

An Appraisal of Rational–Emotive Therapy

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Albert Ellis's rational–emotive therapy (RET) is scrutinized on several conceptual and empirical grounds, including its reliance on constructive assessment and its ethical stance. Its professional impact thus far exceeds its scientific status. Opinion varies on how even to define irrational beliefs; 1 consequence is problems in assessing them. Meta-analytic reviews provide support for the general utility of RET, but more qualitative reviews question both the internal and external validity of much of the published research. Lacking are process studies that can shed light on the mechanisms of therapeutic change, a situation likely due to the complexity of RET and to a lack of consensus as well about its very definition. Perhaps more progress can be achieved by forsaking studies of RET as a package and shifting instead to examination of specific therapeutic tactics in particular circumstances.

Rational–emotive therapy (RET) was developed by Albert Ellis in the 1950s in response to his dissatisfaction with the effectiveness and efficiency of psychoanalysis (Ellis, 1957, 1962). RET is based on an “ABC” theory of psychopathology, the core premise of which is that activating events (A) do not directly cause emotional and behavioral consequences (C). Beliefs (B) about these events are instead the most critical causes of feelings and actions. If one adheres to rational beliefs (defined by Ellis as those that promote survival and happiness, are likely to find empirical support in the environment, and express preferences), then difficulties and losses will lead to “appropriate” negative emotions such as sorrow, annoyance, or regret. If one holds irrational beliefs (those that are unlikely to find empirical support and reflect “musts” and demands; e.g., “I must do well and win approval, or else I rate as a rotten person”; Ellis & Bernard, 1985), then setbacks will lead to “inappropriate” negative emotions such as depression, anxiety, and extreme anger.

Rational–emotive therapists attempt to teach patients to forcefully dispute their irrational beliefs. Disputation can involve questioning the evidence for the belief or the utility of holding it, questioning catastrophic implications the patient may have drawn about her or his situation, or demonstrating that the belief is illogical (e.g., if there is no valid measuring instrument for human worth, how can a person be said to be completely worthless? [DiGiuseppe, 1991]). Sometimes the therapeutic focus is on the form rather than on the content of the belief; intervention here entails changing shoulds or musts into woulds (e.g., “It *would* be nice if Alice did not behave as she does in front of my friends—and maybe there is a way I could persuade her not to—but that does not mean she *should* not”).

In-session verbal disputation, sometimes supplemented by imaginal disputation, as in systematic rational restructuring (Goldfried, Decentecco, & Weinberg, 1974), is routinely complemented by homework assignments such as self-monitoring attempts to use disputation on one's own. Behavioral assignments tend toward in vivo rather than imaginal exposure and toward situations the patient is likely to find most difficult. Shame-attacking exercises, for instance, might call for a socially phobic patient to do something ridiculous in public to see that nothing catastrophic results.

Like other psychotherapeutic approaches, the applicability of RET is largely a function of the therapist's construction of the patient's problem (Davison, 1991). People seldom consult a therapist with clearly stated irrational beliefs (an exception perhaps being patients who have heard or read about RET and have already conceptualized their predicament in rational–emotive terms). For example, an overweight man who wishes to lose pounds might well be served by a functional analysis of his eating in terms of escape from social–evaluative anxiety that is construed as deriving from unproductive (irrational) needs to please everyone all the time.

RET has had a strong impact on the profession of psychotherapy, being in the historical forefront of the cognitive trend; Albert Ellis is regarded by clinicians as one of the most, if not the most, influential of psychotherapists (D. Smith, 1982; Warner, 1991). RET has been applied creatively to many clinical problems (Ellis & Grieger, 1986), explained to the lay public as a self-help method (Ellis & Harper, 1975), and adapted as a psychoeducational program for children (Knaus, 1974). Less clear than its professional impact is RET's scientific status, the primary subject of the remainder of this article. We shall examine progress on this front in terms of debate on three fundamental issues: (a) What is an irrational belief? (b) How can irrational beliefs be measured? and (c) What is RET, and what does research say about its effectiveness? It is commonly held that confronting criticism and opposing viewpoints is an effective means of making scientific progress (Kenrick & Funder, 1988). We shall argue that this has been true for RET theory and research with respect to our first two issues but not yet with regard to treatment research per se.

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What Is an Irrational Belief?

Several conceptual definitions that have been offered for irrational beliefs seem problematic on close inspection. For instance, Ellis and Bernard (1986) proposed that “rational thoughts are defined in RET as those thoughts that help people live longer and happier” (p. 7), which would only render true by definition the prediction that irrational beliefs lead to dysfunction.

Alternatively, Ellis and Bernard (1986) portrayed rational beliefs as deriving from rigorous information processing, indicating that “nondisturbed individuals tend to . . . regulate their emotions and actions by . . . applying the rules of logic and the scientific method to evaluating these consequences” (p. 9). By this definition, we would have to conclude that much of the thinking of nondistressed people is irrational, because considerable research indicates that the stories people tell themselves in order to live (Didion, 1979) frequently have illusionary elements (e.g., Geer, Davison, & Gatchel, 1970; Taylor & Brown, 1988). Indeed, it is possible that, to achieve something unique or outstanding, one sometimes has to harbor beliefs that might be seen as unrealistic by those not committed to a cause (Bandura, 1986, p. 516). Ellis (1989) conceded the following:

Some unrealistic and illogical ideas—such as the dogmatic belief that one absolutely will go to heaven and experience eternal bliss if one prays to God every day—may sometimes lead to little disturbance and to some benefits, so they easily can be tolerated. Only self-defeating shoulds and musts had better be surrendered! (p. 203)

This specification of which unrealistic views are problematic (“self-defeating” ones) tends to make the definition of irrationality more like the essentially tautological one proposed by Ellis and Bernard (1986).

Thus, it is difficult to devise a rigorous, consistent definition of irrationality in terms of scientific methods and empirical accuracy. Ultimately, RET therapists—and their patients—decide that it would be more personally useful, hence better, to think about the world in certain ways. This decision is based on what one believes is functional and not necessarily on what is strictly objective or rational (Davison & Neale, 1990). This implies that a critical aspect of RET—as indeed for all forms of psychosocial intervention (Davison, 1976, 1991)—is its ethics, because definitions that allude to notions of utility presuppose a set of values, whether implicit or explicit, concerning what constitutes a useful, worthwhile existence. Like all other therapists, but more explicitly and straightforwardly than most (Woolfolk & Sass, 1989), Ellis advocates an ethical system. To wit: Ellis assumes generally that people should lead happy and long lives and specifically that it is desirable, in attaining this aim, to “maximize their individuality, freedom, self-interest, and self-control rather than to submit to the control and direction of others” (Ellis, 1990, p. 88).

A pragmatic solution to the challenge of defining irrationality in RET has been to define irrational beliefs by examples, proceeding from lists of a dozen or so such beliefs commonly encountered in clinical practice (Ellis, 1962), to lists of several hundred specific ones, to a few general categories with many derivatives (Ellis & Bernard, 1985). Questions about the theoret-

ical adequacy of these ostensive definitions have prompted new attempts to conceptually define irrationality. For example, Rorer (1989a, 1989b) has reformulated RET theory in terms of comprehensively critical rationalism (Bartley, 1984) and derived two categories of irrational beliefs: “(1) grandiose beliefs that the world or someone or something in it should be different than it, she, or he is, because one wants it to be, and (2) beliefs that evaluations are factual rather than definitional” (Rorer, 1989a, p. 484).

How Can Irrational Beliefs Be Measured?

A fundamental requirement for research on rational–emotive theory is valid measurement of irrationality. In a series of reviews (e.g., T. W. Smith, 1989) and empirical studies (e.g., Zurawski & Smith, 1987), T. W. Smith and his collaborators have argued that the most commonly used measures of irrational beliefs lack discriminant validity. Specifically, the Rational Behavior Inventory (RBI; Shorkey & Whiteman, 1977) and especially the Irrational Beliefs Test (Jones, 1968) correlate about as highly with depression and anxiety measures as with each other, suggesting that they might be measuring the broad-band disposition of negative affectivity (Watson & Clark, 1984). Confounding of measures of irrational beliefs with negative emotion measures undermines the interpretive logic of studies correlating irrational beliefs with distress, or relating change in such beliefs to change in distress, as tests of RET theory.

This issue has been addressed through the development of several recent questionnaire measures designed to maximize discriminant validity, in part by taking pains to write items that do not include emotion statements such as the RBI’s “I often get excited or upset when things go wrong” (Robb & Warren, 1990, p. 304). The Belief Scale (Malouff & Schutte, 1986), for instance, was judged by independent raters to contain items reflecting only beliefs rather than emotional or behavioral consequences (Robb & Warren, 1990). Accordingly, it has shown some evidence of discriminant validity, correlating positively with anxiety and depression measures but more strongly with other measures of irrational beliefs (Malouff & Schutte, 1986; Malouff, Valdenegro, & Schutte, 1987).

Thus, there are grounds for optimism that critiques of assessments of irrational beliefs have had a favorable impact. Next steps in this area could include developing measures based on more refined abstract definitions of irrationality, such as Rorer’s (1989a, 1989b), rather than on the early lists of examples of irrational beliefs. Also, researchers might explore the utility of measurement formats other than the standardized questionnaire, in hopes that such new methods might be more sensitive to the possibility that some irrational beliefs are tacit except in stressful situations (Davison, Feldman, & Osborn, 1984; Muran, 1991) involving the thwarting of particularly central personal goals (Ellis, 1991).

What Is RET, and What Does Research Say About Its Effects?

RET has fared well in meta-analytic reviews of treatment outcome research. The original psychotherapy meta-analysis

(M. L. Smith & Glass, 1977) cited RET as yielding the second-highest (to systematic desensitization) average effect size among 10 major forms of psychotherapy. A quantitative review of 70 RET outcome studies (Lyons & Woods, 1991) found RET to exceed the effectiveness of no-treatment (average $d = 0.98$) or wait-list controls (average $d = 1.02$). Average effect sizes for comparisons of RET with behavioral ($d = 0.30$) or alternate cognitive-behavioral ($d = 0.14$) methods were also positive, albeit much lower.

Qualitative reviewers, however, have been critical of the methodological adequacy of much of the evidence on which such quantitative summaries are based (Haaga & Davison, 1989a; Kendall, 1984; Zettle & Hayes, 1980). Perhaps the clearest expression of this point of view was offered by Hollon and Beck (1986):

RET appears to have the least clear empirical support of any of the major variants [of cognitive-behavioral therapy], although that state of affairs may derive as much from the fact that the bulk of the trials involving that approach were earlier, less rigorously conducted efforts. (p. 476)

Such negative appraisals of RET outcome research and its impact seem to us to derive from two main sources.

Insufficient Testing of Unique RET Hypotheses

First, distinctive RET hypotheses about mechanisms of change, as opposed to general comparisons of the overall effectiveness of RET and other treatments, have not been tested often (Haaga & Davison, 1989b). For example, RET is hypothesized to exceed the effectiveness of other cognitive-behavioral treatments by virtue of promoting unconditional self-acceptance and reducing "secondary problems" such as self-criticism about having problems (Boyd & Grieger, 1986). This viewpoint (which is obviously reminiscent of Carl Rogers) resonates with an increased recent emphasis in behavior therapy on acceptance (Hayes, 1987; Linehan, 1987) but has not been reflected in RET research, which has tended to use conventional self-esteem indices rather than measures of self-acceptance (Haaga & Davison, 1989a).

Inattention to Generally Applicable Method Criteria

Second, RET outcome studies have tended to fare poorly in terms of generic methodological criteria (Kazdin, 1986). The norm has been to use inexperienced therapists, conducting brief group RET for subclinical problems, with no follow-up evaluation and outcome measured largely in terms of self-reported symptoms and irrational beliefs. These limitations call into question the validity of even apparently favorable results. Some reassurance on these issues can, however, be culled from the quantitative review by Lyons and Woods (1991), who found larger effect sizes for studies with therapy patients as subjects than for studies of student subjects, as well as larger effects for studies rated as high in internal validity (e.g., using low-reactivity measures and random assignment).

Some remaining sources of concern in this respect include (a) nonreporting of the clinical significance of treatment effects (Jacobson & Revenstorff, 1988), (b) infrequent collection of fol-

low-up data (57 of 70 studies reviewed by Lyons and Woods [1991] did not report follow-up results), and (c) inattention to attrition (61 of 70 studies did not report on attrition rates; Lyons & Woods, 1991). Taking attrition into account seems especially important in view of Ellis's advocacy of a forceful style of intervention, hypothesized by some to promote attrition (e.g., Young, in Ellis, Young, & Lockwood, 1987) and reactance on the part of patients (Goldfried & Davison, 1976).¹

Like removing emotional content from measures of irrational beliefs, adhering to these generically relevant methodological criteria seems feasible, and some RET research already has done so. Mersch, Emmelkamp, and their colleagues (Mersch, Emmelkamp, Bogels, & van der Sleen, 1989; Mersch, Emmelkamp, & Lips, 1991), for example, compared RET with social skills training for carefully diagnosed social phobics, using self-report and observational outcome measures, 14-month follow-up assessment, extensive information on the reasons for subject dropout and on the seeking of further treatment by some subjects during the follow-up period, with a specific focus on prediction of differential response to treatments based on patient characteristics. To be sure, the substantive results might be viewed as disappointing (both treatments appeared to be helpful, neither significantly more so than the other, and treatments matched to the relative deficit of a patient—low social skill or high irrational beliefs—were no more effective than mismatched treatments), but the method appears to have been sound in many ways.

A more difficult method criterion for RET researchers to meet is achieving a clear definition and measurement of RET itself, the independent variable (Haaga, Dryden, & Dancy, 1991). Conflicting evaluations of RET's research status often turn on differing interpretations of what is included and excluded by the label *RET* (Ellis, 1989; Lazarus, 1989; Mahoney, Lyddon, & Alford, 1989). Commenting on our earlier qualitative review of RET outcome research, Ellis (1989) stated that "these RET experiments have almost always unclearly defined what RET really is and have only very partially included the main RET methods" (p. 229) and that "virtually none of the outcome studies cited by Haaga and Davison deal with . . . preferential and 'real' . . . RET. Aside from a few studies (such as Forsterling, 1985), it has not yet been tested" (p. 231).²

A survey of 41 published RET outcome studies indicated that a majority ($n = 23$) provided no information about attempts to measure treatment adherence, the extent to which treatment conformed to the specifications of the therapy system being evaluated (Haaga et al., 1991). Moreover, most studies ($n = 38$) did not assess the differentiability (by blind raters) of RET

¹ A prior question is whether RET practitioners actually follow Ellis's lead on this point. Survey data indicate that a majority of experienced RET therapists disagree with Ellis's view that "excessive" therapist warmth reinforces unhealthy beliefs about needs for approval, and nearly one half (47%) disagreed with his contention that "forceful persuasive disputing is usually more effective than more subtle, perhaps indirect disputing" (Warren & McLellarn, 1987, p. 85).

² Forsterling (1985) was not a treatment outcome study but instead a series of studies of students' ideas about the relations between (ir)rational beliefs and emotional reactions to success and failure.

from comparison treatments, and all but one failed to measure the quality of RET intervention; the exception (Warren, McLellarn, & Ponzoha, 1988) used global ratings of competence by Albert Ellis on the basis of session tapes. Thus, low treatment integrity or low therapist competence might always be cited to explain away any unfavorable results with RET. Conversely, favorable results might be ascribed by skeptics to non-RET interventions inadvertently included in the RET condition.

If the only problem in this respect were insufficient attention to the need to measure treatment integrity and quality, this could be readily corrected in future research. However, there might be limits in principle to how well researchers can represent and measure RET as depicted by theorists. Ellis (1980) defined RET broadly, subsuming as its "elegant" or "specialized" (Dryden & Ellis, 1988) form the aspects researchers have typically focused on as distinctive of RET (e.g., forceful disputation of irrational beliefs) and as its "inelegant" or "general" form essentially the entirety of other cognitive-behavioral approaches. This expansiveness of definition leads to quite basic disagreements. For instance, should exposure in vivo be considered a RET intervention for anxiety disorders, or is this a different approach, to be controlled for (Lazarus, 1991) or excluded (Mersch et al., 1989) when evaluating RET? Is Beck's (1964) cognitive therapy something other than RET, as implied by the organization of this special section and by theoretical (Haaga & Davison, 1991) and empirical (DiGiuseppe, McGowan, Sutton Simon, & Gardner, 1990) comparisons of the two, or is it a fallback RET technique to be used when specialized RET's forceful disputation fails to work?

Conclusion: Which Way to Go?

Previous reviews of RET have noted the difficulty of pinning down precisely what it includes and excludes as a therapeutic system, differentiating it from related approaches, and evaluating whether these differences make a difference in outcome. The high evaluation given by most researchers to standardization of treatment techniques within a condition, as well as differentiation from other systems, reflects an acceptance of what Docherty (1984) described as a "technological model" of psychotherapy. It is possible that further theoretical refinements will lead to greater consensus on what RET is and is not and how it might be applied and measured as a standardized technology. History does not support boundless optimism on this score, though. Researchers appear to be caught between the Scylla of being so vague about what was done that readers are unsure what to make of their results (Haaga et al., 1991) and the Charybdis of specifying RET in a way that its adherents view as partial and of insufficient scope (Ellis, 1989).

Perhaps it is time to consider the possibility that RET is not susceptible to traditional scientific outcome evaluation. Just as studies of "behavior therapy" (e.g., Sloane, Staples, Cristol, Yorkston, & Whipple, 1975) have given way to studies of, say, breathing retraining for panic attacks, perhaps studies of RET will be replaced by studies of specific tactics in particular circumstances (e.g., logical disputation of self-rating for depressed persons voicing global negative self-evaluations). Such studies could begin to address the theoretically and clinically interest-

ing issue of when and for whom RET's distinctive methods are helpful. Ellis currently advocates using specialized RET disputation techniques first, then, "if they do not seem to work too well in individual cases, I add various other therapeutic modalities" (Ellis, 1989, p. 218). Ellis has estimated that 30% of patients respond well to this initial disputation phase (Ellis et al., 1987). Research aimed at determining prognostic indicators of who these patients are, whether others would benefit more from specialized RET disputation later in treatment rather than at the beginning or from omitting philosophical disputation altogether, and so on could be highly valuable even in the absence of professional consensus as to whether these variations speak directly to the efficacy of RET.

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