CHAPTER II
LITERATURE REVIEW

Disruptive Behavior Disorders

According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (American Psychiatric Association, 1994), Disruptive Behavior Disorders (DBDs) are described as a group of syndromes “characterized by behavior that is socially disruptive and is often more distressing to others than to the people with the disorders” (Luiselli, 1991). The DSM-IV includes four classes of syndromes within this category of disorders: Attention Deficit Hyperactivity Disorder (ADHD), characterized by prominent symptoms of inattention and/or hyperactivity-impulsivity; Conduct Disorder (CD), evidenced through a pattern of behavior that violates the basic rights of others or major age-appropriate societal norms; Oppositional Defiant Disorder (ODD), indicated by a pattern of negativistic, hostile, and defiant behavior.

Defining Conduct Disorder

The DSM.-IV describes the diagnostic criteria for conduct disorder as:

A repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated, as manifested by the presence of three (or more) of the following criteria in the past 12 months, with at least one criteria being present in the past 6 months.

Researchers have noted that the criteria for conduct disorder do not include precisely what an individual has done, or indicate specifics regarding the psychodynamics of the individual (Behar & Stewart, 1982; Kazdin, 1996; Hare, 1993;

According to the American Psychiatric Association (1994), the diagnosis of conduct disorder is becoming more prevalent. Kazdin, A (1996), a researcher in the area of conduct disorder, notes that the diagnosis of conduct disorder constitutes one of the most frequent basis for referral of children and adolescents for psychological and psychiatric treatment.

Children and adolescents with CD frequently initiate and react in an aggressive manner toward others. Such behavior includes threatening or intimidating others, initiating physical fights cruelty toward people and animals, and the use of weapons. The physical violence associated with this disorder may take the form of stealing while confronting the victim (e.g., mugging, armed robbery), forced sexual activity (e.g., rape), assault, or even homicide (DSM-IV, APA, 1994). Examples of property destruction include fire setting and vandalism with the intention of causing damage. Under the category of deceitfulness or theft, behaviors typically evidenced by children and adolescents with CD include shoplifting, conning others, and breaking into homes or cars. Finally, truancy, running away from home and staying out at night despite parental prohibitions is examples of serious rule violations often evidenced by children and adolescents with conduct problems (DSM-IV, APA, 1994).

Truant behavior often begins prior to age 13, as does staying out at night, running away from home are to be considered a symptom of CD, this behavior must have occurred at least twice or only once if the youth did not return home for a long period of time. Running away in response to physical or sexual abuse is not considered a symptom of CD (DSM-IV, APA, 1994).
Conduct Disorder diagnosis can be made with three or more of the diagnostic criteria that must have been present during the past twelve months, and one criterion must have been present during the last six months. It should be noted that the pattern of conduct disordered behavior is typically evident in numerous settings (e.g., home, school, community). In addition, the manifestation of this behavior must cause significant impairment in social, academic, or occupational functioning.

CD in children and adolescents includes a wide array of antisocial behaviors such as aggressive acts, theft, vandalism, fire setting, lying, truancy, and running away. The common theme is that the behaviors tend to violate social rules and expectations. Many of the behaviors often reflect actions against the environment, including both persons and property (Kazdin, 1985). The victims of conduct disordered children’s and adolescent’s antisocial and aggressive acts may include siblings, peers, parents, teachers, and strangers. The antisocial behaviors of this population have the potential to turn into acts of murder, rape, robbery, arson, drunk driving, and spouse and child abuse (Kazdin, 1993). The disorder is seldom diagnosed before school age, but parents of these children often recall early irritability and uncooperativeness (Robins, 1991). It has been suggested that the behavioral picture of CD varies with developmental stage (Robins, 1991). Achenbach and Eldelbrock (1981), in a cross-sectional study of 2600 children between the ages of 4 and 16, described the behaviors comprising CD as varying by the ages of the children. In the youngest group of subjects, mothers reported arguments, stubbornness and tantrums.
The Causes and Origins of Conduct Disorder

“The process of identifying an emotional disorder is a difficult one for many reasons. For instance it cannot be stated with certainty that something “goes wrong” in the brain, causing a child to act in a particular way. And, contrary to early psychiatric theories, it is impossible to conclude that a mother or father did something “wrong” early in the child’s life, causing an emotional or behavioral disorder or mental illness” (PACER Center, 1992).

However, some studies have shown that emotional disorders such as CD and antisocial personality disorder are developed through a void in the emotional aspect of the parent child relationship. In addition, the relationship may be marked by anger and coldness toward the child. Therefore, this type of relationship distorts what a healthy relationship is and the experience from this emotionally distance relationship results in CD and antisocial behavior disorder in the adolescent.

Many studies have noted a link between bad conduct and alcohol problems, but exactly how they are related is not fully understood. In the past, bad parenting was believed to be the cause of conduct disorder but it is now recognized that the disorder like alcoholism in adults probably also has a genetic cause (Indiana University, Biotech Week, 2005).

Age at Which Conduct Disorder Can Be Diagnosed

Conduct disorder can emerge at the preschool level up through adolescence. Adults who exhibit conduct disordered behavior are generally diagnosed as suffering from Antisocial Personality Disorder. Identifying the conduct-disordered child early
and providing adequate treatment may help interrupt the progression from conduct disorder into Antisocial Personality Disorder.

The DSM-IV (American Psychiatric Association, 1994) lists two subtypes of conduct disorder: the childhood-onset type (prior to the age of 10 years) and the adolescent-onset type. In addition, the subtypes have severity specifies from mild to severe.

**Subtypes of CD**

There are two subtypes of CD: Childhood-Onset Type and Adolescent-Onset Type. CD with childhood onset is characterized by the presence of at least one criterion prior to the age of ten. This type of CD is usually associated with males, who are frequently aggressive toward others and who evidence disturbed peer relationships. In addition, these individuals often displayed symptoms of Oppositional Defiant Disorder during early childhood and are more likely to develop Antisocial Personality Disorder in adulthood than those children with Adolescent-Onset Type CD (DSM-IV, APA, 1994). CD with adolescent onset is characterized by the absence of conduct disorder symptoms prior to the age of ten. Individuals with this type of CD are less likely to display physical aggression and generally have more normalized peer relations, although they often demonstrate conduct problems in the company of peers (DSM-IV, APA, 1994).

**Gender Differences in Conduct Disorder**

The male-to-female ratio for conduct disorder is about four to one (American Psychiatric Association, 1987). This gender difference holds for all ages, from 4 years of age to adulthood, although the precise ratio may vary somewhat (Rutter &
The higher prevalence rate of conduct disorder in boys than girls is also noted by Zoccolillo (1993). Who states that the precise sex ratio is difficult to specify because of varying criteria. For example, Achenbach (1991) notes that boys tend to externalize their behavior, whereas girls tend to internalize their behavior.

Robins and Rutter (1990), note that conduct disorder emerges differently in boys than in girls. In boys, it is more likely to emerge in childhood, whereas in girls it is more likely to emerge in adolescence. However, Webster-Stratton (1996) notes that research concerning gender-specific correlates of the early onset of conduct problems is in its infancy. Webster-Stratton studied conduct problems in male and female children between preschool and early school grades (age 3 to 7). Her results indicated significant gender differences in behavioral symptoms according to independent home observations. However, she noted that reports of gender differences in behavioral symptoms were influenced by the gender of the reporting person. She also noted the girls and boys were observed to have the same levels of total externalizing behavior and verbal deviance.

Crick, Cases, and Mosher (1997) studied girls 3 to 5 years of age. They found that preschool girls are significantly more relationally aggressive and less overtly aggressive than preschool boys. Their study also found that relational aggression is associated with social-psychological maladjustment for preschool-aged children. This was the first evidence that relationally aggressive behaviors appear at relatively young ages. It also confirmed what previous studies have shown, namely that relational aggression is highly damaging to children.
Some research indicates that being of female (but not male) gender serves as a protective factor against the development of conduct problems for the daughters of substance abusers (Gabel & Shindledecker, 1992).

**Prevalence**

Conduct problems are the most commonly referred psychological problems that bring children to the attention of mental health professionals in both inpatient and outpatient settings. Due to differences in the definition of conduct problems, as well as variations in the rate of conduct problems in children of different ages, gender, socioeconomic classes, it is difficult to accuracy measure its prevalence (Frick, 1998). Severity behavior must be considered when attempting to estimate the frequency with which conduct problems occur in children and adolescents. Less severe conduct problems (i.e., irritability, disobedience, temper tantrums) are more common in the general population, whereas, more severe types of conduct problems (vandalism, theft, assault) are less common (Frick, 1998).

It must also be noted that conduct problems increase in frequency during adolescence. In preschoolers, the prevalence of serious oppositional conduct problems is estimated between 4 to 9%. Furthermore, in school-aged children, prevalence of oppositional conduct problem is between 6 to 12%, however, Conduct problem of a more severe nature occurs in 2 to 4% of children. Markedly increasing in adolescence, the prevalence of oppositional conduct problems is estimated at 15%, with more severe conduct problem between 6 and 12% (Frick, 1998). Lynam (1996) notes that delinquency among adolescents is virtually normative, and nearly two thirds of
adolescents surveyed admitted to one of the following antisocial behaviors: aggressiveness, theft, drug abuse, arson, or vandalism.

Gender is also related to the prevalence rate of conduct problem. In general, and not surprisingly so, boys demonstrate more conduct problems than girls do. This finding, however, is mediated by age. According to Szatmari et al (1989) in preschool, boys with conduct problem outnumber girls with conduct problem by a ratio of 4 to 1. In adolescents, however, this ratio narrows to 2 to 1. Additionally, males tend to account for more of the violent and aggressive conduct problems, whereas, females are more likely to commit less aggressive type of conduct problem. Thirty-two percent of the female offenses are violent crimes, as compared with 53% of the male offenses which are violent in nature (Frick, 1998).

Zoccolillo (1993) indicates that female antisocial behavior may be hidden and more difficult to detect. Women with histories of childhood conduct problem may direct their aggression towards family members and friends, resulting in social dysfunction in relationships, which is termed by Crick and Gropeter (1995) as “irrational aggression”. Carlson, Tamm, and Gaub (1997) revealed that girls with oppositional behaviors were rated as more appropriate and less inattentive, but unhappy and more socially impaired, than boys with oppositional problems.

The generally accepted prevalence estimate for CD is 6% to 16% for school-aged males and 2% to 9% for school-aged females (DSM-IV, APA, 1994). In an epidemiological study of childhood and adolescent disorders, Cohen et al. (1993) found prevalence rates of CD to be 3.8% for girls and 16% for boys in the 10-13 year age group, 9.2% for girls and 15.8% for boys in the 14-16 year age group, and 7.1% for girls and 9.5% for boys in the 17-20 year age group. Conduct Disorder affects a
great number of children and adolescents. In fact, it appears that the prevalence of CD has increased from several decades ago, making CD one of the most frequent mental health problems for children (DSM-IV, APA, 1994).

**Co-morbidity of Conduct Disorder**

The literature review suggests high rates of co-morbidity in children with a diagnosis of Conduct Disorder. Children with Conduct Disorder frequently show signs of Attention Deficit/Hyperactivity Disorder (ADHD) (Hinshaw, 1987). Children suffering from ADHD are more likely to exhibit oppositional or conduct disorder than those suffering from Attention Deficit Disorder (ADD) (Dykman & Ackerman, 1993).

Substance abuse is another common co-morbid problem, particularly seen in adolescents (Lynsky & Ferguson, 1995). The researchers note that Conduct Disorder tended to precede or emerge at the same time as the onset of substance abuse and that, in youth with Conduct Disorder and other troublesome behaviors. Substance abuse is likely to simply be another antisocial behavior.

Academic difficulties and lower levels of intellectual functioning are also associated with Conduct Disorder (Moffitt, 1993). Although academic dysfunction is a definite risk factor for subsequent Conduct Disorder, this relation is not unidirectional. Conduct Disorder also predicts subsequent failure at school and lower levels of educational achievement (Bachman, Johnson, & O’Malley, 1978; Ledingham & Schwartzman, 1984).

There seems to be controversy about the degree to which academic underachievement contributes to the development and/or maintenance of conduct disorder, or is caused by Conduct Disorder. The conduct-disordered academic
underachiever frequently exhibits a learning disorder (Bachman et al, 1978; Glueck & Glueck, 1968; Ledingham & Schwartzman, 1984; Mandel, 1997). However, research by Frick, et al, 1991) noted that “the apparent relation between CD [conduct disorder] and AU [academic underachievement] was found to be due to its co-morbidity with ADHD”.

Poor interpersonal relations are also correlated with Conduct Disorder. These youths can have very poor social skills and inappropriate peer relations (Behar & Stewart 1982; Carlson, Lanhey, & Neeper. 1984).

Some children with Conduct Disorder also experience Affective Disorders; in particular Dysthymic Disorder and Anxiety. Grzenko and Pawlick (1994) found that children with disruptive behavior problems often score higher on depression and hopelessness scores.

In addition, research studies show that Conduct Disorder symptoms can be seen in bipolar subjects (Carlson, Bromet, & Jandorf 1998).

Yeager and Lewis (2000) likewise speak of psychotic symptoms often being missed in children and adolescents. They state:

“Of note, in spite of its prevalence, a history of hallucinations is rarely revealed freely by adolescents, as frightening as hallucinations may be. These youngsters are keenly aware that such experiences are abnormal and they almost invariably deny them for fear of being labeled [sic] “crazy”. The authors recently examined a 15-year-old boy who had gone on a shooting spree, killing and wounding several children. We learned that periodically. Since 12 years of age, he had heard voices in his head inciting him to violence. In fact, not long before the killings, he had
jumped up in class and shouted. “Goddamn these voices in my head!” [Sic] He was immediately punished for swearing. Apparently, his teacher didn’t listen to the rest of his exclamation”.

The authors also note that the psychiatric status of aggressive adolescents suggest that the more violent the youngster, the more likely he or she is to exhibit psychotic symptomology, in particularly paranoid ideation. They noted that in a prospective study of nine children who committed murder and were subsequently evaluated, all had histories of psychotic symptoms, including auditory hallucinations, delusions, loose and illogical thinking, and paranoid ideation. They tended to misperceive cues and lash out at imagined threats (Yeager & Lewis, 2000).

Yeager and Lewis (2000) also write about the rates of dissociative disorder in a group of residentially treated children with a diagnosis of Conduct Disorder. They state that, in the group of behaviorally disturbed severely abused youngsters in residential treatment, dissociative symptoms abounded. Of the 23 boys evaluated in the residential setting, 6 (23%) met DSM-III - R and DSM-IV criteria for DID (Tafoya, et at 1996). The only girl evaluated in this group also met criteria for DID; of note, because of their distractibility and episodic aggression.

Sommers-Flanagan, J. and Sommers-Flanagan. R. (1998), in their article ‘Assessment and Diagnosis of Conduct Disorder,” caution clinicians to be aware that sometimes Conduct Disorder may overlap with other DSM - IV disorders. They further note that Conduct Disorder symptoms may be secondary to more treatable disorders. They recommend that counselors develop a differential and coexisting diagnostic checklist, whereby they ask themselves if the following disorders are also present: Adjustment Disorder, Attention Deficit/ Hyperactivity Disorder, Depression,
Dysthymic Disorder, Oppositional Defiant Disorder, Substance Abuse, PTSD, Bipolar Disorder, or Child or Adolescent Antisocial Behavior. In addition, they note the importance of examining the family environment, social forces, and cultural circumstances of each client. McMahon (1994) also argues that greater attention must be paid to issues related to co-morbidity, developmentally appropriate assessments, as well as interventions.

**Children and Adolescents with Conduct Disorder**

Conduct disorder is one of the most commonly diagnosed disorders in child mental health. The approximated prevalence rate is between 6 to 16 percent for boys and 2 to 9 percent for girls. In pre-pubertal children, the prevalence rate of Conduct Disorder drops to 1.9 to 8 percent for boys and 0 to 1.9 percent for girls. Among adolescents, the prevalence rate for boys is 3.4 to 10.4 percent and .8 to 8 for girls (APA.1994).

While gender differences noticeably decrease in adolescence due to the increase in rate among girls, the one consistent thread shared by all the individuals diagnosed with Conduct Disorder is a lack of concern for societal roles and the rights and feelings of others, because of its heavy reliance on social norms in detecting the presence of the disorder. Conduct Disorder is an especially unique disorder to diagnose (American Psychiatric Association, 1994).

A large number of adolescents do show severe patterns of antisocial behavior, and are considered to have Conduct Disorder. But do not have a history of less severe Conduct problems predating the disorder. Instead, when these children adolescence, they begin to show a severe pattern of antisocial behavior (e.g. cruelty to others, stealing, running away from home, truancy, breaking and entering rape). Rates and
arrest (33%) and convictions (30%) are comparable to the arrests (41%) and conviction (43%) of adolescents who show the childhood onset trajectory (Moffitt, Caspi, Dickson, Silva, & Stanton, 1996). In fact, adolescents with this late-onset pattern of Conduct Disorder outnumber youth showing the childhood onset at a rate of about 3 to 1 (Moffitt et.,al.,1996).

Adolescents showing antisocial behaviors at a later onset also tend to be less aggressive and violent (Hinshaw et al., 1993; Moffitt et al., 1996), less impulsive (Moffitt, lynam, & silva, 1994), have fewer cognitive and neuropsychological deficits (Moffitt et al., (1994).

Research indicates that one of the most frequent basis for referring children and adolescents for psychological and psychiatric treatment is a diagnosis of conduct disorder (Kazdin, 1996). In addition, conduct disorder is one of the most costly disorders to society (Robins, 1981). Research also shows that generally, behavior problems subsumed under the label of conduct disorder tend to be resistant to treatment and relatively stable over time (Quay, Routh, & Shapiro, 1987; Kazdin, 1987, 1996). Furthermore, Rutter. et al., (1998) show, in follow-up studies of children with Conduct Disorder, that a significant percentage (one-third to one-half depending on the study) of the children have their problematic behavior persistent into adulthood, where they receive a diagnosis of Antisocial Personality Disorder. Loeber (1982) demonstrated that the more extreme the antisocial behavior, the more stable it is over childhood and adolescence.

Other researchers note that once a style of aggressive responses becomes characteristic in an individual, it remains remarkably stable across time, situation, and even across generations within a family (Haussmann, Ebon, Lefcowitz, & Walder,
Aggression is also a key factor in predicting later persistent and serious delinquent and criminal behavior (Stattin & Magnusson, 1989). The literature is vast about children with conduct disorder inflicting harm to others including to their parents, family, and peers. Some studies suggest treatment for children with conduct disorder is not effective (Hare, 1993). Other studies demonstrate that although a “cure” may not occur, some interventions are effective in decreasing the behaviors associated with conduct disorder (Kazdin, 1996).

Some researchers have studied the effect of children’s behavior on their parents (Hare, 1993; Kazdin, 1996; Lytton, 1990). Research shows that when children with anti-social behavior do attend treatment they can positively influence their parents’ and families’ functioning as a whole (Kazdin & Wassdlil, 2000).

A general consensus in the literature is that CD is one of the most common forms of psychopathology for children and adolescents (Steiner, 1997). Recent estimates suggest that 2% to 6% of children in the United States (approximately 1.3 million to 1.8 million cases) meet criteria for the disorder (Kazdin, 1985). The ratio of boys to girls with CD is estimated to be between 5:1 and 3.2:1, depending on the age range studied. Boys are affected more commonly at all ages, but as the children mature, the gap between boys and girls closes (Steiner, 1997). The disorder constitutes the most common reason for referral for psychiatric evaluations of children and adolescents, accounting for approximately 30% to 50% of referrals in some clinics (Steiner, 1997).

The prognosis for CD is poor: approximately 50% of children with the disorder who are referred to clinics will also exhibit antisocial behavior as adults (Boyle & Offord, 1990). Similar to ADHD, precursors such as family environment,
failure to make a strong attachment to caregiver, difficult temperament, school failure, and low IQ have been suggested to play a role in the development of CD (McGee & Williams, 1999; Frick, Lahey, Hartdagen, & Hynd, 1989; Frick, et al, 1991).

A variety of parent and family characteristics has been found to be associated with CD (McGee & Williams, 1999). Criminal behavior and substance abuse are two of the stronger and more consistently demonstrated parental characteristics (Stewart & Leone, 1978). In a sample of 177 clinic referred children aged 7-13, Frick et al. (1991) found an association between a diagnosis of CD and family functioning. A high rate of Antisocial Personality Disorder and substance abuse was found in parents of children with severe conduct problems. Similarly, Loeber, Green, Keenan and Lahey (1995) followed clinic referred 7-12 year old boys for 6 years and discovered that 70% of the sample from the low socioeconomic group, with at least one substance abusing parent, developed CD over the course of the study.

Review of literature have indicates that the relationship between marital dissatisfaction and child conduct problems to be reasonably consistent among clinic referred populations (Frick, Lahey, Hartdagen, & Hynd, 1989). Jouriles, Pfiffner & O’Leary (1988) examined relationships involving marital conflict, parenting, and toddler conduct problems of 60 mother-toddler dyads (30 boys and 30 girls), and found that general marital discord and marital conflict were related to observations of child deviance and reports of conduct problems in a toddler-aged sample. This relationship was evident for both boys and girls. Some studies have also shown a consistent link between parental divorce and CD (Lahey, Hartdagen, Frick, McBurnett, Conner, & Hynd, 1988).
Additionally, Kazdin (1997), described dysfunctional parent/child relations for CD children, characterized by less acceptance by their parents, less warmth, affection, and emotional support, and less attachment, compared to parents of non-referred youth. Renken et al. (1989), in a study of 191 elementary school children, also found a link between aggressive/antisocial behavior and maternal rejection, hostility, and unavailability. Some research suggests that difficult temperaments in children create a risk for developing behavioral disorders (Lewis, 1994). Coon et al. (1992) reported that CD children were rated by parents as having more difficult temperaments than their peers. Maziade et al. (1990) found that a greater proportion of seven-year-olds with extremely difficult temperaments were diagnosed with externalizing disorders at ages 12 and 16 than were those with easy temperaments. However, research has also suggested that parents may inaccurately label their child as deviant, due to their own personal maladjustment (Webster-Stratton, 1988).

Academic deficiencies have been indicated in CD children. Difficulties such as low achievement level, poor grades, being left behind in school, early termination from school, and deficiencies in a specific skill area such as reading seem to be associated features of CD (Kazdin, 1997). Conduct disordered children tend to score poorly on intelligence tests (Lewis, 1994) and generally, on the average, are reported to have a slightly lower IQ (Robins, 1991).

A study by Matthys et al. (1995) investigated the behavior of children with CD in interaction with each other and with normal control children in a semi standardized setting over a period of 25 minutes. The researchers found that CD children, in interaction with each other, initiated significantly more antisocial behavior (fighting, demanding) and less prosaically behavior (intended to benefit the other child) than control children in interaction with each other. It seems highly likely that repeated and
reciprocated aggressive interactions with other children further escalate the
development of aggressive behavior (Reid, 1993; Sussman, 1993).

Achenbach and Howell (1993) have reported that parents and teachers ratings
of a random sample of 7 to 16 year olds discovered that the prevalence of children’s
behavioral/emotional problems has increased over a 13 years span.

Studies have been reported that children and adolescents labeled as
“problems” develop a negative view of themselves and of others (Patterson, 1982). In
an observational study of conduct-disordered children and their families, conduct
disordered children were found to display internally focused negative cognitions
(Dadds, Sandes, Morrision, & Rebgetz., 1992). Additionally, a negative self-schema
mechanism has been found in aggressive adolescents when asked to explain their
attributions about a peer in social situations (Dodge & Tomlin, 1987). Social-
cognitive dysfunction has been found in violent and aggressive preadolescent males,
with theses boys displaying negative attributional biases (Lochman & Dodge, 1994).
In sum, a negative view of themselves and others, negative self-schemas, and negative
attributional style seem to characterize the cognitive processes of conduct-disordered
youth.

Patterson’s work (1982) with coercive children has illuminated the coercive
cycle that occurs in the family and the resultant lack of successful social skills that
develops. A deficit in social skills has been substantiated in the research on conduct-
disordered youth and poor interpersonal relationships correlated with conduct-
disordered behavior (Herbert, 1987; Kazdin, 1996). Additionally, children and
adolescents with behavioral problems tend to be in a great conflict with family
members, authority figures, and press (Haddad, Barocas, & Hollenbeck, 1991;
Kazdin, Siegel, & Bass, 1992; Robin & Foster, 1989). Both deficits in social skills functioning and increased level of conflict in families with conduct-disordered children underscore the behavioral deficits often displayed by these adolescents. Additionally, these factors support the crucial role that the family often plays with these youth (Kazdin et al., 1992).

**Rational Emotive Behavior Therapy**

Albert Ellis founded Rational Therapy (1955) (RT), which he renamed Rational Emotive Therapy (RET), and is currently referred to as Rational Emotive Behavior Therapy (REBT) (Ellis, 1962, 1994; Ellis and Dryden, 1997). Originally trained as a psychoanalyst, Ellis developed REBT in response to his dissatisfaction with psychoanalytic therapy. He stated that through practice he had concluded that dynamic therapy lacked efficacy and efficiency (Ellis, 1994; Hagga and Davidson, 1993).

According to Ellis (1994), once he began to practice and promote it, “REBT became the first of the ‘cognitive’ and ‘cognitive behavior’ therapies”. Many clinicians within the psychological community regard REBT as a form of cognitive behavior therapy (CBT). However, much of REBT’s theory and practice, particularly its philosophical perspective and emphasis on disputation methods, are distinct from the therapies of Beck (1976) and others (e.g., Mahoney, 1974; Meichenbaum, 1977).

REBT is based on the notion that cognition, emotion, and behavior are inherently integrated and fluid. REBT encompasses a philosophical outlook, a model of personality and disturbance, and theories of therapeutic change (Ellis & Maclaren, 1998). In practice, REBT is an active-directive, structured, pragmatic, and comprehensive approach to treating emotional and behavioral disturbances.
Originally, Ellis applied REBT through the structure of simple conceptual schema of emotional disturbance. He called his schema the ABC’s of REBT or the A-B-C model (Walen, DiGiuseppe, & Dryden, 1992). Ellis employed the model to illustrate the impact beliefs have on emotional and behavioral functioning. When developing the model, Ellis coined the term “irrational beliefs,” to describe when he perceived as dysfunctional thought processes (Ellis, 1994). More recently, REBT proponents have revised and refined the A-B-C framework in an effort to increase its utility and efficacy (Ellis, 1991; Ellis & Dryden, 1997; Wessler & Wessler, 1980).

REBT has greatly influenced and contributed to the professional practice of psychotherapy, as well as the layperson’s understanding of mental health treatment. Practitioners have described Ellis as one of the most influential and inventive of psychotherapists (Bernard, 1995; Lazarus, 1989; Smith, 1982). Ellis and colleagues have successfully applied REBT to a variety of contexts and settings, from self-help book to psychoeducational programs for children. Due to Ellis’s persistent determination, as well as the prowess of his disciples, REBT has grown into one of the most popular forms of psychotherapy and counseling (Hagga & Davision, 1993; Terjesen, 1998).

Ellis and Maclaren (1998) have stated that, “over 250 controlled studies of the effectiveness of REBT have been published, and the great majority of them show positive results” (p.7). Furthermore, a number of REBT outcome study reviews have concluded that REBT is an effective form of psychotherapy (e.g., DiGiuseppe, Miller, & Trexler, 1979; Engels, Garnefski, & Diekstra, 1993; Haaga & Davision, 1989; Lyons & Woods, 1991; McGovern & Silverman, 1984; Oei, Hansen, & Miller, 1993; Silverman, McCarthy, & McGovern, 1992; Smith & Glass, 1977).
The Origins of REBT

Ellis derived the basic principles of REBT from the writings of a number of ancient and modern philosophers. His philosophical influences were Greek and Roman stoics, such as Zeno of Citium, Epicurus, Epictetus, and Marc Aurelius. In addition to the stoics, Ellis adapted the ideas and philosophies of Asian thinkers, such as, Confucius, Buddha, and Lao Tsu. Modern philosophers, Immanuel Kant, John Dewey, and Bertrand Russell were influential in Ellis’s development of REBT as well (Ellis, 1994). The philosophic notion that the manner in which person perceives and interprets a situation, directly affects his or her psychological welfare is the foundation for REBT.

Through adopting and adapting these ancient ideas, Ellis derived a psychological theory and therapeutic method that has evolved into REBT (Ellis & Dryden, 1997).

Authors have declared that the essence of REBT lies in the words of Epictetus, a Stoic philosopher from the first century A.D. Epictetus wrote, “Men are not disturbed by things, but by the views which they take of them.” REBT, in part, is a philosophical theory based on the premise that dysfunction is primarily a result of an individual’s perceptions, belief system, values, and interpretations of the world around him or her (Walen, DiGiuseppe, & Dryden, 1992).

The Theory of REBT

Ellis (1994) derived REBT from the premise that by nature, human cognition, emotion, and behavior are intertwined and holistic. Consequently, attitude, appraisal of self, others, and the world, largely influence emotional response and behavior. In
the domain of psychological disturbance, thoughts, feelings, and behavior are interactive and modifications in one are apt to produce modifications in the other. According to REBT theory, our perceptions of events interact with our beliefs, emotions, and behavior. Furthermore, when people recognize that they largely control their emotional and behavioral reactions, they are likely to think and act more functionally (Ellis, 1999).

A fundamental REBT principal described by Walen et al. (1992) is the notion that “cognition is the most important proximal determinant of human emotion” (p. 15). Essentially, this concept implies that the manner in which people think and interpret events greatly influences their emotional response. According to REBT theory, past and present external events contribute to people’s emotions, but they do not directly cause or bring about emotional reactions. Internal perceptions and evaluations, more so than external events, greatly determine emotional response. Furthermore, “multiple factors, including both genetic and environmental influences, are etiologic antecedents to irrational thinking psychopathology” (Walen et al., 1992).

Ellis (1994) stated that human are predisposed to think in an illogical, unscientific manner. Additionally, people function within an ecological, political, and social system. Therefore, society fosters and maintains humans’ predisposition to think in an irrational fashion. REBT theory subscribes to the notion that hereditary and environmental factors contribute substantially to irrational thinking, but ultimately humans maintain and perpetrate their own disturbance. In view of that, REBT emphasizes the present as opposed to historical influences of cognition and behavior. According to REBT theory, by focusing on the “here and now,” we can challenge and reformulate our irrational ideas in an attempt to perceive the world in a
healthier more adaptive manner. By practicing rational thinking, human beings can learn to adjust their unhealthy self-defeating emotions (Walen et al., 1992).

Although Ellis has subscribed to the theory that human have the capacity to modify dysfunctional thoughts and feelings, Walen at al. (1992) acknowledged that such modification “will not necessarily come about easily”. Reformulating beliefs is a true challenge that often requires persistence, insight, and motivation. Ellis (1994) reported that through a variety of “cognitive-persuasive methods”, such as educating, challenging, and discussing, many people are able to alter their unhealthy ways of thinking. Accordingly, one of the goals of REBT is to teach the client scientific reasoning. Ellis (1979) argued that individuals, who practice scientific thinking, will most likely experience profound emotion; however they will have the ability to regulate that emotion. Furthermore, by subscribing to the scientific method people can more accurately evaluate their beliefs, emotions, and behaviors.

Ellis’s contemporaries (e.g., Beck, 1976; Maultsby, 1984; Meichenbaum, 1977) have described dysfunctional cognitions as distorted inferences, or “automatic thoughts” (Beck, 1976). An inference is “a perception of reality which goes beyond the information immediately available to an individual and is personally significant” (Dryden & Neenan, 1996). In contrast, Ellis has described dysfunctional beliefs as primary evaluative cognitions and philosophical tenets rehearsed since childhood, reflecting grandiose demands and appraisals of the self, others, and the world. Beck and others have asserted that the content of beliefs inaccurate inferences, rather than their absolutism result in emotional and behavioral disturbance. Conversely, Ellis (1994) has hypothesized that inferences are a result of underlying irrational beliefs and are therefore peripheral to psychological dysfunction.
Irrational Beliefs: A crucial component of REBT is the idea that “dysfunctional thinking is a major determinant of emotional distress” (Walen et al., 1992).

According to REBT theory, elements of psychopathology and disturbed emotional states are the result of disturbed thought processes or irrational beliefs. Dryden and Neenan (1996) defined irrational beliefs as “evaluative cognitions couched in the form of rigid, dogmatic, and absolute musts, should, have to’s, got to’s, and ought’s”.

Specifically, irrational beliefs typically consist of exaggeration, illogic assumptions, overgeneralization, erroneous deductions, absolutist, and dogmatic ideas. According to Ellis (1994), irrational beliefs surface when people inflate a sensible “preference” or “desire” to an exaggerated absolutist “must” or “demand”.

Typically, irrational beliefs are recognizable through language such as “must,” “ought,” “should,” “have to,” and “need” (Walen, 1992). Although these words may indicate the existence of an irrational belief, their presence is not a requirement or always indicative of irrational beliefs. A more accurate indicator of an irrational belief is when the belief is accompanied by what Ellis has termed “unhealthy negative behavior.” By definition, these emotions are disruptive, likely to prevent clients from reaching their goals, and may lead to self-defeating behavior. In addition, unhealthy negative emotions such as depression, anger, anxiety, and guilt, are usually coupled with irrational beliefs (Dryden & Neenan, 1996).

In Ellis’s (1962) original version of Reason and Emotion in Psychotherapy, he organized the thousands of irrational beliefs he had heard from his clients into a list of eleven major ideas. This list included beliefs about variety of areas involving the
irrational processes of absolutism, blame, awfulizing, and low frustration tolerance. He defined absolutism as demands that exist just below consciousness and were the foundation for nearly all irrational beliefs and emotional disturbances. He described blame as the tendency to utterly condemn oneself or another. Ellis defined awfulizing as judging something or someone as completely bad or the worst someone or something could possibly be. Low frustration tolerance was described as the process of rating an event as intolerable.

By the mid 1970’s, Ellis and colleagues began to emphasize fewer areas of absolutistic beliefs and asserted that blame, awfulizing, and low frustration tolerance were derivatives of absolutism demandingness, or musts (Ellis, 1979; Ellis & Harper, 1975). Based on this notion, Ellis declared that all irrational beliefs fall into one of three core irrationalities of absolutism or the “three major musts.” These three core irrational beliefs included self-demandingness, other-demandingness, and world-demandingness. Core irrational beliefs such as, “I must be accepted at all times under all conditions” or “I must perform perfectly on all tasks” exemplify self-demandingness. Other-demandingness was defined as absolutist ideas about other people. For example, “You must treat me fairly at all times, or you are a bad person.” Finally, world-demandingness was considered dogmatic beliefs about the world in general. For example, “life must be fair and things should go my way all times” (Ellis, 1994).

In addition to the concept of the three major musts, Elli’s colleagues (e.g., Bernard & DiGiuseppe, 1989; Burgess, 1990; Campbell, 1985) modified the original list of 11 irrational beliefs and organized them into the following four core categories; demands, awfulizing, low frustration tolerance, and global evaluations of human worth. Irrational beliefs classified as demands incorporated unrealistic and dogmatic
expectations of oneself, others, and events. For example, “I must get my boss’s approval,” “I have to get an ‘A’ on my chemistry test,” and “I should be making more money.” Ellis (1994) hypothesized that the other there core irrational belief categories are all derivatives of demandingness.

REBT theorists have defined the core category of awfulizing as the human tendency to exaggerate the negative consequences of a situation to an excessive degree. Irrational beliefs which fit into the “awfulizing category, typically incorporate words such as, “terrible,” “horrible,” and “awful.” For example, the student who gets a “D” on a chemistry test might state, “it is awful that I did not get an A.” The employee who turned down for a raise, may report, “It is terrible that I did not get the raise I deserve” (Walen et al., 1992).

Ellis and his colleagues have described low frustration tolerance, the third core irrational belief classification, as a person’s “perceived inability to put up with discomfort or frustration in one’s life and to envisage any happiness while such conditions exist” (Dryden & Neenan, 1996). These irrational beliefs originate from the concept of short-term hedonism and instant gratification. Dryden and Neenan have hypothesized that low frustration tolerance is largely responsible for the continuation of psychological disturbance. The authors have asserted that in terms of mental health, human beings typically avoid hard work and long-term commitment. People seek the “quick-fix” and want to be free of all psychological disturbances, without doing any work. Thus, they indulge their low frustration and remain unhealthy. Low frustration tolerance is categorized by phrases like, “I can’t stand it” or “it’s too hard.” An example of low frustration tolerance is the student who does not study for a chemistry test, gets a D and says, “I can’t stand getting a D” or complains about the D and then erroneously believes, it is too hard to get an A on the test.
Theorists have described the fourth core irrational belief category as global evaluations of human worth. Global evaluations of human worth are ratings made on the self or others. According to REBT theory, human beings cannot be rated as “good” or “bad” and only behaviors, not the individual, are ratable. Furthermore, global rating may also include the assumption that someone is worthless due to poor behavior. In the case of the student who earned a D on a chemistry test, the student may irrationally conclude that “because I got a D on my chemistry test, I’m a worthless person.” Or the employee who was turned down for the raise may state, “Because my boss won’t give me the raise, my boss is a bad person.” Overall, global rating of the self or others seems to result in significant emotional distress and self-defeating behavior.

Walen et al. (1992) addressed the notion that irrational beliefs or dysfunctional thinking can be modified into healthier, more logical ways of thinking. The authors have stated, “If distress is product of irrational thinking, the best way to conquer distress is to change this thinking”. Based on this concept, the REBT therapist’s role is to teach clients to examine their thoughts, determine if they are thinking in an irrational manner, dispute their irrational beliefs, and substitute healthier beliefs. By doing so, clients learn that if they change their dysfunctional beliefs to functional ones, they can in turn decrease emotional distress and ultimately increase functional behavior. According to REBT theory, the client and the therapist work together to dispute irrational beliefs and change them to rational beliefs.

Rational Beliefs: Rational beliefs are flexible, non-absolute, evaluative cognitions understood and interpreted in a preferential manner. Dryden (1999) identified four types of rational beliefs: “preferences, anti-awfulizing, high frustration tolerance, and self-acceptance/other acceptance”. Preferences are the central rational
belief that the three other rational beliefs are derived from. Ellis has indicated that therapists and clients can modify all irrational beliefs to rational beliefs. For example, the student who received a D on the chemistry test may change the belief “it’s awful that I didn’t get an A on my chemistry test” to a more rational flexible belief. This belief could be, “I wish I got an A on the chemistry test, but it’s not the end of the world that I didn’t. This belief demonstrates a rational, flexible, realistic, logical, preferential manner of thinking.

Walen et al. (1992) described five criteria for rational beliefs. Firstly, “a rational belief is internally consistent,” meaning that the belief is logical and coherent. Secondly, “a rational belief is empirically verifiable,” suggesting that the belief can be supported by empirical evidence. The third criterion Walen et al (1992), delineated is the notion that “a rational belief is not absolutist,” but rather it is a preference, a desire, hope, wish, or want. Rational statements typically consist of phrases such as, “I would prefer,” or “I would very much like, “these phrases communicate a preferential, conditional stance as opposed to an absolutist demand. The fourth criterion is that “a rational belief results in adaptive emotion.” A common misconception of REBT is that rational thinking promotes emotional detachment. The authors have asserted quite the contrary, suggesting that rational thinking facilities healthy negative emotions.

Healthy negative emotions such as sadness, disappointment, regret, and concern typically allow people to reach their goals and perform self-helping behaviors. These emotions are negative as oppose to positive because they still result in moderate emotional discomfort but are not debilitating. The fifth assumption of rational beliefs is that, “a rational belief helps us attain our goals,” (Walen et al., 1992),meaning that rational beliefs are consistent with human beings’ life goals, such
as avoiding conflict, living happily without pain and maintaining satisfying relationships.

Unhealthy and Healthy Negative Emotions: According to REBT theory, negative emotions are feelings that may cause discomfort and interfere with individual functioning (Ellis, 1994; Dryden & Neenan, 1996). Ellis has classified negative emotions into two categories, healthy and unhealthy or appropriate and self-helping behaviors. Healthy negative emotions are feelings that facilitate goal attainment and self-helping behaviors. Healthy negative emotions are associated with preferential, rational thinking. Dryden (1999) stated that, “negative emotions are healthy because they encourage people to change what can be changed or make a constructive adjustment when the situations they face cannot be changed”. Unlike healthy negative emotions, unhealthy negative emotions impede goal attainment and may lead to self-defeating behaviors. Based on REBT theory, inappropriate emotions correlate with demanding, irrational beliefs (Dryden & Neenan, 1996).

In an effort to promote therapist-client communication, REBT practitioners teach clients a topology and vocabulary of emotional states distinguishing between healthy and unhealthy negative emotions. Therapists instruct clients to identify and label their emotions by examining their physiological, behavioral, and cognitive functioning. For example, therapists may ask clients to describe how their body is feeling. If they describe symptoms of autonomic nervous system hyper-reactivity, such as a racing heart and shortness of breath, therapists might ask clients if they feel anxious. Therapists introduce the concept of unhealthy and healthy negative emotions once the emotional state of clients is established. Typically, REBT therapists use a standard vocabulary of inappropriate and appropriate emotions. Table 1, which was
derived from a table in Dryden and Neenan, (1996), illustrates examples of these unhealthy negative emotions and their healthy counterparts.

The A-B-C Model

When Ellis originally developed REBT, he devised the REBT A-B-C model, a simple, holistic, cognitively oriented theory of personality designed to assess humans’ emotional disturbance (Ellis, 1991). According to Mahoney, Lyddon, and Afford (1989) the underlying premise for Ellis’s A-B-C model was that thought greatly influences emotion and behavior. Furthermore, the A-B-C model asserted that emotional distress, disorder, and dysfunction are indicative of irrational thought processes. In Ellis’s original system, “A” represented the Activating Event” or adversity. “B” stood for people’s evaluative belief or beliefs about the event or (A). The (B) consisted of two components, rational belief, and irrational beliefs, “C’ stood for the emotional and behavioral reactions, or consequences, to holding the particular belief at point (B).

The fundamental premise of the original model was that individuals filter their perceptions of particular activating events (A) through the beliefs (B) that they hold about themselves or the world. Consequently, these rational beliefs or irrational beliefs led to a number of possible emotional and/or behavioral consequences (C). Table 2 is an outline of Ellis’s original A-B-C model.
Table 2.1

Unhealthy and Healthy Negative Emotions

<table>
<thead>
<tr>
<th>Unhealthy</th>
<th>Healthy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety</td>
<td>Concern</td>
</tr>
<tr>
<td>Depression</td>
<td>Sadness</td>
</tr>
<tr>
<td>Anger/Rage</td>
<td>Annoyance</td>
</tr>
<tr>
<td>Hurt</td>
<td>Disappointment</td>
</tr>
<tr>
<td>Shame</td>
<td>Regret</td>
</tr>
<tr>
<td>Guilt</td>
<td>Remorse</td>
</tr>
</tbody>
</table>

Table 2.2

The Original A-B-C Model

<table>
<thead>
<tr>
<th>Moral</th>
<th>Definition</th>
<th>Elaboration</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Activation Event</td>
<td>Adversary (real or imagined)</td>
</tr>
<tr>
<td>B</td>
<td>Belief</td>
<td>Irrational / Rational</td>
</tr>
<tr>
<td>C</td>
<td>Consequences</td>
<td>Emotional/Behavioral, Unhealthy/Healthy</td>
</tr>
<tr>
<td>D</td>
<td>Disputation</td>
<td>Identifying, questioning, and challenging</td>
</tr>
<tr>
<td>E</td>
<td>New Effect</td>
<td>Cognitive/Behavioral</td>
</tr>
<tr>
<td>G</td>
<td>Goals</td>
<td>Existing values and desires</td>
</tr>
</tbody>
</table>

Furthermore, the original model included “D” and “E.” whereby the primary — of REBT was to teach clients how to identify and dispute (I) irrational and dysfunctional ideas that result in unhealthy negative consequences. Ultimately, the client and therapist dispute irrational beliefs in order to arrive at point (E), healthy effects, both cognitive and behavioral (Mahoney et al, 1989).
Another significant aspect of the original model was the letter “G.” which stood for “Goals” and represented the values, and desires that people bring to their ABC’s of personality and emotional disturbance. Ellis (1994) stated that from a biological perspective, as well as the tenets of social learning theory, human beings are goal-seeking and their “Fundamental Goals” or ‘FGs” are to survive, avoid pain and be content humans. Moreover, Ellis defined the sub goals or “Primary Goals” of human beings as encompassing various levels of happiness and contentment.

Although Ellis’s original A-B-C model was constructive and perhaps even revolutionary for its time, the model had significant limitations. Critics, REBT theorists, and Ellis himself recognized that the A-B-C model did not account for distinctive cognitive, emotional, and behavioral processes (Ellis, 1991; Ellis & Dryden, 1997; Wessler & Wessler, 1980). Consequently, over the past 40 years, Ellis and colleagues (e.g., DiGiuseppe, 1991; Ellis, 1994; 1991; Wessler & Wessler, 1980) have revised and updated the A-B-C model, while keeping the foundation intact. For example, additions have included a self and self-acceptance theory, the concept of secondary disturbances, emphasis on constructivism, emotive techniques, and behavioral techniques.

However, more than other modifications, Ellis (1991) and others (e.g., Dryden, 1999) have emphasized the fluidity and interactions of thoughts, feelings, and behavior (Dryden. 1999). Ellis has asserted that cognition, emotion, and behavior are an interactive process. Furthermore, Ellis has indicated that the A-B-C model is a holistic system, with continual collaboration between the (A), (B), (C), and (G). Revised REBT theory has endorsed the notion that irrational belief are not just intellectual, cognitive, or philosophic beliefs but are also emotive and behavioral. In
addition, these irrational beliefs are an important part of peoples’ goals, activating events, and disturbed consequences.

The Practice of REBT

The A-B-C framework provides that structure for the therapeutic practice of REBT. In an effort to facilitate therapeutic change, REBT practitioners apply the A-B-C model in an active-directive manner, utilizing a variety of techniques (e.g., cognitive, emotive, and behavioral). Ellis (1994) and colleagues (e.g., Dryden, and DiGiuseppe 1990; Dryden, 1999; Ellis & Dryden, 1997; Walen et al., 1992) have described REBT treatment sessions as a series of steps driven by a “hypothetical-deductive approach to knowledge” (Dryden, 1999).

In general, before engaging in REBT methods therapists will orient their clients to the REBT structure and approach. When initiating REBT, Dryden and DiGiusappe (1990) have recommended that therapists immediately establish a problem-solving orientation for their therapy session. By establishing this agenda, therapists can communicate to clients that they are there to help them with their emotional problems and that sessions will be focused and interactive. Clinicians can initiate a problem-solving approach by simply asking clients the issue they would like to address. Therapists may ask their clients what problem they want to address first (Ellis, 1994; Walen et al., 1992).

Following the introduction of the problem-solving approach, therapists work with clients to identify and establish target problems (Dryden & DiGiuseppe, 1990). When the practitioner and client work together, therapy becomes like a partnership. At this point, it is important for therapists to distinguish between practical and emotional problems with their clients. For instance, if a male client has reported that
the problem he wants to discuss is his unemployment his therapist might point out that his unemployment is a practical problem. On the other hand, how he feels and thinks about his unemployment is an appropriate area to address in therapy. Therapists may also explain to clients that if they can better cope with their emotional disturbance they are likely to effectively address their practical problem (Ellis, 1994).

Following identification of a target problem, REBT therapists typically evaluate clients’ emotional consequences or (C) in the A-B-C model. Therapists assess for inappropriate, unhealthy negative emotions, such as depression, anger, guilt or anxiety. According to REBT theory, an unhealthy negative emotion is a target for change because it ‘impedes client’s ability to reach theft goals, to enjoy themselves, and may result in self-defeating behavior” (Walen et al 1992). In the case of the unemployed male, his therapist may inquire “How do you feel about being unemployed?’ At this stage of assessment, it is important for the clients to identify their emotions. Vague descriptions of affect such as, “I feel miserable” does not establish an appropriate target for change. If therapists and clients do not agree on the targeted emotion then therapy may be unproductive and ineffective. Therefore, it is advantageous for therapists to discuss emotions and emotion identification with their clients (Dryden & DiGiuseppe, 1990).

Following identification of an emotion (C), it is appropriate to have the client discuss a specific and clear activating event or (A). For example, in the case of the unemployed male his therapist may be aware that the man’s employment status is the event disturbing him, but identifying a specific disturbing event related to his unemployment would facilitate the therapeutic process. The therapist might ask him to identify the situation that is most disturbing to him. Is it the way his boss fired him, his lack of money or the rejection he has recently received on job interviews? If the
client indicates that the way his boss fired him is what is really making him angry, the therapist has a specific event to focus on. An important point is that an (A) does not necessarily have to be an external event. A number of experiences, such as an imagined event, a thought, or a feeling qualify as an (A) (Dryden & DiGiuseppe 1990).

Following the identification of (A) and (C) redefining clients’ goals may be useful. For example, it might be constructive for the unemployed man and his therapist to discuss reducing his anger. The therapist might suggest that an appropriate goal for the session is to show the man how he can feel annoyed (healthy negative emotion) with his former boss as opposed to angry. At this point it may also be advantageous for the therapist to identify and assess any “secondary emotional problems.” According to Dryden and Neenan (1996), secondary emotional problems are “disturbed feelings derived from primary disturbances, e.g. ashamed about feeling anxious, angry about feeling hurt”. Secondary problems are important to address because they may interfere in the process of treating a primary disturbance and clients typically understand and appreciate the rationale for addressing secondary problems. If therapists determine that a secondary problem exists, an effective intervention would be to utilize the A-B-C model, with the primary disturbance functioning as the activating event.

After (A), (C), and secondary problems have been addressed the next step is to teach the “B-C connection.” The B-C connection is the REBT notion that “individuals’ evaluative beliefs not only precede but also largely determine their emotional states or consequences” (Dryden & Neenan, 1996). This concept is a crucial and necessary part of effectively conducting REBT. Typically, individuals believe that (A) causes (C). For example, the man whose boss fired him from his job
might erroneously believe that his ex-boss made him angry. The therapist’s goal is to illustrate to the man that his ex-boss did not make him angry, but rather what he is telling himself about his boss made him angry. To illustrate this point the therapist might ask, “what are you telling yourself about your boss that is making you angry?” This question not only elicits an irrational belief or inference but also conveys the idea that other people do not cause unhealthy negative emotions (Walen et al, 1992).

The next step of the process is to identify clients’ irrational belief about the activating event. Typically this is accomplished through questions such as “what are you telling yourself about A to make yourself disturbed about C” as described above. At this point, the goal is to identify the core irrational belief or beliefs clients are holding. Getting to the core irrational beliefs usually requires a REBT technique called “Inference Chaining” (Walen et al, 1992). Inference chaining is the process of linking beliefs or inferences. In the case of the unemployed man, he might respond to the above question by stating, “My boss should not have fired me in front of my coworkers” The therapist might then use inference chaining by stating “and because he did fire you in front of your coworkers that means...” (The therapist is attempting to get the man to finish his sentence). The man might then respond, “He’s a jerk and he shouldn’t treat me that way!” At this point it appears that the man is holding the irrational belief that other people must treat him the way he wants to be treated and if they don’t they are bad people. This irrational belief falls into the demanding and evaluations of worth categories of core irrational belief.

After the core irrational belief or irrational belief has been identified, therapists try to show clients the connection between their beliefs and their emotions. Therapists may accomplish this by offering the clients a hypothesis. For example, the unemployed man’s therapist may point out to his client that as long as he believes
other people must treat him fairly he will be angry whenever he is treated unfairly. In order to test the man’s understanding of the B-C connection the therapist might inquire, “so in order to change your feeling of anger to a feeling of annoyance, what do you need to change first?” (Dryden & DiGiuseppe, 1990).

Once therapists have established that their clients comprehend the relationship between beliefs and emotions, the practitioner progresses to point (D), disputing, according to the A-B-C model. Disputation, originating from REBT’s epistemological position, is the process used to show clients that their irrational beliefs are unproductive, illogical, and inconsistent with reality. Therapists administer cognitive disputation using three basic disputing strategies, empirical, logical, and functional arguments.

Furthermore, therapists employ a number of disputing styles, such as Socratic, didactic, humor, and metaphorical (Beal, Kopec, & DiGiuseppe, 1996).

If the unemployed man’s therapist was to dispute his irrational belief of “people should always treat me fairly” in a Socratic style, using an empirical approach, the therapist might ask, “Where’s the evidence that people must treat you fairly?” Or, if the therapist was to use a didactic style, with a functional/practical strategy, the therapist may state, “it seems that when you hold the belief that your boss should have treated you fairly, especially when he did in fact treat you unfairly, it seems to result in your feeling angry and not actively looking for a new job.” Authors have theorized that REBT therapists prefer the Socratic style of disputation because the process of asking clients questions encourages them to think for themselves and allows the development of their own ideas. Yet Ellis is best known for his use of a didactic style
when teaching clients the difference between irrational beliefs and rational beliefs (DiGiuseppe, 1991; Dryden & DiGiuseppe, 1990).

Following disputational arguments, assuming therapists have success fully convinced their clients that the irrational belief they are holding is illogical, dysfunctional, and unrealistic, a rational alternative belief is created. Beal et al. (1996) have asserted that clients are more likely to discount their irrational beliefs if they have a superior belief to replace it, such as a rational alternative belief. As described previously, rational alternative beliefs or rational beliefs are flexible, non-absolute, preferential, and evaluative cognitions. Rational beliefs are typically composed of preferences, wishes, want, hopes, and likes. For example, the unemployed man may replace his irrational belief with the rational alternative of ‘I do not like the fact that my ex-boss treated me unfairly and wish he had not, but there is no evidence that he must treat me fairly.’

Once a client and therapist have agreed on an effective rational belief a therapist will attempt to strengthen the client’s endorsement of the alternative rational idea. Therapist can ask clients how they think they would feel if they really believed the rational belief. The intention of this question is to identity positive negative emotions. The unemployed man is likely to feel annoyed as opposed to angry if he takes on the rational belief described. A homework assignment such as writing down his rational belief and reading it when he feels angry may be effective. The therapist could also ask his client to create more coping statements reflecting the belief that people do not have to treat him fairly and if they do they are not bad people, just people who acted unfairly.
REBT Group Therapy

Many techniques of psychotherapy utilized group therapy for expediency reasons. That is, it is more practical and less expensive for client and not necessarily because it notably fits in with the theory underlying these methods (Ellis & Dryden, 1987). Ellis (Ellis & Dryden, 1987) has proposed that REBT distinctly uses an educational rather than a medical or psychodynamic model (Ellis, 1962, 1971, 1973, 1984; Elis & Grieger, 1977; Ellis & Whiteley, 1979). Ellis proposed that REBT is truly group-oriented, more than most other methods of psychotherapy, and its practitioners frequently use groups as the method of choice rather than because of special circumstances.

The small-scale group REBT main goals are similar to those for individual therapy, but also utilize the group process as a means to educate and elucidate about change. Ellis (Ellis & Dryden, 1987) reports that REBT groups try to teach the group members:

1. To understand the basis of their emotional and behavioral problems and to use this understanding to overcome their current symptoms and function better,
2. To understand the difficulties of other group members and be of some therapeutic help to these others;
3. To minimize their (and the others’) basic disturbability, so that for the rest of their lives they will tend to feel and respond appropriately rather than inappropriately emotional; and
4. To achieve not only a behavioral but also a pronounced philosophic change, including accepting (though not necessarily liking) unpleasant reality; relinquishing self-sabotaging thinking; discontinuing from awfulizing about
life’s misfortunes; taking full responsibility for their own emotional difficulties, and stopping all forms of rating and, instead, learning to fully accept themselves and other as fallible and error prone humans (Ellis & Dryden, 1987).

In REBT group therapy, the therapist actively and directively shows group participants who are bringing up their emotional problems that they are largely creating these problems themselves by inventing and rigidly holding on to irrational beliefs (IBs), vigorously questions and challenges these beliefs, and encourages and pursues all the group members to look for and dispute the irrational beliefs of the other members. All group participants are taught to use the scientific method to empirically counter the upsetting cognition of themselves and other members. REBT groups includes a number of role playing and behavior modification methods—such as assertion training, in vivo risk-taking, and behavioral rehearsal—that can be done during individual therapy sessions but may be more effective in group. REBT group members get practice in talking other group participants out of their irrational beliefs (IB’s) and thereby consciously and unconsciously begin to talk themselves out of their own self-defeating irrationalities (Ellis & Dryden, 1987).

Therapists may conduct REBT through numerous modalities, including individual, couples, family, and group therapy. This investigation employed group RERT. Ellis began to practice group REBT in 1959. He currently conducts ongoing therapy groups consisting of eight to ten members. Members are both male and female, range in age from 18 to 60, and exhibit a wide range of psychological disturbances. Ellis uses his therapy groups to train fellows and interns at the Albert Ellis Institute; therefore, each group is led by Ellis with an assistant leader or leaders.
Although Ellis employs a co-leader for his REBT groups, he has stated that group REBT can be conducted with a single therapist (Ellis & Dryden, 1997).

The goals and structure of group REBT are comparable to individual REBT. The primary goal of group REBT is to reduce psychological disturbance by examining and altering group members’ thoughts, feelings, and behavior. An additional goal of group REBT is to “understand the difficulties of other group members and be of some therapeutic help to these other” (Ellis & Dryden, 1997).

Structurally, when practicing group REBT, therapists utilize an active-directive style. Through this approach, therapists attempt to teach group members that they themselves create and sustain much of their emotional disturbance and dysfunctional behavior. Ellis and Dryden (1997) suggested that because REBT therapists typically employ an educational approach to therapy, a group setting is especially conducive to REBT. REBT therapists challenge and dispute dysfunctional, dogmatic, and irrational thinking while encouraging members to look for and dispute the irrational beliefs of other group members. Ellis has stated that in REBT group, ‘all group participants are steadily taught to think realistically and logically and to vigorously undermine, and to logico-empirically contradict, the disturbance-creating philosophies of other member” (Ellis & Dryden, 1997).

Group REBT is unique in a number of ways. For example, common forms of group psychotherapies such as psychoanalytic, Jungian, and experiential, emphasize transference and counter transference issues. These traditional therapies focus on under lying group process themes and free interaction. Although Group REBT therapists do not ignore or discount these psychological concepts, they do not focus on these processes as other psychological orientations might.
According to Ellis and Dryden (1997), REBT typically adopts an “individualized content focus” under the assumption that group members enter group therapy to address the problems they are experiencing with themselves, others, or the world. Furthermore, therapists conduct group REBT in a very structured and systematic fashion and employ a “take turns” format, devoting an allotted time to each member. Although critics have described this structure as “undesirable since it discourages free interaction,” (Yalom, 1995, p. 181) this method appears to be most conducive to the goals and procedures of group REBT (Ellis & Dryden 1997).

Similar to individual REBT, group REBT places great importance on homework assignments and members implementation of these assignments. Therapists begin each group session by reading group members homework assignment, to determine whether the client has done the assignment. If the client did not do the homework, the reasons why are explored and the homework may be reassigned. After the homework is reviewed, the member is encouraged to discuss a problem experienced during the past week, address goals and plans, or bring up anything he or she would like to address.

Once the therapist or client has identified an emotional or behavioral problem such as anxiety, depression, or procrastination, the leader and other members look for the client’s dysfunctional beliefs associated with the problem under discussion. For example, if a group member has reported that she has been putting off doing her taxes, the group leader might ask, “what are you telling yourself about doing your taxes?” If the client responds by stating, “I hate doing my taxes, I can’t stand giving the government all my money” the members or leader may point out to the client that she seems to be thinking in an unhealthy manner. At this point, the leader (or other members) may begin to dispute the client’s irrational belief, show her how to dispute
her own irrational belief; formulate a rational alternative belief, and then devise a homework assignment to use during the week to dispute her self-defeating cognitions, feelings, and behavior (Ellis, 1992).

**REBT as Introversion**

Rational-emotive-behavior therapists are multimodal in their approach to changing individuals’ self-defeating behaviors. Rational Emotive Behavior Therapy (REBT) utilizes techniques borrowed from other therapeutic systems. This is often referred to as theoretically consistent eclecticism (Ellis & Dryden, 1997). Practitioners of REBT incorporate cognitive, emotive (affective), and behaving interventions in therapy. In the following section the cognitive, emotive, and behavioral interventions used in this research are discussed.

**Cognitive Methods of REBT**

Cognitive interventions are used in REBT to help individuals to evaluate and think about alternative ways to view themselves, others, and the world (Wessler & Wessler, 1980). Cognitive techniques encourage individuals to understand how they think instead of the practitioner telling them how they think. Some of the cognitive interventions of REBT used in this research include disputation of irrational beliefs, cognitive homework, and changing one’s language.

The cognitive method of disputing of individuals’ irrational beliefs is coupled with teaching them how to challenge irrational beliefs on their own in REBT (Corey, 1991). Clients are constantly challenged by the therapist who questions their self-statements and beliefs to help the clients realize their thoughts and beliefs are causing the disturbance. Individuals who refuse their irrational beliefs become more self-
helping and rational. The intervention of disputation helps individuals to diminish their “must,” “oughts,” and “should.”

The use of cognitive homework encourages individuals to make lists of their problems and dispute these beliefs (Corey, 1991). Cognitive homework interventions help individuals deal with anxiety, challenge their irrational thinking, and dispute negative, self-fulfilling prophecies of failure.

The process of changing individuals’ language patterns and the acquisition of new self-statements enables clients to think and behave differently (Corey, 1991). Changing clients’ language involves analysis of their language patterns. Since REBT therapists believe that language shapes thinking and thinking shapes language, this intervention changes individual’s language of “must”, “oughts,” and “should” to one preferences. Through the use of new self-statements, individuals empower themselves with non-absolutistic preferences.

**Emotive Methods of REBT**

Emotive techniques enable individuals to imagine themselves in different situations. In these imagining exercises, individuals are guided by the practitioner in the rehearsal of positive emotions and action goals (Wessler & Wessler, 1980). The emotive techniques used in this research include rational-emotive imagery, role playing, and reverse-role play. These emotive interventions help individuals change their thoughts, emotions, and behavior (Ellis & Yaeger, 1989).

Rational-emotive imagery is utilized to establish new emotional patterns through intense mental practice (Corey, 1991). Maultsby (1984) described rational-emotive imagery as a way individuals can imagine themselves thinking, feeling, and
behaving the way they would like to think, feel and behave in real life situations. Ellis (1979) felt that individuals who practice rational-emotive become desensitized and no longer act and feel inappropriately over anxiety producing events.

Role-playing is the second emotive technique used to help individuals view themselves as worthwhile. Role-playing involves the therapist showing the clients what they are telling themselves to create their disturbances (Corry, 1991). Through role-playing, individuals are able to work through underlying irrational beliefs which are tied to their inappropriate feelings.

Reverse-role play is designed to get the client arguing against their own dysfunctional belief. The therapist role-plays adopting the client’s belief and vigorously argues for it; while the client tries to convince the therapist that the belief is dysfunctional. It is especially useful when the client now sees the irrationality of a belief, but needs help to consolidate that understanding.

Behavioral Methods of REBT

When therapists use behavioral techniques, they engage Individuals in an activity that they fear or avoid (Wessler & Wessler, 1980). The goal of behavioral interventions is to help individuals change the idea of the underlying emotion. This allows individuals to reevaluate the consequences of their behavior (Wessler & Wessler, 1980). Behavioral interventions used in this research include use of reinforcement and penalties, and skill training.

Reinforcement and penalties are used by individuals in conjunction with homework activity assignments. Individuals are immediately rewarded for completion of their homework. Penalties are given for not carrying out homework assignments.
Ellis (1996) stressed that individuals need to reinforce themselves after the completion of homework assignments and to omit the rewards or to assess a penalty or punishment for non-completion of homework projects.

Using skill training, group members learn and practice particular important interpersonal skills in the group sessions, for example, learning to listen to others, accepting them with their poor behavior, communicating openly with them, and forming relationships with them (Ellis 2001).

**Rational Emotive Behavior Therapy with Children and Adolescents**

Flanagan R., Povall L., Dellio M., Byrne L. (1998), studies forty-four (17 male, 27 female) public school youngsters aged 9-11 years participated in a 12 week group treatment to enhance and improve social skills. The effectiveness of two treatments were compared: problem-solving and problem-solving plus Rational Emotive Behavior Therapy. Pretest-posttest data were evaluated using the Social Skills Rating System and the Child-Adolescent Survey of Irrational Beliefs a measure of four classes of irrational beliefs that are therapeutic targets of REBT. Treatment integrity was assessed by rating segments of audiotaped sessions with Vanderbilt Psychotherapy Process Scale-Revised. Data indicate that the effect sizes for social skills and the components of the CASI were larger for the group receiving the combined treatment.

Gossette, Robert L., O’ Brien, Richard M. (1993), reviewed comparisons of rational emotive education treatment, which is a form of RET used in schools to determine its effectiveness in forestalling future maladjustment through the early detection and eradication of irrational beliefs. 33 unpublished dissertations and 4 published reports found RET effective in about 25% of comparisons with wait list,
placebo, and other treatment conditions. The major effects of RET were changed in scores on self-report measures of irrational beliefs and less on emotional distress. There was little or no change in behavior. Little justification was found for continued use of RET in schools.

Thorpe (1975) designed a study comparing the merits of rational-emotive therapy (self-instructional training), systematic desensitization, behavior rehearsal, and a placebo control group, in increasing assertiveness in college students. Students in the rational-emotive therapy group were made aware of their irrational self-statements and rehearsed more appropriate rational statements. In the systematic desensitization condition, students were desensitized to making assertive responses via relaxation. Students in the behavioral rehearsal group observed the therapist model the appropriate responses, which they then rehearsed. In the placebo control group, students discussed the etiology of non-assertiveness. The length of treatment was six sessions. Dependent measures included self-report, behavioral, and physiological ratings for a situational test in which the students had to respond assertively. Results indicated the general superiority.

Maultsby (1984) has developed a program with rational emotive therapy that is essentially designed for use in high schools and college classrooms. His goal was to teach students to utilize rational emotive therapy in analyzing their emotional upsets and to give them an effective method for solving their personal conflicts.

Maultsby, Knipping, and Carpenter (1974), investigated the efficacy of rational emotive therapy as a preventive measure. In a pilot study, two groups of emotionally disturbed high school students were used as the sample population. One group received the rational emotive therapy course and the other group served as a
control group. Dependent measures included several personality assessment scales the Rotter Scale by Rotter, the Personla Orientation Inventory by Shostram, and the Maultsby Common Trait Inventory by Maultsby. Results indicated significant differences in the positive direction on all three measures in the group receiving the rational emotive course.

A second study using college students again demonstrated that the group receiving the rational-emotive course showed more pretest-posttest improvement on scales that were highly correlated with emotional adjustment. Maultsby, Costello, and Carpenter (1974) attempted to validate the efficacy of rational-emotive therapy as a preventing mental health program with college students. The sessions lasted for 75 minutes and met twice a week for 15 weeks. The instructor of the course was unaware of the nature of the hypotheses. A control group consisted of 30 students who were enrolled in an introductory psychology course taught by the same instructor. The dependent measure was a mental health adjustment scale. The results, as measured by the scores on the mental health adjustment scale, showed that the rational-emotive therapy group yielded more positive results than the control group.

Since the elementary school environment may be an important setting for instituting preventive efforts, there has been increasing interest in developing mental health programs that would remote emotional and behavioral adjustment (Spivack and Shure, 1974). In concordance with these views, Ellis has recommended that the principles of rational-emotive therapy be taught to elementary school children. Rational emotive education (Knaus, 1974) is a direct extension of rational emotive therapy.
Children are taught many of the same principles of RET, including the common irrational beliefs that Ellis (1962) articulated, as well as the concepts of self-acceptance and mistake-making. In addition, specific lessons are designed to help children cope with disappointments and frustrations by teaching them to limit their “musts”, “should” and “demands”. Materials used in rational emotive education are simplified for easier understanding by children.

A meta-analysis was performed by Gonzalez, Nelson, Gutkin, Saunders, Galloway, and Shwery (2004) on 19 empirical studies on the effectiveness of REBT with children and adolescents. Their finding suggested that REBT is a valuable tool for treatment outcomes with children and adolescents, and it more favorably affects those with disruptive behaviors. There appears to be no difference between studies with high or low internal validity and the greatest impact was shown for those receiving longer durations of therapy.

Morris (1993) conducted an experiment to compare adolescents diagnose with Conduct Disorder (CD) and adolescents diagnosed with Attention Deficit Hyperactive Disorder (ADHD) for group effectiveness. He used “a 12-week treatment program based on the principles underlying REBT and designed for “at risk” adolescents” (Morris, 1993, p. 125). Significant differences were found on the CD subjects, who overall reported higher levels of anger and frustration at the outside of the study. This experiment clearly showed a reduction in irrational thinking, depression, and state and trait anger for these subjects. However, no significant differences were found in the ADHD group on any dimensions of the study. Morris makes note that the ADHD subject’s difficulties are perceived to be out of the individual’s control, which would directly affect one’s ability to take responsibility for disturbances, as REBT requires the client do.
The Efficacy of REBT

Researchers have conducted numerous studies on REBT and its impact. These reviews have shown that investigators have applied REBT to a number of disorders and it has demonstrated positive therapeutic results. However, reviewers (Gossette & O’Brien, 1992; Kendall et al. 1995; Zettle & Hayes, 1980) have consistently reported that many REBT outcome studies have been compromised by significant methodological flaws (e.g., lack of control groups, nonclinical samples, a minimal number of treatment sessions, and lack of behavioral measurements). Despite these weaknesses, numerous researchers (e.g., DiGiuseppe, Miller, & Trexler, 1977; Engels, Gamefski, Sc Diekstra, 1993; Haaga & Davison, 1989; Jorm, 1989; Lyons & Woods, 1991; McGovern & Silveiman, 1984; Silverman, McCarthy, & McGovern, 1992; Oei et a, 1993; Smith& Glass, 1977) have concluded that REBT is an effective form of therapy. The following section describes meta-analytic investigations and qualitative reviews of REBT outcome research.

Smith and Glass (1977) performed the first psychotherapy meta-analysis. This investigation explored the overall effectiveness of numerous psychotherapies. The authors examined 375 outcome studies of numerous interventions, from psychodynamic to behavioral therapies. Thirty-five REBT studies were included in the analysis. Overall, 10 types of therapies were analyzed. The authors computed 833 effect size measures, yielding an average effect size of .68 (SD = .67). When classified into categories of therapy type, REBT showed the second highest average effect size which was .77.

Quantitative reviews of specific types of therapy or disturbances followed the Smith and Glass (1977) paper. For example, Polder (1986) conducted a meta-analysis
to determine the effectiveness of CBT. The analysis included 53 controlled studies that employed CBT of various categories (e.g., modeling, REBT, CT) with adult populations. The author computed 996 effect sizes with an average effect size of .69, suggesting the overall effectiveness of CBT. Folder reported that REBT demonstrated the largest effect size of all the CBTs examined.

Jorm (1989) investigated the reduction of personality traits associated with anxiety. In examining this issue, she conducted a meta-analysis of psychotherapy outcome studies that included dependent measures assessing anxiety. The analysis was comprised of 63 studies, classified into nine different therapeutic categories. All studies included a control condition, random assignment, and a measure of anxiety or neuroticism. The author reported that across all therapies the mean effect size was .53. However, the therapy category of “rational-emotive and related therapies” demonstrated the largest effect size (1.25). Unfortunately, the investigator failed to define “other therapies” making interpretation of the study difficult. Despite this weakness, findings are still encouraging.

Lyons and Woods (1991) performed a meta-analysis of 70 REBT outcome studies conducted between the years 1972 to 1988. Studies included in their analysis compared REBT to a baseline measure, a control group, or another form of therapy. The authors reported an overall effect size of .95 (SD .93). When REBT was compared to alternative treatment conditions (e.g., behavior therapy and cognitive behavior modification) the only significant differences found were between REBT and baseline conditions, with a mean effect size of 1.37. Authors also reported that there were no significant differences found between the effect size of individual or group therapy formats.
Engels et al. (1993) published the most recent REBT meta-analysis to data. The authors attempted to answer the question of REBT’s efficacy relative to no-treatment controls, placebo groups, and other treatment methods. In addition, Engels et al., (1993) examined whether REBT with a behavioral emphasis and employment of behavioral techniques was more effective than REBT with a cognitive focus and predominately or exclusively cognitive treatment. Inclusion criteria consisted of a control group condition (no-treatment or waiting-list), reports of all statistics necessary for estimating effect size, and a treatment method derived from the REBT model. The investigators compiled 28 REBT outcome studies from the years 1971 to 1987.

An overall analysis of REBT compared to placebo treatment or no treatment yielded an effect size of 1.62 (SD =1.44). Based on their analysis, the authors concluded that REBT is an effective form of psychotherapy. Furthermore, based on their results REBT’s effects were sustained over time with a delayed treatment effect for behavioral outcome measures. In addition, no significant differences were found for the hypothesis that REBT with an emphasis on behavioral techniques is more effective than REBT with a cognitive focus. Results also suggested that REBT was just as efficacious as systematic desensitization and combination treatments. However, Engels at al. (1993) suggested that the results of their study be interpreted conservatively due to the heterogeneity of the set of studies analyzed. According to the authors, despite the employment of specific inclusion parameters, the studies examined were heterogeneous in regards to design, dependent measures, diagnostic category, and comparison therapy used.

In addition to quantitative reviews demonstrating the efficacy of REBT, researchers have conducted qualitative reviews of REBT outcome studies that also
have shown support for REBT’s utility. For example, DiGiuseppe et al. (1979), reviewed REBT outcome studies by dividing 22 studies into non-comparative and comparative categories. The authors concluded that although a number of studies demonstrated methodological weaknesses (e.g., inadequate control groups and minimal comparison studies); their findings suggested that REBT is an effective form of treatment. However, within their review DiGiuseppe et al. (1979). Included studies that were not “strictly speaking rational-emotive therapy outcome studies” (p. 219) and fell under the category of general CBT. These studies demonstrated “similarity” or incorporated “key element” (p. 219) of REBT. The authors failed to operationally define what they considered similarity or key elements. This oversight is problematic and is an example of ambiguity within the REBT empirical literature.

Subsequently, McGovern and Silverman (1984) executed a follow-up review of REBT outcome studies. The authors evaluated the efficacy of REBT by examining studies conducted between the years 1977 to 1982. They reported that 31 of the 47 studies reviewed demonstrated “significant findings favoring the RET position” (p. 16). Furthermore, in the “remaining studies the RET treatment groups all showed improvement and in no study was another treatment method significantly better than RET’ (p. 16). McGovern and Silverman indicated that their findings supported the conclusions of DiGiuseppe et al (1979), but their analysis found fewer methodological errors within the studies evaluated. Furthermore, the authors also included general CBT studies but evaluated them separately. This distinction is conducive to the empirical validation of REBT because it reduces the possibility of erroneous interpretations and conclusions.

Silverman et at. (1992) followed up the McGovern and Silverman (1984) review with an examination of 89 studies conducted from 1982 to 1989. The authors
classified studies as comparative, non-comparative, or combination investigations. Combination studies were defined as “RET with other therapies or are not appropriate for the first two sections”. Forty-nine of the studies reviewed demonstrated support for REBT’s efficacy. In addition, similar to McGovern and Silverman, no other treatment method proved to be significantly more effective than REBT. However the authors reported that their review suggested that REBT combined with other REBT treatments, such as rational emotive imagery, might be the most effective intervention.

Haaga and Davison (1989) evaluated outcome studies of REBT, organizing their analysis by psychological disorder or problem treated. The authors concluded that REBT demonstrated effectiveness for a variety of psychological disturbances on a number of self-report measures. However, Haaga and Davison argue that the value of REBT outcome research is limited due to ambiguities within REBT theory, such as the measurement of irrational beliefs. The authors suggested that further research be conducted to advance the scientific status of REBT.

Overall, the investigations described above reported that REBT is effective for treating a number of psychological problems.