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Rational Emotive Behavior Therapy: Current Status

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In this review of the current status of rational emotive behavior therapy (REBT), we consider two of Ellis's strategies that have helped preserve REBT's presence in the professional zeitgeist. We argue that REBT should be viewed as a unitary approach to cognitive-behavior therapy (CBT) and outline its distinctive theoretical and practical features. We acknowledge the reciprocal influence that REBT and CBT have had on one another and provide three examples of such influence. Finally, we provide a brief summary of the current status of REBT research.

Keywords: REBT; CBT; research; Albert Ellis

Before we outline the current status of rational emotive behavior therapy (REBT), we want to consider and evaluate briefly two strategies employed by its founder, Albert Ellis, which have helped keep REBT at or near the forefront of the field of psychotherapy over the past 50 years. Without these strategies REBT might not have a current status for us to review.

Ellis Strategy I: REBT's Contribution to . . .

Since establishing what is now known as REBT in the mid-1950s, Ellis was very successful at showing that REBT has a perspective on and can make a contribution to a wide range of theoretical and practical trends in the field of counseling and psychotherapy. Thus, Ellis has outlined the REBT position on such theoretical trends as constructivism (Ellis, 1990), existentialism (Ellis, 1977), humanism (Ellis, 1972a), objectivism (Ellis, 1968a), and postmodernism (Ellis, 1997, 2000). Practically, he has written about how REBT can be applied to all major therapeutic arenas: (a) individual, couple, family, and group therapy (Ellis & Dryden, 2007); (b) how it can be used with a broad range of clinical issues, including addictive behaviors, anxiety, borderline personality disorder, depression, morbid jealousy, obsessive-compulsive disorder, and posttraumatic disorder (Ellis, 2001); and (c) what its application is to such fields as emotional education (Ellis, 1971), encounter groups (Ellis, 1969), executive leadership (Ellis, 1972b), hypnosis (Ellis, 2001), and marathons and intensives (Ellis & Dryden, 2007). He has also written on the REBT perspective on a variety of therapeutic approaches such as abreactive therapy (Ellis, 1974), experiential therapy (Ellis, 1970), psychoanalysis (Ellis, 1968b), and reality therapy (Ellis, 1999), among others

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(Ellis, 1994). Whatever theoretical or practical trend was emerging in the field, one could be sure that Ellis would sooner rather than later offer an REBT slant on the trend. Not only would Ellis give the REBT position on the current issue, he would promote the REBT version of the issue and highlight this in his presentations and writings. He did this consistently over the years, the most current examples being postmodernism (Ellis, 1997, 2000) and acceptance (Ellis & Robb, 1994).

While this strategy has had the distinct advantage of keeping REBT's presence to the fore in the professional zeitgeist, it has been problematic in a field where the increasing emphasis has been on empirically supported treatments. While we will discuss the research literature later in the paper, we will say here that Ellis's keenness to show how REBT can be practiced with a broad range of clinical problems has not been matched by empirical evidence to support the scientific (rather than the practical) wisdom of doing so, although we are not suggesting that the former factor has caused the latter. The reality is that Ellis was not an active psychotherapy researcher and was not as successful as Aaron T. Beck at attracting such researchers to rigorously investigate his practical claims.

Ellis's Strategy II: The Two REBTs "No-Lose" Argument

If the first strategy was used by Ellis to keep REBT's presence to the fore in the broader field of counseling and psychotherapy, his second strategy (what we have called the "two REBTs 'no-lose' argument") was designed to ensure that Ellis covered all bases within the more specific tradition of cognitive-behavior therapy (CBT). Basically, Ellis's (1979a, 1979b) argument was that there are, in fact, two forms of REBT. The first form, which he called elegant or specific REBT, emphasizes the importance of focusing on and helping clients to change their rigid and extreme beliefs, hypothesized by Ellis and other REBT therapists to be at the very core of emotional and behavioral disturbance (Ellis, 1979a). The second form, which he called inelegant or general REBT, uses, for both theoretical and practical reasons, a large variety of cognitive, emotive, and behavioral techniques and is synonymous with the broader approach known as CBT (Ellis, 1979a). Here the emphasis is on effecting change but not necessarily by changing the rigid and extreme beliefs specifically targeted by elegant REBT. In general REBT, it is recognized that change can be brought about by helping people in other ways, for example by helping them to change their distorted inferences (Beck, 1976), to activate themselves behaviorally (Veale & Willson, 2007), and to learn new skills such as assertiveness (Alberti & Emmons 2001).

This dual approach enabled Ellis to emphasize specific REBT when it suited his purpose and to use general REBT in response to critics who thought that REBT neglected particular variables or techniques. Ever since, this clever ploy has enabled REBT therapists to claim to be CBT or REBT therapists as the need arose and has, for example, helped REBT therapists to claim that they practice an empirically supported therapy (i.e., CBT).

However, this second strategy has meant that it is not easy to answer the question, "What is REBT?," and it has also meant that some people practice or teach general REBT when they think that they are practicing or teaching specific REBT.

The confusion engendered by Ellis's two strategies exists as much today as it did 21 years ago when Ellis wrote a similar state of the art article for this journal (Ellis, 1987). We will try to reduce some of this confusion in this article. More specifically, we will outline a unified approach to REBT and its distinctive features and consider its empirical status.

One REBT, but Different Types of Therapeutic Change

Rather than argue that there are two forms of REBT, we want to argue that there is one approach, but within that approach there are different types of therapeutic change that can be targeted

and achieved with different clients. One of the problems encountered by what we have termed the "two REBTs 'no-lose' argument" is that it stated that specific REBT sought to effect belief change (sometimes known as philosophic change) while general REBT sought to effect other kinds of change when it was clear that belief change could not be brought about (Ellis, 1979a). Another problem with this view is that REBT's well-known technique of disputing irrational beliefs was a province of specific REBT, and if you were not doing this, you were by default practicing general REBT.

Instead, we would like to argue that there can be a single approach to REBT that details belief change as its preferred target but that incorporates and targets other types of change (e.g., inferential change, behavioral change, and situational change) when belief change is not possible with certain clients or is not acceptable to others. This unified approach also means that it is possible to target one form of change, utilize techniques in the service of such change, but in fact achieve a different form of change. For example, an REBT therapist might target belief change with a client and challenge her irrational beliefs, but the outcome of this work might be inferential change for the client. In the "two REBT" way of looking at things, it might be said that the therapist is practicing specific REBT but achieving results more in keeping with general REBT. In the unified approach, the therapist is practicing REBT, but the interventions yielded a different effect than that intended. Conversely, another client might resist a therapist's attempts to dispute his irrational beliefs (designed to effect belief change), but he might achieve such change by learning and practicing new skills. Again, we argue that it is clearer to say that the therapist here is practicing a unified approach to REBT, but their interventions have a different effect than that intended.

If we think of REBT as a unified approach with a range of targets of change and with a variety of techniques with intended effects that may result in unintended effects, then taking this approach can help us answer such questions as, "Which techniques with which clients yield which types of change?" rather than such questions as "Which form of REBT should be used with which clients?"

Note that this view can incorporate both the idea that REBT therapists may have a preferred target of change (e.g., belief change) and that they are prepared to make compromises and target other types of change when pragmatically indicated (Dryden, 1987).

The Distinctive Features of REBT

As the general field of CBT has matured it has spawned a number of different approaches within this tradition. Accompanying this trend has grown the increasing interest in what is distinctive about different approaches to CBT. Now that we have put forward the case for a unified approach to REBT, let us outline the distinctive features of this approach, which is a précis of a book-length work on the subject (Dryden, 2008).

The Distinctive Theoretical Features of REBT

1. It espouses postmodern relativism, which is antithetical to rigid and extreme views and holds that there is no absolute way of determining reality.
2. It has a unique position on human nature (see Table 1 and Figure 1).
3. It puts forward a distinctive "ABC" model (see Table 2 for an example), which highlights key inferential aspects of "A" and argues that "C" can be emotive, behavioral, and cognitive in nature. It also stresses that "ABCs" are best understood within a situational context.
4. It holds that rigid beliefs are at the core of psychological disturbance.
5. It holds that flexibility is at the core of psychological health.
6. It argues that extreme beliefs (awfulizing beliefs, low frustration tolerance [LFT] beliefs, and depreciation beliefs) are derived from rigid beliefs.

7. It argues that nonextreme beliefs (antiawfulizing beliefs, high frustration beliefs, and acceptance beliefs) are derived from flexible beliefs.
8. It distinguishes between unhealthy (dysfunctional) negative emotions (UNEs) and healthy (functional) negative emotions (HNEs). For example, guilt (UNE) is distinguished from remorse (HNE).
9. It can explain why some clients' inferences are highly distorted (i.e., they are so when they are cognitive consequences of irrational beliefs).
10. It has a unique position on human worth and advocates unconditional self-acceptance (USA).
11. It distinguishes between ego and discomfort disturbance and health, but notes that they often interact.
12. It has a decided focus on metaemotional disturbance (e.g., shame for feeling unhealthy anger).
13. It argues that the biological basis of human irrationality is often stronger than its social-learning basis.
14. It favors what might be called choice-based constructivism and argues that humans frequently have to "go against the grain" when striving for therapeutic change.
15. It has a clear position on what constitutes good mental health with flexibility and nonextremeness at its heart.

TABLE 1. The Nine Basic Assumptions Concerning Human Nature and Relevant Questions

Freedom / Determinism
How much internal freedom do people have and how much are they determined by external and internal (e.g., biological) factors?
Rationality / Irrationality
To what extent are people primarily rational, directing themselves through reason, or to what extent are they guided by irrational factors?
Holism / Elementalism
To what extent are people best comprehended as a whole or to what extent by being broken down into their constituent parts?
Constitutionalism / Environmentalism
To what extent are people the result of constitutional factors and to what extent are they products of environmental influences?
Changeability / Unchangeability
To what extent are people capable of fundamental change over time?
Subjectivity / Objectivity
To what extent are people influenced by subjective factors and to what extent by external, objective factors?
Proactivity / Reactivity
To what extent do people generate their behavior internally (proactivity) and to what extent do they respond to external stimuli (reactivity)?
Homeostasis / Heterostasis
To what extent are humans motivated primarily to reduce tensions and maintain an inner homeostasis and to what extent are they motivated to actualize themselves?
Knowability / Unknowability
To what extent is human nature fully knowable?

Source: Hjelle & Ziegler, 1992.

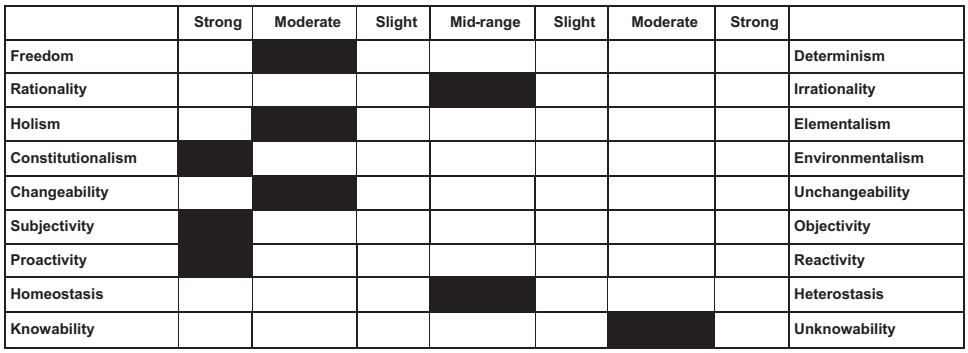

Figure 1. REBT's position on the nine basic assumptions concerning human nature. The shaded areas indicate the degree to which REBT favors one of the two human bipolar extremes. *Source:* Reprinted with permission from Ziegler (2000).

TABLE 2. REBT-based Conceptualization of Anxiety and Depression

"A" = Inference related to the personal domain	Threat to ego or discomfort	Loss or failure
"B" = Irrational beliefs	Demand and awfulizing belief, LFT belief, depreciation belief (self, others, life)	Demand and awfulizing belief, LFT belief, depreciation belief (self, others, life)
"C" = Emotional = Behavioral = Thinking	Anxiety • Withdraw from threat • Avoid threat • Overcompensatory behavior • Eliminate threat • Neutralize threat	Depression • Withdraw into self • Avoid rewarding activity

Note. LFT = low frustration tolerance.

The Distinctive Practical Features of REBT

16. It argues that the therapeutic relationship in REBT is important but not curative and draws fully on working alliance theory (Bordin, 1979) as a way of understanding the importance of bonds, views, goals, and tasks in therapy.
17. It takes a flexible approach to case formulation, using this to guide interventions, particularly in complex cases. However, it argues that one can do good therapy without making such a formulation and holds that frequently this formulation can be developed during therapy rather than fully at its outset.
18. It has a decided psychoeducational emphasis and argues that its theory of disturbance, and of change, can actively be taught to and implemented by clients.
19. It has a preferred order of treatment and argues that client problems should ideally be dealt with in the following order: (a) disturbance, (b) dissatisfaction, and (c) development.
20. It advocates an early focus on clients' irrational beliefs (IBs).
21. It does not just suggest disputing clients' IBs; it also encourages clients to develop and strengthen rational beliefs (RBs).

22. In keeping with other CBT approaches it uses empirical and pragmatic arguments in disputing beliefs, but uniquely it also uses logical arguments.
23. It suggests using a variety of therapeutic styles.
24. It discourages the use of gradualism (i.e., proceeding very slowly) because this often reinforces clients' LFT beliefs.
25. It has a realistic view of change and encourages clients to accept that change is hard work, and consequently it urges therapists to be forceful and energetic as long as doing so does not threaten the therapeutic alliance.
26. It stresses, whenever possible, the importance of teaching clients general rational philosophies and encourages them to make a profound philosophic change (changing general IBs to general RBs) if they are capable of doing so.
27. It recognizes that clients may not be able or willing to change their IBs, and in such cases it recommends making compromises with ideal of belief change.
28. It suggests that therapists focus on their clients' misconceptions, doubts, reservations, and objections to REBT.
29. It recommends the principle of therapeutic efficiency—bringing about changing in the briefest time possible.
30. It is a form of theoretically consistent eclecticism—advocating the broad use of techniques, from wherever, but to achieve goals in keeping with REBT theory.

REBT and CBT: Reciprocal Influence

So far in this article, we have argued that REBT should be regarded as a single approach within the CBT tradition with distinctive features. Its development, however, has always tended to take place away from the center of what is "hot" in CBT. For example, a brief glance at the recent conference programs of British, European, American, and international conferences on CBT would reveal a dearth of REBT-based papers. Despite this off-center development, there is evidence that REBT and the general field of CBT have had an influence on one another. We will briefly examine a few examples of this reciprocal influence, detailing the REBT position wherever relevant.

Low Frustration Tolerance (LFT)

The concept of LFT has been in the REBT literature for many years. It is actually an extreme belief relating to a person's perceived inability to tolerate frustration in its broadest sense. As a result of holding this belief the person will act impulsively or take avoidant steps to rid himself of the frustration. LFT has sometimes been referred to as discomfort disturbance or non-ego disturbance (Dryden, 1999) to contrast it with ego disturbance. As Dryden (1999) has argued, LFT or non-ego disturbance is a much broader concept than the inability to tolerate frustration. Indeed, Dryden (1999) identified 44 different types of such disturbance.

LFT (as broadly conceived) appears, for example, as a key feature of dialectical behavior therapy (DBT) in its conceptualization of borderline personality disorder (BPD; Linehan, 1993). Here it appears as "distress intolerance." As Linehan notes, the inability to accept that pain and distress are part of life "leads itself to increased pain and suffering" (1993, p. 147). This is the same as REBT's equation: Frustration + LFT = Disturbance. Also, the concept of distress intolerance is reminiscent of the REBT concept of secondary disturbance, where the person disturbs herself about her distress (Walen, DiGiuseppe, & Wessler, 1980).

In DBT, the therapeutic task is to teach BPD clients to develop distress tolerance skills, which in REBT would be conceptualized as helping them to develop such skills based on the attitudinal task of showing themselves that they can tolerate such feelings and that it is worth it to them to do so.

Acceptance

Towards the end of his life, Ellis (2004) made "acceptance" a cornerstone of REBT theory. Our view is that this was in keeping with his first strategy of providing the REBT view on a "hot" topic in CBT and moving it to the forefront of the approach. His view was that the goal of REBT therapists is to help clients strive for unconditional self-acceptance (USA), unconditional other-acceptance (UOA), and unconditional life-acceptance (ULA).

Well before that, however, acceptance played an important, if not as pivotal, role in REBT theory, which predated the work of theorists in the field of acceptance and commitment therapy (ACT). But how similar is the concept of acceptance in ACT and REBT? Hayes, Strosahl, Bunting, Twohig, and Wilson (2004) state that "acceptance involves taking a stance of non-judgmental awareness and actively embracing the experience of thoughts, feelings and bodily sensations as they occur" (p. 7). Here, you will note the object of acceptance is on internal processes, while in REBT it is much broader (directed towards self, others, and life conditions). However, if we just compare the REBT and ACT views on acceptance towards "thoughts, feelings and bodily sensations" we see similarities and differences between the two approaches. While both share the view that acceptance involves taking a stance towards such internal phenomena, REBT's stance is more explicitly attitudinal than ACT's. The latter implies an attitude that it is good to take a stance of nonjudgmental awareness towards these phenomena, but this is not made clear. By using the word "embrace," Hayes et al. (2004) imply that such a stance is positive (the hallmark of a positive attitude is a positive judgment), but again this is not made clear.

REBT and ACT would agree on the importance of being aware of these internal processes, but would disagree on the role of judgment in being aware. ACT clearly argues that acceptance is based on awareness that is nonjudgmental, while REBT argues that such awareness can involve being judgmental in the sense of liking or disliking an experience and preferring, but not demanding not to experience, a thought, feeling, or bodily sensation that is aversive to the person.

Thus, if a male client were to experience the thought "I want to kill my mother," his ACT therapist would encourage him to be aware of the thought in a nonjudgmental way and to see what happens when that stance is taken. By contrast, his REBT therapist would first encourage him to acknowledge and keep the idea that he doesn't like having this thought and would prefer not to have it, would then help him to give up the idea that he must not have the thought, and finally would encourage him to proceed with life whether or not he has the thought, but without engaging with it. The client's ACT therapist would share the latter aim in the commitment phase of treatment.

REBT and ACT would both agree, however, that attempts to control, and worse, to eliminate such a thought is a major root of the perpetuation of disturbance related to the thought, but they differ on how this is best achieved. The previously mentioned client's REBT therapist would also, more explicitly, help him to see if he was depreciating himself for having the thought and would teach him to accept himself for having it. His ACT therapist would view the client's self-depreciation belief as another thought towards which he should adopt the stance of non-judgmental awareness. His ACT therapist certainly would not attempt to teach him how to accept himself for having the aversive thought.

It is interesting that the respective pioneers of REBT and ACT recently expressed different views on the feasibility of these different approaches being integrated, with Ellis (2005) viewing such integration as being more possible than Hayes (2005).

Cognitive Specificity

The cognitive specificity hypothesis of cognitive therapy puts forward the idea that different emotional disorders have different cognitive and behavioral underpinnings. We have taken this

idea and shown how it can be used in an REBT conceptualization of emotional disorders. Let us outline how we distinguish between anxiety and depression from an REBT perspective using REBT's "ABC" framework (see Table 2).

This REBT conceptualization shows how REBT therapists draw upon the work of other CBT therapists. Thus, at "A" in the "ABC" framework, we use the Beckian concept of the personal domain (Beck, 1976), which shows that the inferences that people tend to make in anxiety are different from those that they make in depression. And at "C" we agree with Salkovskis (1996) that people use safety-seeking maneuvers (both behavioral and cognitive) in anxiety to protect themselves from threat at "A." Despite this influence, it is important to note from this conceptualization that the central role accorded to beliefs in anxiety and depression is preserved.

The Empirical Status of REBT

We think that the evidence-based status of REBT should be evaluated simultaneously at two levels: (a) the evidence-based status of REBT theory and (b) the evidence-based status of REBT clinical strategies derived from the theory.

The Evidence-Based Status of REBT Theory

What Is Known. The following is known about the empirical status of REBT theory (for full details see David, Schnur, & Belloiu, 2002; David, Szentagotai, Kallay, & Macavei, 2005a):

1. The ABC model as a general framework of the cognitive-behavioral perspective in psychology—the role of the cognitive appraisal of events in the generation of feelings and behaviors—has received strong support (e.g., Lazarus, 1991) as the basic framework of cognitive-behavioral psychotherapies (e.g., Dobson, 2000).
2. Irrational beliefs, as a particular type of cognitive appraisal, be it primary or secondary appraisal (see Lazarus, 1991), are considered important causal mechanisms involved in several clinical conditions, such as low frustration tolerance (low frustration tolerance is involved in anger, awfulizing is involved in anxiety and pain, while self-downing is a fundamental component of depressed mood; e.g., David et al., 2002, 2005a; Solomon, Bruce, Gotlib, & Wind, 2003).
3. Demandingness is considered a central irrational cognitive process, meaning that the impact of an activating event (e.g., a traumatic event) on the affective or behavioral consequences is mediated by demandingness as a *primary irrational appraisal mechanism,* and LFT, awfulizing, and global evaluation/self-downing as *secondary irrational appraisal mechanisms* (see David et al., 2002; DiLorenzo, David, & Montgomery, 2007). A recent study supporting this perspective was conducted by DiLorenzo et al. (2007). They investigated the interrelations among irrational beliefs in generating distress among students, at the beginning of the semester and before a midterm exam. A total of 99 students completed the Attitudes and Beliefs Scale II (a measure of irrational beliefs) and the Profile of Mood States–Short Version (a measure of distress), at the beginning of the semester (Time 1) and before the exam (Time 2). Demandingness, awfulizing, LFT, and global evaluation/self-downing were directly related to distress levels at both times (ps $< .05$). Mediation analyses showed, however, that the impact of demandingness on distress was mediated by awfulizing, LFT, and global evaluation/self-downing. Of course, demandingness might follow LFT, awfulizing, or global evaluation/self-downing, as a part of the reappraisal process (see Lazarus, 1991); in this case, for example, demandingness can be a part of the reappraisal process (i.e., metacognition), while LFT, awfulizing, and global evaluation/self-downing can be, as described previously, secondary appraisal mechanisms involved in the appraisal process (Lazarus, 1991).

4. Irrational beliefs are considered cognitive vulnerability factors. In other words, they will only generate a clinical condition in conjunction with more or less explicit stressful activating events. Thus, one can endorse irrational beliefs, but unless they are activated by stressful activating events, the person will experience no distress or maladaptive behaviors.
5. Irrational beliefs held about specific activating events create distorted descriptions and inferences (e.g., automatic thoughts, intermediate and core beliefs) about that event. For example, Szentagotai and Freeman (2007) found that the depressed mood of patients suffering from major depression is exacerbated by automatic thoughts, which in turn are influenced by irrational beliefs. In this study, the authors examined the relationship between irrational beliefs and automatic thoughts in predicting distress (i.e., depressed mood in 170 patients with major depressive disorder). Although both constructs have been previously hypothesized and found to generate emotional distress in stressful situations, the relationships between these two types of cognitions in predicting distress have not been sufficiently addressed in empirical studies. Results show that both irrational beliefs and automatic thoughts are related to distress (i.e., depression/depressed mood) and that the effect of irrational beliefs on distress is partially mediated by automatic thoughts.
6. There is a specific pattern of irrational beliefs for various clinical mood states: Demandingness and LFT for anger; demandingness and awfulizing for anxiety; demandingness and global evaluation/self-downing for depressed mood (see e.g., David et al., 2002).

What Is Unknown. We don't know the following about the empirical status of REBT theory (for full details, see David et al., 2002, 2005a):

1. RBs have often been conceptualized as a low level of IBs, rather than as an independent construct; in other words, RBs and IBs have been viewed as bipolar constructs. However, research indicates (e.g., Bernard, 1998) that rational and irrational thinking are not bipolar constructs; thus a high IBs score does not necessarily entail a low RBs score. Unfortunately, few measures assessing IBs have an independent scale for RBs, and little research has been done by using RBs scores independent of the IBs score. Therefore, we do not clearly know what their role is in health promotion and the prevention of clinical conditions.
2. While it is known that IBs generate dysfunctional descriptions and inferences (e.g., Szentagotai & Freeman, 2007), it is not known whether RBs produce functional descriptions and inferences during specific activating events.
3. It is not known whether there is a qualitative, a quantitative, or both a qualitative and quantitative difference between functional and dysfunctional feelings (e.g., depressed mood vs. sadness; anxiety vs. concern; anger vs. annoyance; guilt vs. remorse) and how RBs and IBs are related to these differences. Recent research (e.g., David, Montgomery, Macavei, & Bovbjerg, 2005b) tends to suggest a binary model of distress (a qualitative distinction), but the data are not yet definitive. Indeed, negative affect (i.e., emotional distress) has been traditionally described as a unitary construct (Russell & Carroll, 1999; Watson & Tellegen, 1999). By a unitary construct, we mean that distress levels fall along a continuum moving from low to high, regardless of whether one is measuring specific negative affect (e.g., depressed mood, sadness, anxiety, concern) or general negative affect obtained by summing the scores of specific negative affect items. On the other hand, Ellis (1994) described distress as a binary construct consisting of two different components: functional negative feelings (e.g., sad, concerned) and dysfunctional negative feelings (e.g., depressed mood, anxious), which can vary independently. In two studies involving 55 U.S. patients suffering from breast cancer, and 45 Romanian patients diagnosed with the same illness, David et al. (2005b) compared hypotheses derived from the unitary and the binary models of distress. Results revealed that in a stressful situation (i.e., upcoming breast surgery), high levels of irrational beliefs were associated with a high level of both functional and dysfunctional negative feelings, while low levels of irrational beliefs were associated with low levels of dysfunctional negative feelings and high levels of functional negative feelings. These results

supporting the binary model of distress, observed in both the U.S. and Romanian samples, suggest the generalizability of the data in favor of the binary model.

The Empirical Status of REBT Clinical Strategies

What Is Known. Empirical outcome research in REBT has unfolded over three periods (based on David et al., 2005a): (a) before 1970, (b) from 1970 to 1990, and (c) from the beginning of the 1990s to present. Before 1970, rigorous empirical research regarding REBT efficacy (i.e., how REBT works in controlled conditions) and effectiveness (i.e., how REBT works in real-life clinical conditions), based on experimental or quasiexperimental designs, was seldom conducted. After 1970, a series of outcome studies were published. These studies set the basis for a more rigorous quantitative approach to exploring the efficacy of REBT.

To date, several qualitative reviews (e.g., David et al., 2005a; DiGiuseppe, Miller, & Trexler, 1977; Ellis, 1973; Haaga & Davison, 1989a, 1989b; Zettle & Hayes, 1980) have examined the efficacy of REBT. Although generally positive, these qualitative reviews have also pointed to some methodological problems that should be corrected in order to strengthen the conclusion that REBT is an effective treatment.

Outcome research has become the basis for a quantitative approach in examining the efficacy of REBT, and for allowing meta-analyses to address many of the criticisms advanced in previous REBT qualitative reviews (Engels, Garnefsky, & Diekstra, 1993; Lyons & Woods, 1991). Concerning REBT outcome research, quantitative reviews are of two types: (a) general, focused on cognitive behavioral psychotherapy overall and (b) specific, focused specifically on the efficacy of REBT.

General Quantitative Reviews. REBT has generally fared well in quantitative reviews of psychotherapy. For example, one of the first psychotherapy meta-analyses (Smith & Glass, 1977) cited REBT as yielding the second highest average effect size among 10 major forms of psychotherapy. However, the number of REBT outcome studies included in psychotherapy meta-analyses is small, and most authors place all forms of CBT into a single category (e.g., Wampold et al., 1997). Although psychotherapy meta-analyses usually show that CBT has the highest overall effect size, as REBT is included in the general CBT category, the degree to which REBT independently contributes to these results is unclear.

Specific Quantitative Reviews. Two important meta-analyses have directly evaluated the efficacy of REBT (i.e., Engels et al., 1993; Lyons & Woods, 1991). The following synthesis of REBT efficacy is based on these two quantitative meta-analyses:

1. REBT is useful for a large range of clinical diagnoses and clinical outcomes. Interestingly, REBT seems to have a much larger effect on "untargeted variables," which do not have an obvious relationship with the treatment (e.g., physiological measures such as blood pressure), than on "targeted variables," which have a direct and obvious relationship with the treatment (e.g., irrational beliefs). This suggests that the effect of REBT is not due to compliance or task-demand characteristics.
2. Typically, there is no difference in efficacy between individual and group REBT.
3. REBT is equally effective for clinical and nonclinical populations, for a wide age range (9–70 years) and for both males and females.
4. Higher numbers of REBT sessions correlate with better results.
5. In general, the higher the level of training of the therapist, the better the results of the REBT intervention. This is an interesting finding, given that most psychotherapy meta-analyses have found no relationship between therapist training and treatment outcome; future studies should investigate this interesting phenomenon.
6. Higher quality outcome studies have shown greater REBT effectiveness.

What Is Unknown. Some words of caution are necessary, however, regarding the interpretation of these results (e.g., David et al., 2005a; Haaga & Davison, 1993):

1. More attention should be paid to generic methodological criteria such as: (a) formal clinical assessment of psychopathology, (b) adherence to and adequacy of clinical protocols, (c) measures of the clinical significance of change, (d) collection of follow-up data, and (e) subject attrition.
2. Clients taking part in many of the clinical trials are mainly the YAVIS type (Young, Attractive, Verbal, Intelligent, Successful) and some of their problems are subclinical; hence, the generalization of these results to clinical practice should keep this limitation in mind.
3. Both REBT and other therapies have evolved during recent years, and therefore it is possible that earlier studies contaminate the conclusion regarding the relative efficacy of REBT and other therapies. However, the newer generation of REBT randomized clinical trials, adhering to generic methodological criteria, have also offered a positive view on the efficacy of REBT. Overall, these studies found that REBT is an effective treatment compared to various control conditions, and that it has about the same efficacy as most behavioral treatments for obsessive-compulsive disorder (Emmelkamp & Beens, 1991; Emmelkamp, Visser, & Hoekstra, 1988), social phobia (Mersch, Emmelkamp, & Lips, 1991; Mersch, Emmelkamp, Bogel, & van der Sleen, 1989), and social anxiety (DiGiuseppe, McGowan, Simon, & Gardner, 1990). In the case of agoraphobia, both REBT and self-instructional training seem less effective than in vivo exposure (Emmelkamp, Brilman, Kuiper, & Mersch, 1988).

REBT in conjunction with medication has been found more effective than medication alone for major depression (e.g., Macaskill & Macaskill, 1996). In the case of dysthymic disorder, REBT has been shown to be as efficient as medication, but a combination of REBT with medication is much more effective (Wang, Jia, Fang, Zhu, & Huang, 1999). Also, REBT seems to be an effective adjunct in the therapy of inpatients with schizophrenia (e.g., Shelley, Battaglia, Lucely, Ellis, & Opler, 2001). These results encourage future clinical research on the efficacy of REBT in various clinical conditions, particularly considering that some of these studies regarded REBT as a cognitive restructuring strategy, often ignoring its behavioral package (see the studies of Emmelkamp above).

It is important to emphasize that part of the REBT outcome research was conducted on people with subclinical problems. We believe this to be one of the strengths of the approach as it is important to have studies of both clinically severe and subclinical problems. For example, it is important for REBT to work in the case of major depressive disorder, but also to help the large segment of people with less severe, possibly more transient, dysphoric conditions. In simple words, REBT is not only a clinical theory useful for clinical populations but also an educational system with implications for nonclinical and subclinical populations (e.g., depressed mood, lack of assertiveness, test or speaking anxiety) who have an interest in self-help materials and personal development.

Conclusions

Based on empirical studies conducted so far in the field, we can conclude (see David et al., 2005a) that REBT is an efficacious form of psychotherapy for a large spectrum of disorders and populations. However, as some of these studies, particularly earlier ones, have some methodological problems, the conclusions could be tempered, and maybe it is safer to say that REBT is very probably an efficacious form of psychotherapy. One should bear in mind, however, that both older studies and more rigorous recent ones suggest that REBT is at least as efficient as behavioral and other CBTs. Although some REBT proponents (DiGiuseppe et al., 1990; Warren, McLellarn, & Ponzoha, 1988) suggest that REBT should be more efficient than other forms of

cognitive-behavioral intervention because it focuses on fundamental evaluative core beliefs, this assumption has received no empirical support yet. Considering that cognitive-behavioral psychotherapies, although effective, have not yet reached the desired standard of efficacy, as about 30%–40% of people are nonresponsive to these interventions (Antonuccio, Danton, & DeNelsky, 1995), the efficacy of REBT should get more empirical attention, allowing a clear answer concerning its hypothesized superior effect. REBT could be a platform for stimulating empirical studies on the efficacy and on the theory of change advanced by cognitive-behavioral models of psychopathology and human functioning.

Finally, although irrational beliefs seem to be important causal factors in psychopathology, it is not yet clear whether the efficacy of REBT can be attributed to changing irrational beliefs into rational beliefs, as this aspect of REBT theory has been insufficiently studied. Component designs isolating specific beliefs and designs examining the association of changes in beliefs with changes in other outcome measures could provide important evidence for the basic premises of the REBT theory of change. Efficacy studies based on well-controlled randomized clinical trials, and effectiveness studies examining REBT in real clinical settings, are necessary. Finally, a new quantitative meta-analysis to assess recent empirical studies of REBT efficacy is needed.

Afterword

When Ellis (1987) wrote a similar piece in this journal 21 years ago, he speculated on the future of REBT. Space prevents us from doing so here, but even if it didn't, we would be reluctant to speculate on its future at a time when we need to take stock and agree where we are in the present. It is our hope that this current status overview contributes to this process of stock-taking.

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