptance, rating one's behaviors but not one's self (e.g., Boyd & Grieger, 1986). CT writings sometimes endorse this RET position (e.g., Beck, Rush, Shaw, & Emery, 1979, pp. 266-268), but it is not a consistent emphasis. CT theory more commonly appears to support a goal of high self-esteem. For ex-
ample, to operationalize the view of self, Beck employs the Beck Self-Concept Test (Beck, Steer, Epstein, & Brown, 1990), which clearly reflects self-esteem (e.g., by including an item calling for a rating of one’s personality from "more than nearly anyone" to "less than nearly anyone"). Unfortunately, even RET researchers generally ignore this distinction, measuring self-esteem but not self-acceptance in outcome studies (Haaga & Davison, 1989a).

Moreover, RET was said to adopt originally a more optimistic view of the ultimate potential of human development, postulating an inherent self-actualizing tendency similar to that depicted by humanistic theorists (Bernard & DiGiuseppe, 1989). CT theory was silent on the possible existence of such a mechanism (Dryden, 1984). However, Ellis (1987a) seems to have recanted any especially optimistic viewpoint on human potential, citing a universal, purportedly biological, tendency toward irrationality.

Levels of Dysfunctional Thinking

Second, RET holds that the most critical dysfunctional cognitions are absolutistic evaluations and philosophical tenets, beliefs about the significance and implications of events (the “B” in the familiar “ABC” model). CT, on the other hand, emphasizes inaccurate inferences, misperceptions of the descriptive nature of activating events (the “A” in the ABC model; Rorer, 1989; Walen, DiGiuseppe, & Wessler, 1980). Consider a socially phobic patient expecting that others would disapprove of her or his behavior at a party. A CT therapist might begin by challenging the evidence that the patient’s behavior indeed evokes disapproval. RET, on the other hand, would favor an initial attempt to dispute the patient’s implicit belief that it is necessary to avoid disapproval; the accuracy of the patient’s interpretation of the event itself is seen as less important. The patient might even be encouraged to act deliberately in such a way as to garner disapproval, in order to learn firsthand that it can be tolerated by changing the irrational belief in need for approval. Changing the perception of this event without changing the irrational belief (that is, deciding that approval is still proval, in order to learn firsthand that it can be tolerated by changing the even be encouraged to act deliberately in such a way as to

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Primary and Secondary Problems

Third, RET originally was more clear in distinguishing discomfort disturbance or secondary problems (Ellis, 1986) from primary emotional and behavioral problems. That is, a prominent feature of psychopathology in RET theory is the tendency to be intolerant of frustration and other negative emotions. For example, someone might he sad about unfortunate circumstances, but also might compound and prolong the problem by feeling self-pity about this negative emotional state, thus creating discouragement and depression about the original, primary sadness (Ellis, 1987b).

The idea that CT does not take secondary problems into account, though, has become obsolete. Recent work on “depression about depression” highlights a secondary problem as an essential early target in CT for depressed patients (Fennell & Teasdale, 1987; Teasdale, 1985). Likewise, CT for panic (Beck & Greenberg, 1988; Clark, 1986) is predicated on the view that successful treatment requires targeting the patient’s fear of innocuous physical symptoms (usually anxiety symptoms) themselves. Treatment is incomplete if the patient learns only coping skills to reduce anxiety; he or she must learn also that even panicking and losing control is not an unacceptable catastrophe to be avoided at all costs.

Style and Pace

Finally, there were clear contrasts in the preferred style and pacing of interventions. Beck et al. (1979) recommended that the CT therapist not
be very didactic. Extensive use of Socratic questioning, rather than lectures, is believed to model a skeptical, data-based approach to life and to facilitate inductive reasoning. Also recommended are the use of ostensibly less pejorative terms for patient s cognitions (e.g., “unproductive” rather than "irrational" or "nutty"), and greater emphasis on traditionally valued qualities such as warmth and genuineness. In a very Rogerian vein, Beck and Young (1985) claimed that "the most effective cognitive therapists seem to be especially skilled at seeing events though the patient's perspective (accurate empathy)” (p. 208).

In terms of pacing, CT advocates beginning with an elaboration of the patient's frame of reference. This would include, for instance, determining what evidence she or he might have in support of a negative thought. Having had a chance to present her or his case and feel understood, the patient might then be more willing to examine collaboratively anomalous evidence. In contrast, Ellis argued that quite directive interventions are necessary and can begin very early in therapy. He sees it as a common mistake to be insufficiently forceful with patients (Ellis, 1983) and contends that methods based on gradualism (e.g., gradual exposure to a hierarchy of feared situations) inadvertently reinforce the dysfunctional belief that discomfort is dangerous and intolerable (Ellis, 1986).

It has become clear, though, that RET emphases on a rapid, forceful style of intervention are routinely rejected by writers who remain theoretically affiliated with or friendly to RET (e.g., Bernard, 1981; Goldfried & Davison, 1976; Johnson, 1980). Further eroding these stylistic distinctions, survey data suggest that the majority of experienced RET practitioners disagree with Ellis s contention that "excessive therapist warmth reinforces unhealthy beliefs about the need for approval, and 47% disagreed with his view that "forceful persuasive disputing is usually more effective than more subtle, perhaps indirect disputing” (Warren & McLellarn, 1987, p. 85).

The RET hypothesis that gradualism reinforces discomfort anxiety remains a clear theoretical contrast; for example. CT for panic disorder (Beck & Greenberg, 1988) incorporates gradual in vivo exposure to previously avoided situations. This distinction could support interesting research on mediation of RET outcomes [e.g., Does RET lower anxiety sensitivity (Reiss, Peterson, Gursky, & McNally, 1986) and help patients avoid self-criticism about recurrent anxiety symptoms after treatment?]. To date, however, such research has not been reported (Haaga & Davison, 1989b).

To summarize, several theoretically based distinctions between RET and CT have become similarities, and remaining contrasts are potentially testable but have been ignored when outcome studies are designed.

We believe keeping in mind the original distinctions listed above could be highly valuable. Overgeneral definitions (e.g., RET is everything in CBT) and research questions (Is RET superior to "placebo"?) are unlikely to yield new knowledge and more comprehensive theory. Specifying the exact implications of subtle differences between these treatment models might. That is, it might be more heuristic to sharpen RET-CT distinctions than to blur them further. To achieve this aim, it might be useful, in a theoretically integrative vein, to consider a framework that can subsume RET and CT, and suggest conditions under which the differential aspects of each would be appropriate. CT theory itself is unlikely to meet this need because it makes no pretense of incorporating the unique aspects of RET. RET, on the other hand, purports to be capable of incorporating unique aspects of CT under the rubric of "inelegant" (Ellis, 1980) or "general" (Dryden & Ellis, 1988) RET. This position is conceptually problematic, however, because no guidelines other than trial and error are provided for determining when the specialized vs. general RET strategies and techniques would be indicated (Haaga & Davison, 1989b).

More promising sources of guidance might be found in basic psychological theory and research. Along these lines, Rorer (1989) stated that "we . . . need from cognitive psychology (including cognitive-social psychology) a theory of the way in which beliefs are formed and changed, and the procedures for implementing the theory in practice” (p. 542). We consider as potential answers to this need two social cognitive models, lay epistemology and self-discrepancy theory, with no pretense of being exhaustive.

Lay Epistemology

The theory of lay epistemology was advanced by Kruglanski (1980) as a general account of the logical and motivational bases on which people form or change beliefs. It has been applied to the special case of belief change in psychotherapy by Kruglanski and Jaffe (1988) and Murphy (1985). Murphy's (1985) three-dimensional taxonomy of interventions aimed at belief change is particularly clear in illustrating this application. The dimensions include the following:

I. The source of "epistemic authority ” for a proposed belief change. According to the theory of lay epistemology, "knowledge . . . is inevitably biased” (Kruglanski & Jaffe, 1988, p. 256) in that any array of
Factory progress toward it given existing personal skills), a means shift of one fail to satisfy a subjectively important goal. Broadly speaking, directions people in distress suffer because they believe they have failed or will or their validity (Is the belief accurate?), and consensus-authority (relying on the modal opinion of a group, such as the family, therapy group, or peer group).

2. The motivation to change a belief. Beliefs can be challenged with respect to their utility (What are the consequences of holding this belief?), their logical consistency (Does this belief fit with other beliefs you hold?), or their validity (Is the belief accurate?).

3. The type of therapeutic shift desired. The theory assumes that people in distress suffer because they believe they have failed or will fail to satisfy a subjectively important goal. Broadly speaking, directions for changing such a belief could include an assessment shift (reappraisal of one’s standing relative to the goal or the likelihood of making satisfactory progress toward it given existing personal skills), a means shift (developing new skills needed to reach the same goal), or a goal shift (reconsidering the goal).

Probably all of the combinations derivable from these three dimensions are used at some time or other by practitioners of RET or CT. Still, one’s predominant conceptual scheme can guide these choices in many instances. RET theory implies favoring goal shifts driven by logical consistency challenges (perhaps after a motivational phase of challenging utility), and supported by self-authority or especially expert authority. CT theory implies preferring assessment shifts driven by validity challenges and supported by self-authority.

One contribution of the theory of lay epistemology to integration in CBT could be in highlighting underutilized sources of belief change, for example, the relatively neglected consensus authority for belief change (viz., social support interventions). The theory suggests, in other words, that there may be exceptions to Bandura’s (1977) widely accepted dictum that the most convincing learning nearly always stems from personal experience in the form of behavioral enactments.

Moreover, highly practice-relevant research on individual differences in response to the preferred intervention styles of each CBT (if these are distinguished) could be conducted within the lay epistemological framework. For example, Wessler (1988) claimed that

some people do not respond to ... logico-empirical disputing ... because their knowledge is not based on empirical evidence ... [Their] thinking is more conventional and less reflective, or preconventional and based on tradition and the dictates of authority ... Cognitive change in such cases depends on the therapeutic relationship and the willingness of the person to trust and accept the expertise of the therapist. (p. 152)

This implies that specialized RET disputation would most benefit those patients who particularly value logical consistency of beliefs. Research on this idea could provide a blueprint indicating when and for which patients aspects of specialized RET would be useful.

To our knowledge no data yet exist to link lay epistemologies with outcome in RET or CT, but a study of preferences for diverse therapy styles is suggestive. Nonclinical subjects whose scores on a self-report measure of general epistem style suggested a strong commitment to rationalism, which emphasizes deductive reasoning and “involves testing the validity of one’s beliefs in terms of their logical consistency” (Lyddon, 1989, pp. 423-424), reacted more favorably to a description of RET than to alternative therapies.

Self-Discrepancy Theory

Self-discrepancy theory contends that “it is the relations between and among different types of self-beliefs ... that produce emotional vulnerabilities rather than the particular content or nature of the actual self or of any other individual self-belief” (Higgins, 1989, p. 94). In particular, the theory identifies two vantage points on the self (one’s own and the standpoint of a significant other), each of which may be combined with three types of selves: (a) the actual self, your mental representation of the characteristics you or someone else thinks you possess; (b) the ideal self, your representation of the quantities that you or a significant other would like you ideally to possess; and (c) the ought self, your representation of what you or a significant other believes you should be like.

The theory contends that people are especially vulnerable to sadness or depression if they show a large discrepancy between the actual/own self and the ideal/own or ideal/other self. In other words, if what you think you are actually like falls far short of the ideal qualities to which you aspire (or that you think a significant other wishes you could attain), you are apt
to feel dejected. Conversely, people are vulnerable to anxiety, or more generally "agitation-related problems" (Higgins, 1989, p. 97), if they show a large discrepancy between the actual/own self and the ought/own or ought/other self. This may be translated as perceiving one’s attributes to "not match the state that she or he personally believes it is his or her duty or obligation to attain or believes some significant other person considers to be his or her duty or obligation to attain (Higgins, 1989, p. 97).

Research has substantiated the predictions that (a) depressed patients show especially large actual/ideal self-discrepancies while patients diagnosed as socially phobic had greater actual/ought self-discrepancies (Strauman, 1989); and (b) actual/ideal discrepancies add to the prediction of self-esteem beyond what can be gleaned from asking subjects only what they believe they are actually like (Moretti & Higgins, 1990). Thus, there is some empirical basis for accepting discrepancies among self-representations as a meaningful psychological construct, as well as the idea that different emotional states relate to different types of self-discrepancies.

From the standpoint of self-discrepancy theory, perhaps specialized RET, when successful, would have its greatest impact on the "ought self. That is, calling into question the various shoulds, oughts, and musts by which we sometimes guide ourselves might be expected to reduce the level of demands exacted by the ought self, leaving the ideal self and actual self essentially intact. As noted earlier, specialized RET is unlikely to dispute a patient’s cognitions regarding what she or he is like (actual) or prefers that she or he could be like (ideal), but only the accompanying absolutistic demands that one should possess these qualities (ought). By contrast, some of the main techniques of traditional CT (e.g., conducting in vivo tests of hypotheses about oneself and one’s behavior in order to evaluate their accuracy) seem to be attempts to bolster the patient’s perception of her or his actual self and perhaps thereby bring it into closer agreement with the "ideal self."

If the foregoing interpretation is valid, we might expect CT to be especially useful in the treatment of disorders characterized by high actual/ideal self-discrepancies (e.g., depression) and RET to be especially useful in the treatment of disorders associated with high actual/ought self-discrepancies (e.g., social phobia). Outcome studies of CT for depression and of RET for social phobia are generally consistent with this expectation (for reviews, see Dobson, 1989; Haaga & Davison, 1989a). To be sure, previous research has not included the measures and analyses needed to evaluate directly the hypothesis that reduction of particular self-discrepancies underlies beneficial effects in CBT. This interpretation of the differential utility of CT vs. specialized RET is, of course, highly speculative, yet it is testable.

We are optimistic that basic theory and research on the formation and change of beliefs can shed light on the efficient application of differential aspects of RET and CT, but we are not so delusional as to think that the step from basic social/cognitive theory to improved therapy outcomes is a short, simple one. Accordingly, we next address some of the possible pitfalls to be encountered.

1. Applying lay epistemology or self-discrepancy theory to the prescriptive choice of RET vs. CT for types of patients rather than particular beliefs at particular moments may be an overgeneralization. Our prescriptions assume a trait-like quality to self-discrepancies (some patients have actual/ideal self-discrepancies, others actual/ought) or epistemic authorities (some trust logic, others experience) that may not be justified. These characteristics may instead be context specific (e.g., I trust the evidence of my experience with respect to work, the expertise of my peers regarding relationships) or temporally unstable. Underscoring this concern is the modest test reliability of measures of self-discrepancies (.39 to .53 over a 4-6 week period) reported by Moretti and Higgins (1990). Alternatively, self-discrepancies and epistemologies might be cross-situationally consistent and temporally stable, but show such high comorbidity that differential treatment prescriptions would rarely be possible. For example, just as psychiatric syndromes often co-occur (e.g., Sanderson, Beck, & Beck, 1990), so too a large proportion of patients might show several types of self-discrepancies (e.g., actual/ideal and actual/ought).

2. Our metatheory of patient-treatment matching might be wrong. Our application of lay epistemology to RET and CT was predicated on identifying areas of familiarity and strength for patients (e.g., If you respect the credibility of logical consistency, you should find RET simpatico), whereas our application of self-discrepancy called for eradication of weaknesses (e.g., If your greatest dysfunction is an actual/ought self-discrepancy, then RET’s attack on the ought self should reduce this problem). Many speculations about patient-treatment matching implicitly assume that one gets best results by matching treatment components to patients’ deficits (focus on social skills for socially awkward patients, on cognition for skilled but self-critical ones). This metatheory, dubbed the “compensation” model (Cronbach & Snow, 1977), may seem self-evidently correct; its utility goes without saying in other realms of intervention. Who would take their car to be repaired by someone who said, “Well, your tire is flat, but I would rather work with the battery, since that is a strong point of Hyundai”? Nevertheless, empirical research on patient-treatment matching in psychotherapy sometimes supports compensation (e.g., Michelson, 1986), sometimes a
"capitalization model" of focusing on patients' strengths (e.g., Rude, 1986). Alternatives to choosing one or the other model include blends of the two. Arnkoff (1981) advocated beginning with methods that draw on clients' strengths and are consistent with their expectations for therapy, as a way of facilitating trust, then using this trust as a base from which to push the client to work on weaker areas and thereby maximize long-term change.

3. The theory and metatheory could be correct, but current RET and CT techniques might not work in the hypothesized manner. Even if, for instance, a patient shows consistently high actual/ought self-discrepancies, and long-term therapeutic change is best accomplished by compensating for this deficit, RET disputations might not be specifically effective in doing so. Assumptions about what areas of functioning are specifically affected by what treatment techniques have not always fared well empirically (e.g., Haaga et al., 1991; Imber et al., 1990).

4. Even if the theory and metatheory are correct, the techniques specifically effective as predicted, demonstrating this in a convincing manner will be difficult. For practical reasons, most treatment outcome studies use small sample sizes, which renders them inadequate in terms of statistical power for documenting modest effects (Kazdin & Bass, 1989). In the present case, there is little reason to believe, for instance, that an advantage of RET or CT for subsets of patients would be huge. Research on patient-treatment matching in psychotherapy suggests that such effects are usually small (Dance & Neufeld, 1988), although some reviewers remain optimistic that more conceptually informed, methodologically sound research will yield greater fruit in this area (Beutler, 1991; Smith & Sechrest, 1991). Effects accounting for small proportions of the total outcome variance are not necessarily unimportant (Abelson, 1985; Rosnow & Rosenthal, 1989), but they can be detected as statistically reliable only with large samples.

In view of the hazards just listed, we take the unusual position of recommending that no one currently apply our suggestions in clinical practice (“Do not try this at home”). Leaping directly into application from basic social psychological research would omit too many necessary steps in the development of an empirically informed clinical practice (Wilson, 1981). It would be more sensible to conduct research testing some of the assumptions in our chain of reasoning (e.g., evaluating the cross-situational consistency of epistemological predilections, evaluating in analogue studies the impact of differential RET and CT techniques on people with varying self-discrepancies). Such a piecemeal approach could enable us to fine-tune weak points (e.g., by modifying aspects of a belief-change technique) before conducting large-N comparative outcome studies looking for aptitude-treatment interactions. If we instead leap immediately to the latter stage, we run a grave risk of discouragement that might unnecessarily short-circuit a potentially useful line of inquiry. Rather than swing for the fences, let us try the less exciting but more probable feat of hitting a ground ball to the right side to move the runner over.

CONCLUSION: CASE STUDY IN CONTEXT

We examined differences between two cognitive-behavioral therapies, RET and CT, noting that the main differences are ignored in research or are disappearing through an informal process of cross-fertilization between the approaches. Our goal was to articulate and rationalize a belief that healthy integration might depend as much on appreciating differences of emphasis in current systems (Wachtel, 1987) as on distilling commonalities (Goldfried, 1980). Where commonalities can direct attention to powerful basic principles (e.g., the importance of changing tacit beliefs), research on sharpened distinctions as to how these principles are best actualized can set the stage for more adequate integrative theorizing.

The question arises as to how our argument fits in the larger framework of integrative strategies. As noted in the introduction, we see our emphasis on distinctions as offering a needed complement to “common factors” positions that downplay or minimize differences, and as exemplifying the position advocated by Goldfried and Safran (1986). Besides the common factors approach, taxonomies of integrative and eclectic systems (e.g., Arkowitz, 1989) generally include (a) technical eclecticism (Beutler, 1983; Lazarus, 1967; 1989), the importation into one’s own clinical work of techniques demonstrated in other orientations to be effective, but without attempting to integrate them at the conceptual level (see Note 2); and (b) conceptual integration of aspects of apparently opposed therapeutic systems (e.g., Messer, 1983; Safran, 1990; Wachtel, 1977). We see our suggestions as unlike conceptual integration in that we are leaving specialized RET and CT more or less intact, and suggesting ways of identifying for whom each might best be prescribed, as opposed to deriving a consistent, coherent approach that would then look different from either of its conceptual parents. Our position overlaps with technical or prescriptive eclecticism for this very reason, that we are suggesting different strokes for different folks.

On the other hand, another contrast sometimes offered between technical eclecticism and conceptual integration is that whereas the latter relies on organizing theory, the former eschews “the syncretistic muddles that arise when attempting to blend divergent models into a super-organizing theory” (Lazarus, 1986, p. 67). On this dimension we side more with the conceptual integrators, for it is explicitly theory(ies)
we are using to derive prescriptive recommendations concerning RET and CT.

This partial indeterminacy in locating our views may stem from overlap among the three major types of integration just noted. In particular, the centrality of theory in various strategies of eclecticism/integration may be more a matter of degree than is implied by this taxonomic scheme. In discussing Lazarus's technical eclecticism, for instance, Messer (Lazarus & Messer, 1991) argued that the theory-free "facts" Lazarus purports to rely upon before importing a technique from a different conceptual framework are inextricably tied to that other theoretical framework. This hermeneutic, social constructionist epistemology (e.g., Davison, 1991; Gergen, 1982; Mahoney, 1991; Messer, Sass, & Woolfolk, 1988) would gainsay Lazarus's assertion that a technique can be plucked from an orientation other than one's own and then applied as if it would be able to enjoy whatever empirical support it had in the original framework. As Messer poetically puts the Kuhnian (Kuhn, 1962) metatheory, there is no "Immaculate Perception."

ENDNOTES

1. And yet Ellis does not ignore social realities. Strictly behavioral aspects of RET, present from the start (Ellis, 1962), have the therapist focus as well on how the client interacts with his or her social environment with at least the implicit goal of changing the person's intercourse with that environment so that, in addition to the person catastrophizing less when things go awry, events will become increasingly favorable and the client will appreciate them as such.

2. Technical eclecticism seems to have supplanted simple eclecticism as a favored "orientation." The latter has been roundly criticized over the years because it lacks a theoretical rationale for guiding the therapist's borrowing of techniques. "Use whatever works" is still the operating principle, but technical eclectics rationalize this use on the basis of a systematic theory into which the borrowed technique can be placed. Without theoretical guidelines—and Lazarus's (1976) own "multimodal therapy" is mainly a cognitive-behavioral approach drawing on social learning theory—to help the therapist conceptualize the client's problem and the processes of therapeutic change, eclecticism is but one step away from chaos, whereby choices are made on the basis of whim, personal preference, or "what feels right" (Davison & Neale, 1990).

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Disappearing Differences and Integration


