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A Review of Outcome Studies of Rational-Emotive Therapy, 1977-1981

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A REVIEW OF OUTCOME STUDIES OF RATIONAL-EMOTIVE
THERAPY: 1977 - 1981

by

Terrance E. McGovern

A Thesis Submitted to the Faculty of the Graduate School
of Loyola University of Chicago in Partial Fulfillment
of the Requirements for the Degree of
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VITA

The Author, Terrance Edward McGovern, is the son of Edward Arthur McGovern and Ann (Wagner) McGovern. He was born March 20, 1947, in Chicago, Illinois.

His elementary education was obtained in the parochial schools of Chicago, Illinois, and secondary education at the St. Laurence High School, Burbank, Illinois, where he graduated in 1965.

In January, 1967, he entered Chicago State University which he attended for three years, and completed his final year at Roosevelt University in Chicago, Illinois, where in May, 1980, he received the degree of Bachelor of Science with a major in psychology. While attending Chicago State University, he was elected Editor-in-chief of the college newspaper during 1970, and was awarded a writing talent scholarship.

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Chapter I

BACKGROUND, THEORY, AND PURPOSE

Background

Ellis (1977) first introduced Rational-Emotive Therapy in 1955. Since that time it has come to be accepted as one of the major clinical models (Ellis, 1977; Shertzer and Stone, 1980; Cory, 1977). With its growing use by clinicians, social workers, and other mental health professionals, Rational-Emotive Therapy (RET) has been the subject of a considerable amount of research.

Ellis has provided insight and has described his development of Rational-Emotive Therapy in one of his early works (Ellis, 1962). Initially a practitioner of psychoanalysis, Ellis moved towards psychoanalytically oriented therapy, and then to an Adlerian approach before coming to his formal development of RET. The cardinal feature of RET (Ellis, 1977; Ellis and Harper, 1975) is the idea that emotional disturbance is the result of faulty or irrational thinking--thinking which leads an individual to hold non-empirical, nonverifiable ideas.

This concept lead Ellis (1962) towards the development of the following theory of the ABC's of emotional disturbance. Thus, A or the Activating Event does not directly cause C or emotional Consequence, but is first meditated, assessed, and evaluated at B, the Belief system of the individual. Therefore, in order to change C a corresponding change of B will have to occur.

Theory

Ellis has further outlined some thirty-two clinical and theoretical hypotheses, along with a vast array of supporting research, of the RET position (Ellis, 1977). These hypotheses, as stated by Ellis, are listed here:

1. thinking creates emotion
2. semantic processes and self-statements affect behavior
3. mood states depend on cognition
4. awareness, insight, and self-monitoring affect behavior
5. imaging and fantasy mediate emotions and behaviors
6. cognition, emotion, and behavior are interrelated
7. cognition can affect biofeedback and control of physiological processes
8. there are innate influences on emotions and behavior
9. expectancy influences behavior
10. perceived locus of control influences behavior
11. attribution errors influence emotions and behavior
12. humans have an innate and acquired tendency to think irrationally
13. humans tend to self-rate
14. cognitive defensiveness depends on self-damning
15. humans have a tendency to low frustration tolerance
16. anticipation of threat often mediates emotional disturbance
17. active-directive therapy is more helpful than passive therapy

18. therapist's disputing and persuasion are desirable
19. homework is desirable
20. perceived insult and intent causes behavior change
21. abreaction of dysfunctional emotions is not therapeutic
22. people have the choice of behavioral change
23. cognitive-behavior methods of self control are effective
24. coping with distress and threat relates to self-perception
25. diversion or distraction has therapeutic value
26. suggestion, autosuggestion, and hypnotic suggestion strongly influence behavior
27. modeling and imitation produce behavior change
28. increasing problem-solving skills is therapeutic
29. role playing and behavioral rehearsal have cognitive components and may be therapeutic
30. skill training may have therapeutic effectiveness
31. there are significant differences between RET and other types of therapy.

Ellis (1977) notes that many of the above hypotheses are not exclusive to RET, but are also true of the entire cognitive-behavioral school (of which RET is a part). Also, it may be inferred from the above hypotheses that the practice of RET encompasses more than techniques for changing a client's beliefs. As Wessler (1981) and others have noted, the practice of comprehensive RET may, and often will, include imaging exercises, role playing, homework assignments,

and many other techniques drawn from other therapeutic schools in the process of aiding a client to achieve his/her therapeutic goals. While the changing of cognitions is seen as a necessary end to comprehensive RET, the means to this end often include a plethora of therapeutic tools. This is an important aspect of RET to note, since many of the studies which will be cited in this thesis compare, for example, RET to RET plus imagery, as if the latter presents a component not incorporated as part of the RET position, when in fact, RET plus imagery is, in practice, simply RET.

Although RET makes use of those tools, primarily RET looks to correct faulty ideation on the part of a client (Ellis, 1960). Ellis (Ellis and Harper, 1975) has identified ten primary irrational ideas leading to emotional disturbance. These are:

1. The idea that you must have love or approval from all the people you find significant.
2. The idea that you must prove thoroughly competent, adequate, and achieving; or, the idea that you at least must have competence or talent in some important area.
3. The idea that when people act obnoxiously and unfairly, you should blame and damn them, and see them as bad, wicked, or rotten individuals.
4. The idea that you have to view things as awful, terrible, horrible, and catastrophic when you get seriously frustrated, treated unfairly, or rejected.

5. The idea that emotional misery comes from external pressures and that you have little ability to control or change your feelings.
6. The idea that if something seems dangerous or fearsome, you must preoccupy yourself with and make yourself anxious about it.
7. The idea that you can more easily avoid facing many life difficulties and self-responsibilities than undertake more rewarding forms of self-discipline.
8. The idea that your past remains all-important and that because something once strongly influenced your life, it has to keep determining your feelings and behavior today.
9. The idea that people and things should turn out better than they do and that you must view it as awful and horrible if you do not find good solutions to life's grim realities.
10. The idea that you can achieve maximum human happiness by inertia and inaction or by passively and uncommittedly "enjoying yourself."

At various times in the development of RET, since it was first formally introduced in 1955, other irrational ideas were added (Ellis, 1973); and, in fact, Ellis (1977) notes that he had identified 259 specific ideas. In more recent history, however, these lists of ideas have been reduced and subsumed under three major categories (Wessler and Wessler, 1981):

1. Awfulizing
2. Demandingness
3. Self-downing

The Wesslers (1981) note that virtually all clients hold beliefs and ideas in two, and many times all three, of the above categories.

As a cognitive-behavior type of therapy RET often overlaps with various other methodologies, but appears to most closely resemble Arnold Lazarus' Multimodal Therapy (Lazarus, 1981). The Wesslers (1981) assert that, in practice, the two types of therapy are virtually identical. The author of this thesis directed correspondence to both Albert Ellis and Arnold Lazarus on this point and has received replies from both (see Exhibits I and II). In essence, both acknowledge the similarities, while noting some differences, in the two therapeutic paradigms.

Therapy Goals

The process of RET is openly didactic and educational (Ellis, 1975). At the end of therapy it is suggested that the client has not only been able to deal with the problem presented, but he/she further has learned a technique which will enable him/her to cope with many of life's other hassles (Wessler and Wessler, 1981). As Ellis writes in Humanistic Psychotherapy (Ellis, 1973), RET represents a comprehensive approach to psychotherapy which combines experiential-emotive, behavioristic, and cognitive techniques, with the intended goals of leaving the client with: 1. Self-interest; 2. Self-direction;

3. Greater tolerance;
4. Acceptance of uncertainty;
5. Flexibility;
6. Scientific method of thinking;
7. Commitment;
8. Risk taking;
9. Self-acceptance.

Purpose

A review of the literature assessing the effectiveness of RET was accomplished by DiGiuseppe and Miller (1977). This thesis is intended as a continuation of the DiGiuseppe and Miller study of 1977.

Thus, the purpose of this thesis is twofold:

1. to gather in a single document recent research of RET;
2. to allow others a convenient and easy means to review this research.

Limitations

The principal method used to discover the research discussed in this thesis was a computer search of Psych Abstracts. Though this would not indicate an exhaustive and complete accounting of RET outcome studies, it is believed to represent a large percentage of such studies in order to give a fair appraisal.

The sources for this research included both professional journals and Ph.D dissertations. In reviewing this literature, the professional journals were available for in-depth study; the Ph.D dissertations were unpublished, however, and Dissertation Abstracts were utilized. Most of the studies listed in Dissertation Abstracts provide adequate commentary for use in this thesis; some, however, were found to be lacking and were omitted from inclusion. The studies represent the period from 1977

through mid-1981. Though the body of research at first appeared large, it was discovered that many of the Ph.D dissertations were later published in shortened form in professional journals, thus reducing the number of citations.

Format

The format adopted by DiGiuseppe and Miller will be continued in this thesis. In the DiGiuseppe and Miller review, especially in their section on comparative studies, they include studies which combine RET with other therapies. It was thought that greater value would be achieved if these combined therapeutic studies (and others which did not strictly fall under the nominatives of non-comparative and comparative studies) were isolated into a unique section. A discussion section used by DiGiuseppe and Miller is paralleled in this thesis in Chapter III. One addition, not included in DiGiuseppe and Miller, is in Chapter I in this thesis: Background and Theory. Though it might be properly assumed that readers interested in the findings presented in this thesis would possess a basis knowledge of RET, such a chapter was thought valuable in order to: (1) present RET in its current evolutionary form, which may have varied since some readers first became acquainted with RET; (2) provide a basis for comparison for future researchers interested in this area; (3) and to serve as review for those whose memories require refreshing.

CHAPTER II

OUTCOME STUDIES

Introduction

This chapter will be divided into four sections. The first section will examine the findings of prior research. The second section will address non comparative studies of Rational-Emotive Therapy- those outcome studies not comparing RET with other therapeutic methods. The third section will look at comparative studies of RET - those studies comparing RET with another type of therapy. The fourth section looks at those RET outcome studies which combine RET with other therapy methods, or RET studies which do not properly fall within the criteria of the first two sections.

Section 1: Findings of Prior Research

DiGiuseppe and Miller (1977) designed their review under two major headings:

1. Non-comparative studies - outcome studies that do not compare RET with other types of psychotherapy.
2. Comparative studies - outcome studies comparing RET with one or more therapies.

In the DiGiuseppe and Miller review of non-comparative studies, virtually all the research concerns the problem of anxiety. A summary of this research may be found in Appendix I:

Within their review of comparative studies DiGiuseppe and Miller noted comparisons with systematic desensitization, assertive training, behavioral rehearsal, and client-centered therapy, while also noting the absence of comparisons to Gestalt therapy, psychoanalysis, and reality therapy. A summary table for these studies may be found in Appendix II.

The total number of studies used by DiGiuseppe and Miller, as listed, was twenty-two. As will be discussed more fully Chapter III, a large portion of the DiGiuseppe and Miller research showed studies focusing on the problem of anxiety (73%); further, a larger percentage (77%) utilized either college or high school students.

Section 2: Noncomparative Studies

This section will review those studies which do not compare RET with different methods of psychotherapy. These studies generally employ a pre and post test format, and occasionally make use of various control groups. As with the results DiGiuseppe and Miller (1977) reported in their review, this research supports the RET position; though also - like DiGiuseppe and Miller - there are design and methodological shortcomings. Unlike, the DiGiuseppe and Miller review, in which the studies mainly focused on the problem of anxiety, the studies in the period since 1977 cover a far broader range of clinical problems, thus exposing the RET position to greater scrutiny. This section will be divided into several subsections indicating the general problem area addressed by the studies. These are: Anxiety, Multi-symptomatic, and Other.

Anxiety

Hymen and Warren (1978), focusing on test anxiety, used a subject base of eleven undergraduate students and divided them into two test groups; one group received RET plus imagery; the other RET without imagery. Each group received instruction over a three week period, consisting of 6 one hour sessions. Pre and post testing, using the anxiety scale of the Achievement Anxiety Test showed there was no significant difference between the two groups, though anxiety was lowered. The researchers discussed the fact that the results were possibly due to the similarity in the treatment methods, plus the short treatment time. In addition, however, the small size of the subject population and the lack of a control group may be considered further weaknesses of this particular study.

Barabasz (1979), in another study using test anxious students, measured psychophysiological arousal. This study used 148 subjects, who were divided into a treatment, attention placebo, or no treatment group. The treatment group listened to four audio taped RET counseling sessions over a two week period. The dependent measures were skin conductance and peripheral pulse volume. Pre to post test measures found that RET was significantly better than both the placebo and no treatment groups. This study was interesting in that no direct instruction in RET was given, and yet even the short treatment time produced significant results. However, there was not a follow-up study, which could have proved valuable.

D'Angelo (1978), in an anxiety related study, examined the effects of RET in reducing fear of negative evaluation. Seventy-eight subjects were divided into a treatment or a control group. The treatment group received 3 one hour presentations on RET on consecutive nights. Watson's and Friend's Fear of Negative Evaluation Scale was used as a dependent measure. The results showed a significant reduction in fear of negative evaluation for the RET group. Further, a one month follow up showed maintenance of these results.

Katz (1978) compared RET to a relaxation placebo and a no treatment control group, with 30 test anxious students. Subjects were divided equally among the groups. Multivariate analysis showed no difference among the groups at pre-treatment but the RET groups showed significant gains at post-treatment. No follow-up was indicated.

Multi-symptomatic

There were a number of studies in which no single symptom or problem, but rather a variety of presenting complaints, were focused upon. Many of the subjects were simply identified via psychological testing as being in need of help.

Rosenheim and Dunn (1977) examined the effectiveness of Rational Behavior Therapy (RBT) in a military health setting. RBT is a variation of RET which is very similar, but emphasizes greater examination of the accuracy of the perceptions and descriptions of activating events. The subjects (eighteen to thirty-six years of age) consisted of five males and seven females who requested treatment at the center. Treatment

involved both individual and group therapy for all subjects. Dependent measures were the MMPI and Rotter Incomplete Sentence Blank. Analysis of pre and post testing revealed no major personality changes, but implied that RBT was successful in aiding these subjects in reducing excessive anxiety and defensive denial.

Roberts (1977) studied the effectiveness of RET with students who were identified via the Deichmann-Roberts Attitude Inventory (D-RAI), and the California Psychological Inventory (CPI) as being in need of help. Forty-eight students were assigned to a two week experimental condition, while twenty-seven other students served as a control group. Again noting the limited time of RET instruction, a comparison of pre to post testing showed significant improvement for the experimental group on both the D-RAI and CPI.

Krentisky (1978), in a somewhat different kind of study, examined the relationship of age and verbal intelligence to the efficacy of Rational Emotive Education (a method of preventive RET) with older adults. Fifty-nine older adults were assigned to one of three treatment conditions: experimental; attention-placebo; and, a no-contact control. Within all the groups, distinctions were made with regard to levels of age (60-69 and 70-79), and two levels of intelligence. Employed as dependent measures were the Idea Inventory, the Adult Irrational Idea Inventory, the neuroticism scale of the Eysenck Personality Inventory, and the Trait-State Anxiety Inventory. The results demonstrated a significant increase for the RET group in rational thinking and emotional

adjustment when compared to the other control groups. There was no significant difference found on the neuroticism scale. It was further found that neither age nor intelligence was a significant factor in these findings.

Ritchie (1978) researched the effect of Rational Emotive Education on irrational beliefs, assertiveness, and/or locus of control of two hundred fifth grade students. Subjects were assigned to either an experimental or a control group. Three dependent measures were used in pre and post testing: The Children's Survey of Rational Concepts, Form C; The Revised Rathmus Assertiveness Schedule; and, The Intellectual Achievement Questionnaire. The findings showed a significant difference in rational ideas between the experimental and control groups. Further, the experimental group proved better, though not significantly, in assertiveness and locus of control.

Patton (1978), examined the effects of Rational Behavior Training (RBT) upon emotionally disturbed adolescents. All subjects were enrolled in an alternative special education program. The sample consisted of thirty-four adolescents diagnosed as "emotionally disturbed." The subjects were divided into either an experimental or a control group. The experimental group received forty minutes of RBT training for three days per week for ten weeks. Five dependent measures were utilized: the RBT Concepts Test; the Common Perception Inventory; Rotter's Internal-External Locus of Control Scale; the Personal Orientation Inventory; and, the Observational Emotional Inventory. Significant improvement for the experimental

group were found on the RBT Concept Test, the Common Perception Inventory, the Internal-External Scale, and the Time-Competence Scale of the Personal Orientation Inventory. Improvements, though not significant, were noted on the Inner-Directed Support Scale of the Personal Orientation Inventory, and all the subscales of the Observational Emotional Inventory.

Savitz (1979), studied emotional disturbances and the effect of RET. The subjects in this study were thirty-five outpatient clients. The subjects were divided into a treatment and a control group. In this study, treatment group subjects were given fifty minutes of RET group therapy each week for four weeks. Unfortunately, no dependent measures were utilized; however, the referring physician did note improvement for treatment group clients. This is a weak study considering the length of time spent in RET instruction, the absence of objective measures, and the lack of any follow-up.

Other

Bigney (1979), tested the RET position in a marriage counseling situation. The subjects were twelve couples who were assigned randomly to either the experimental or control group. Intrapsychic and interpersonal personality and temperament changes were measured after a twelve hour, six week instruction in RET. Dependent measures included the California Psychological Inventory and the Taylor-Johnson Temperament Analysis. Results favored the experimental group, though none of the findings proved significant. One design weakness in this study was the fact that it was constructed utilizing a post-test only, thus preventing

any knowledge of whether the groups had any significant differences prior to treatment.

Rainwater (1979) conducted a case study utilizing RET to treat an obsessive individual. Measures used included self-report, self-monitoring, and peer-report. Findings showed a significant improvement on all measures. The case study method, though valuable for in depth study, possesses little value as an outcome study; its inclusion in this thesis was based mainly on the fact that it was the only study found dealing specifically with the topic of obsessions.

Stevens (1979) studied the topic of stress with individuals in the Security Service of the U.S. Air Force. Each subject self-rated and worked on five stressful situations prior to treatment. Ratings were evaluated using Rational Self Analysis for promoting rational cognitions. Treatment consisted of a six-hour workshop, with each subject additionally scheduled for three follow-up sessions. All subjects improved in their self-rating of satisfaction with ten stressful situations in a test held two weeks after the workshop. Pre to post testing of the self-satisfaction scores revealed a significant improvement. Particular design weaknesses include the absence of a control group, in addition to the lack of a more objective measure.

Cox (1979) studied the effectiveness of Rational Behavior Therapy with fifteen individuals with alcohol abuse problems who were also criminal offenders. The site of the study was the Alcohol Rehabilitation Unit at the federal Correction Unit in Lexington, Kentucky. Subjects

ranged in age from 21 to 62, with a mean age of 39. There was a treatment group only who participated in RBT training prior to being paroled. A follow-up study showed that only two of the fifteen individuals relapsed to the point where their parole was revoked. Again, the lack of a control group is a weakness of this study.

mental group proved significantly better than the attention placebo and no treatment controls. Follow up to determine whether weight loss was maintained was not included as part of the study.

Dye (1981) investigated the influence of Rational Emotive Education (REE) on the self-concept of maternally deprived adolescents living in a residential group homes. Twenty-four subjects were divided into one of three groups: a treatment group, which received REE; a control group which received non-directional attention; and a no treatment control group. Dependent measurement was made utilizing the Tennessee Self-Concept Scale. Though the results failed to demonstrate any significant findings, the treatment group did show greater gain scores.

In summary, the non-comparative studies generally support the efficacy of the RET position. Further, the studies go beyond those in the DiGiuseppe and Miller (1977) review in that there are more problem areas being researched, and the subject pools are far more diverse. The next section examines the comparative studies.

Section 3: Comparative Studies

The comparative studies are divided into two parts: those studies comparing RET with a single other therapy; and, those studies comparing RET with more than one therapy method.

Part I: Single Therapy Comparisons

Behavior Assertion Training

Eades (1981) compared RET with Behavioral Assertion Training in dealing with problems of assertion and irrational beliefs. The subjects in this study were thirty undergraduate students who were divided into one of three groups; an RET group; a Behavioral Assertion Training group; or, control group. Dependent measures were the Assertion Inventory and the Irrational Beliefs Test, and were used for both pre and post testing. The results showed that both RET and Behavioral Assertion Training were significant at the .01 level from pre to post testing on the Assertion Inventory. However, only the RET group demonstrated gains that were significantly different from the control. Regarding the Irrational Beliefs Test, the findings showed that the RET group had significant gains from pre to post testing, compared to the Behavioral Assertion Training and control groups. Follow-up studies were not indicated.

Cognitive Modification

Cohen (1977) compared RET to Cognitive Modification with test anxious students, who were further identified as being open or closed minded. The subjects were sixteen undergraduate females. Eight subjects were used as a control group, while the remaining eight were divided into one of four treatment groups (of 2 persons per group): RET with open-minded subjects; RET with closed-minded subjects; Cognitive Modification with open-minded subjects; Cognitive Modification with closed-minded subjects. Dependent measures were the Test Anxiety Scale and the

Generalized Anxiety scale. The findings, though lacking significance, demonstrated that the RET open-minded subjects showed greater improvement on post-testing than either the Cognitive Modification or control groups. Further, the RET closed-minded subjects were seen as better when compared to the other groups. Though the study argues for the support of the RET position, there are shortcomings: the distinction of open and closed mindedness lacks explanation, and the lack of adequate subjects for each treatment group eliminates any possibility of generalizability.

Institutional Programs

There are two studies which fall into this category. Institutional Programs employ elements of various therapeutic paradigms which were developed by the house staff of the particular institution.

Foley (1977) studied the self concept of fifty-two male alcoholics. The subjects were divided into two treatment conditions: an institutional alcoholic treatment program; or, this same program plus RET. The latter group received six hours of RET over a two week period. The dependent measure was the Tennessee Self-Concept scale. Though both groups improved from pre to post testing, the findings revealed no significant difference between the two groups on post-test scores. There were numerous design weaknesses to this study including the absence of a control group, as well as the relatively short time of RET instruction.

Block (1978) studied the effectiveness of RET when compared to a school disciplinary/counseling program. The subjects were forty 11th and 12th grade black and hispanic students who were identified by school

personnel as high-risk and failure-and-misconduct prone. Students were divided into one of three groups: an RET group; the school discipline/counseling program; and, a control group. The RET group was given five weekly sessions spread throughout the entire semester. Dependent measures were grade point average, incidents of disruptive behavior, and class cuts. The results showed that the RET group demonstrated the greatest improvement on all variables over an extended period of time. Though this study supports the RET position, it is possible that an intervening variable may have been the fact that the RET group identified themselves as "special." The introduction of another type of therapy would have helped to answer this question.

Psychodynamic Insight Therapy

Kujoth and Topetzes (1977) completed two studies comparing RET with Psychodynamic Insight therapy. In the first of these studies, one hundred and fifteen community college students were divided into two groups: an RET group; and, an insight therapy group. Two dependent measures were utilized: the Multiple Adjective Checklist; and, the Your Irrational Personality Trait Inventory Score. Pre and post testing demonstrated that the Insight group showed no significant change, while the RET group was found significantly less irrational after treatment, with a decrease in undesirable emotionality also evidenced.

The second study was a partial replication of the first study. In addition to the RET and Insight groups, an eclectic therapy group was added. The findings revealed that, once again, only the RET group

improved in variables related to mental health; moreover, they were significantly less irrational after treatment, and exhibited significantly less anxiety and depression. The absence of a control group in both studies are to be considered weaknesses, though both studies appear to be rigorous in other features of design.

Relationships Oriented Counseling

Warren (1979) compared RET, RET plus Rational Emotive Imagery, and Relationships Oriented Counseling in the treatment of interpersonal anxiety. The subjects were sixty junior high school students who were divided into one of four groups: one of the three treatment groups, or a waiting list control. All treatment groups met for seven 50 minute sessions over a period of three weeks. Self report and sociometric measures were used as evaluation. Findings showed that both RET groups showed significant improvement from pre to post testing; and also with respect to the waiting list control on sociometric measures. Self report measures showed no significant results. Further, the RET plus imagery showed greatest improvement, though these findings were not significant.

Smith (1980) compared RET to Relationships Oriented Counseling in the treatment of test anxiety. In this study, sixty junior high school students were assigned to one of either treatment groups, or a waiting list control group. Treatment consisted of seven 50 minute sessions over a three week period. Sociometric and self report measures were used for evaluation. Results showed that on self report measures

RET was significant in pre to post measures. On the sociometric measures RET proved significantly better than the control.

Relaxation Training

Baither and Godsey (1979) researched the relative effectiveness of RET as compared to Relaxation Training in the treatment of test anxiety. One hundred fifty underachieving students were assigned to one of the two treatment groups, or a control group. The dependent measure utilized was the Alexander-Husak Anxiety Differential. Pre and post measurements were taken, and the results showed no significant findings.

Lipsky, Kassinove, and Miller (1980) in a pioneer study, researched the effectiveness of RET compared to relaxation training using an actual patient population. Being tested was the emotional adjustment of community mental health center patients of higher and lower intellectual ability. In addition, the effects of rational role reversal and rational emotive imagery were also studied. The subjects were fifty adults of both sexes ranging in age from twenty to sixty. The subjects were first divided into lower and higher IQ groups, and then divided into one of five treatment groups: an RET group; an RET plus rational role reversal group; an RET plus rational emotive imagery group; a Relaxation Training group; and a no contact control. Four dependent measures were utilized: the Idea Inventory; the Multiple Affect Adjective Checklist; the State-Trait Anxiety Inventory; and the Eysenck Personality Inventory. The findings are detailed as follows: all RET groups proved significantly better than either the Relaxation Training or control

groups on content acquisition; the RET-only group was significantly better than both the Relaxation Training and control on measures of depression and neuroticism, and significantly better than either the Relaxation Training or control group on all dependent measures, except the hostility scale, where both RET groups were significantly better than the control; RET plus rational role reversal was significantly better than RET alone on the depression, anxiety, and neuroticism measures; and RET plus rational emotive imagery was significantly better than RET alone on the anxiety measures. In all cases, intelligence was not found to be a factor. Because of the elaborate design features, and the fact that the researchers used an actual patient population, this may be considered one of the better studies testing the effectiveness of the RET position.

Self-Instructional Coping Therapy

Jackson (1980) examined the effectiveness of RET when compared to Self-Instructional Coping Therapy in problems of assertiveness. Also studied was trait anxiety in treatment. The subjects were forty-three adult women who responded to an assertion training advertisement, and were divided into one three groups: an RET group; a Self-Instructional Coping Therapy group; and a waiting list control group. Results were to be determined by a behavioral role play test, a follow-up in-vivo telephone call (to assess treatment generalizability), and self report measures. In the role play measure each subject was required to role play in fifteen situations, eleven of which were so unreasonable that

refusal behavior was anticipated. The follow-up in-vivo telephone call, to assess refusal behavior, occurred approximately three weeks after treatment and consisted of requesting each subject to submit a 45 minute on-the-spot interview. Both the RET and the Self-Instruction groups were significantly better than the control in the eleven refusal situations. No significant differences were found in the follow-up.

Stress Management Training

Jenni and Wollersheim (1979) compared Cognitive Therapy - based on RET - with Stress Management Training in the treatment of Type A behavior patterns. There were forty-two Type A subjects (determined by a structured interview) who were assigned to one of the two treatment groups, or a waiting list control. Dependent measures were self report, the State-Trait Anxiety Inventory, and physiological arousal measures. Both treatment groups showed improvement on self report measures, and were significant with respect to the control. For those subjects who initially had the highest degree of Type A characteristics, Cognitive therapy was significantly more effective than Stress Management and the control groups. No group reduced the subjects' cholesterol level or blood pressure.

Systematic Desensitization

Beck (1980) compared RET with Systematic Desensitization in the treatment of Speech-Anxious repressors and sensitizers. Twenty-four subjects were assigned to one of the two treatment groups. No control was used. Two dependent measures were used: the Behavior Checklist;

and speaking time. Pre to post test measures showed improvement for both treatment groups, but these results were not significant.

Shackett (1980) compared RET to Systematic Desensitization in the treatment of anxiety. Thirty subjects were assigned to one of two treatment groups; a matched control group was also constructed. Both treatment groups received one hour of therapy for four weeks. The dependent measure was the IPAT Anxiety Scale. The results showed that both the RET and Systematic Desensitization groups were significantly better than the control, but there were no significant differences between the treatment groups.

Part II Multiple Therapy Comparisons

RET, Behavioral Rehearsal, and Systematic Desensitization were compared by Uzoka (1977) in the treatment of test anxiety. Differences were also to be noted between defensive and passive locus-of-control. The subjects were sixty-nine volunteer male undergraduates who were assigned to one of the three experimental conditions, or a control. Dependent measures were: the Alpert and Haber Achievement Anxiety Scale (Debilitating Anxiety AAT-); the Spielberg State-Trait Anxiety Scale; and a self report inventory. The findings revealed that for defensive locus-of-control subjects there was significant improvement for all treatment groups when compared to the control; however, for passive subjects only the behavioral rehearsal and RET groups showed improvement, though this was not significant.

Carmody (1977) compared RET to Self-Instructional Coping Therapy and Behavior Assertion Training in the treatment of assertion problems. The subjects were sixty-three subassertive adult outpatients, who were

divided into one of the three experimental conditions, or a control group. All treatment conditions received four 90 minute sessions. Results were evaluated by behavioral and self report measures. The findings showed that: all treatment groups showed improvement in short term treatment; only the RET group proved significantly better on the self report measure of unproductive cognitions; only the RET group demonstrated significant generalization of treatment gains in an "in-vivo" test-of-transfer during a post test follow-up; and treatment gains for all groups were maintained at a three month follow-up.

Manchester (1978) compared RET to Behavior Modification, Gestalt Awareness, and Nutritive Education in the treatment of obesity and nutrition among minority children. The subjects were seventy-one black, urban, elementary school children ranging in age from five to thirteen. The subjects were assigned to one of the four treatment groups, but a control group was, unfortunately, not employed. Dependent measures included measurement of weight, skinfold, self-esteem, and food consumption. Though all treatment groups were found to be improved from pre to post test measures, there were no significant findings.

In these comparative studies, like those in the prior section on the non-comparative studies, support for the RET position is given strength. A wide range of comparisons with regard to different therapies allows for greater generalizability of RET. The next section will discuss outcome studies where RET is combined with other therapies, or where specific components of RET are being measured.

Section 4: Other Outcome Studies of RET

This section includes those RET outcome studies which do not strictly fall into the headings of the prior two sections. These studies largely consist of RET combined with other therapies; measurements of specific elements of RET; or therapies which are very similar or comprise a generic form of RET.

Rush, Beck, Kovacs, and Hollan (1977) performed one of the major studies of an RET-like therapy. Rush, Beck, Kovacs, and Hollan (1977). The researchers examined and compared Cognitive Therapy and Pharmacotherapy in the treatment of depressed outpatients. The subjects were forty-four severely depressed individuals who were referred to the Mood Clinic of the University of Pennsylvania Medical Center. After initial matching and testing, nineteen of the subjects were assigned to individual cognitive therapy; the remaining twenty-five received drug therapy treatment. Both groups were treated for twelve weeks. Pre and post testing was measured via a battery of extensive psychological tests as well as self report, with different doctors performing the testing than treatment. Further testing at irregular monthly intervals up to one year after the completion of treatment was also performed. Seventy-five per cent of the subjects were suicidal at the time of referral, with the average subject being depressed for a minimum of eight years. The findings significantly favored the Cognitive therapy group at the end of treatment. Further, at a one year follow-up, the results remained significant, with the Cognitive therapy group showing

less than half the relapse rate of the drug therapy group. Up to the time of this study, no form of therapy was shown to be even as effective as drug therapy with this patient population.

Lake (1978) combined RET plus digit temperature biofeedback and compared it with digit temperature biofeedback alone, frontalis EMG biofeedback, and assisted relaxation training in the treatment of migraine headaches. The subjects were twenty-four classical migraine headache sufferers, and were assigned to one of the four treatment groups, or a control group. All treatment groups received four weeks of instruction. The dependent measure was a daily record of headache activity. Findings showed that though all treatment groups improved, there was no significant differences between the groups, or in comparison to the control.

Miller (1977) investigated and compared Rational Emotive Education with Rational Emotive Education plus behavioral rehearsal, and Rational Emotive Education plus behavioral rehearsal and written homework assignments among ninety-six children of high and low intellectual levels. The subjects were divided into one of the three experimental conditions, or a control group. The dependent measures were two measures of content acquisition, one measure of neuroticism, and one measure of trait anxiety. Findings revealed that all three experimental groups were significantly better than the control on all measures, however, there were no significant differences between the two groups. Further, intelligence was not found to be a factor in any of the findings.

Saltberg (1980) compared RET to RET plus bibliotherapy to bibliotherapy alone in the treatment of self-concept problems among thirty

students. The subjects were divided among the three treatment groups. No control group was utilized. Dependent measures were made utilizing Rotter's Locus of Control Scale, the Rational Behavior Inventory, the Tennessee Self-Concept Scale, the Self-Evaluation Scale, and the Ego Strength Scale of the MMPI. The results showed that though there was improvement in all three treatment cases, none was significant when compared to the others. One shortcoming of this study was the absence of a control group; further, pretesting was omitted.

Taylor (1981) combines RET with systematic desensitization and relaxation training in the treatment of text anxious high school students. The combined therapeutic interventions forms what Taylor calls the Lecture Verbal Interaction Method (LVIM). There were 143 subjects divided into six classes of approximately 24 students each: three groups composed of a treatment, placebo, or a control, resulting in two classes to each group. Pre and post testing were conducted using the Stimulus-Response Inventory, the State-Trait Anxiety Inventory, and chapter content algebra tests. The findings show that the treatment group was significantly better on all measures. The above results lend support to the efficiency of RET when used with other treatment methods.

Kassinove, Miller, and Kalin (1980) examined the efficiency of Rational Emotive Bibliotherapy for prospective psychotherapy clients. There were thirty-four subjects, ranging in age from 21-56, who were assigned to either the bibliotherapy, audiotape, or a no-contact control group. Testing for neuroticism and trait anxiety, the bibliotherapy group alone showed significant results; regarding the acceptance

of irrational ideas, both groups showed significant improvement at the end of the pretreatment program.

Zane (1979) combined RET with behavioral rehearsal in the treatment of non-assertive behaviors. The subjects were twelve male and sixteen female individuals. Two groups were utilized: one group was instructed first with RET, and afterwards, behavioral rehearsal; in the other group, the opposite regimen was used. No control was used. Dependent measures were the Conflict Resolution Inventory, the Behavioral Role Playing Assertiveness Test as well as telephone and self report follow-up questionnaires. The results indicated both experimental groups showed significant improvement in pre to post test measurements, with the RET/Behavioral Rehearsal sequence being most effective.

Costello and Dougherty (1977) examined Rational Behavior Training in the classroom. Three groups of twenty-one subjects each represented one of three test conditions: designated as group R were undergraduates enrolled in a fifteen week course in Rational Behavior Training; designated as Group A were adults enrolled in a six week adult education course in Rational Behavior Therapy, group C subjects were undergraduate students in a theology course, and served as a control. Pre and post dependent measurement was accomplished utilizing the Personal Orientation Inventory. Findings on the inner directedness scale showed significant results for both Rational Behavior Training groups; whereas, findings on the time competency scale showed only the group R students with significant change. This latter result, in addition to reflecting treatment

time, also may suggest that greater emphasis is placed on inner directness than time competency in Rational Behavior Training.

Miller and Kassinove (1978) studied the relative effectiveness of Rational Emotive Education among high and low IQ 4th graders. The subjects were ninety-six students who were divided into one of four groups: one group received only Rational Emotive Education lectures; a second group received both lectures and behavioral rehearsal; a third group received lectures, behavioral rehearsal and ABC homework sheets; a fourth group served as a control. Pre to post test measurements showed that there were no significant findings though all Rational Emotive Education groups, particularly those which added behavioral components, showed improvement. Further IQ proved not to be a factor.

Miller (1977) examined two different approaches to the problem of self evaluation in the treatment of social evaluation anxiety. Sixty undergraduates were divided into one of three groups: a Self Acceptance group; a Self Esteem group; or a waiting list control. Under focus here was the RET principle that self acceptance, with its stated goal of non-rating an individual, would produce better results than the self esteem model. Treatment groups received ten weeks of instruction in which the experimental conditions were taught. Dependent measures were the Fear of Negative Evaluation Scale and the Social Avoidance and Distress Scale. The findings revealed that the self acceptance group was significantly more improved when compared with the self esteem or control on pre to post assessment for the Fear of Negative Evaluation

Scale; further the self acceptance group was also significantly better than the control, but not the self esteem group, on the Social Avoidance and Distress Scale.

Hultgren (1977) studied the effectiveness of RET in group parent education. Sixteen mothers responded to an advertisement for a ten week course, and were divided into a Rational Child Management group, or a control group. A post test only control group design was used. The findings showed that the Rational Child Management group was more effective than the control in changing a mother's knowledge of the causes of emotional responses and their child rearing attitudes, but not more effective than no treatment in changing knowledge of child management principles, child rearing practices, rationality of beliefs, or their children's behavior.

In Appendix III there will be found a table of studies used in this chapter.

These studies cover a varied range of problem situations and subject populations. Like the prior two sections, the efficiency of RET is maintained, with no significant results against the RET position. In the next chapter, detailed discussion of this chapter's findings will be put forth.

CHAPTER III

DISCUSSION, SUMMARY, AND RECOMMENDATIONS

Discussion

Since this thesis is an update on the review performed by DiGiuseppe and Miller in 1977, the conclusions in their discussion will serve well as a starting point for this summary. This will allow for a partial continuity between the two studies, as well as permitting for verification or exceptions to be noted.

First, DiGiuseppe and Miller assess their findings in a general way by indicating that the body of research as a whole does support the efficacy of RET; and, specifically, they make the following points.

1. RET is more effective than client-centered therapy with introverted persons;
2. RET is more effective than systematic desensitization in the reduction of general or pervasive anxiety;
3. a combination of cognitive therapy and behavior therapy appears to be the most efficacious treatment for depression;
4. the relative effectiveness of RET versus assertiveness training is inconclusive due to limited and confounded research.

This thesis agrees with the general findings supporting the efficacy of RET. Of the forty-seven studies reviewed, there are thirty-one studies which result in significant findings favoring the RET position. Further, of the remaining studies, the RET treatment groups all show improvement, and in no study does another treatment method prove significantly better than RET. Regarding DiGiuseppe's and Miller's



specific conclusions stated above in comparison with the findings of this thesis: 1. There were no studies found comparing RET to client-centered therapy, thus, no conclusions may be drawn; 2. Of the studies comparing RET to systematic desensitization, there were no significant findings supporting the conclusion that RET is more effective than systematic desensitization; 3. Only one study was found which specifically dealt with the problem of depression (Rush, Beck, Kovacs, and Hollan, 1977). The findings of this study do support the conclusion drawn by DiGiuseppe and Miller; 4. Two studies compare RET to assertive training (Eades, 1981 and Carmody, 1977). In the Eades study both RET and assertive training were significant in pre to post testing, but only RET was significant with respect to the control. In the Carmody study, RET was found significant for some of the dependent measures. Though RET is favored over assertive training in these two studies, no definite conclusions seem warranted.

The next area commented upon by DiGiuseppe and Miller regards methodological shortcomings of the studies they reviewed. Specifically, they note inadequate control groups, and the failure to make comparisons with other forms of therapy. This is also true of the studies reviewed in this thesis, but to a lesser degree. In addition to inadequate or no control groups, some studies are also constructed with a post test only design.

Another point discussed by DiGiuseppe and Miller is the use of nonrepresentative subjects pools, specifically college and high school students. Though many of the studies in this thesis also utilize these school populations as subjects, many other studies have broadened their population base, thus providing a wider test of the RET position. In addition to the high school and college populations, the studies in this thesis also include clinical out patients, elementary school children, adults gained through advertisement, mothers, military personnel, older adults, emotionally disturbed adolescents, minority students, high and low IQ populations, school underachievers, couples in marriage counseling, criminal offenders, overweight adults and children, etc. Thus, it may be concluded that this aspect of research has improved from the studies reviewed by DiGiuseppe and Miller.

DiGiuseppe and Miller also note the absence of studies in their review which deal with client variables such as socioeconomic status and IQ. Again, an improvement may be noted in the studies reviewed in this thesis. Miller and Kassinove (1978) and Krentisky (1978) both performed studies isolating the variables of IQ, demonstrating that it is not a factor in outcome. Block (1978) and Zelig, Stone, and Lehr (1980) both address minority populations of low socioeconomic status, though no comparison is drawn to higher socioeconomic groups. Nonetheless, no research has arisen which would dictate that RET is superior with one socioeconomic group over another. Further, there remains an absence of studies examining racial/cultural factors.

Another area of concern discussed by DiGiuseppe and Miller is the lack of adequate dependent variables, and the weaknesses of existing psychometric scales. This, indeed, remains a problem in the research reviewed in this thesis. In addition to self report measures, which are inherently weak, dependent variables, the sheer number of different scales - this author counted sixty-one different scales used in the forty-seven studies of this thesis - render objective comparisons virtually impossible. DiGiuseppe and Miller suggest a greater use of behavioral measures, which, in fact, some of the studies in this thesis do use: for example, Block (1980) in dealing with obesity uses "pounds lost" as a dependent measure, and Barabasz (1979) uses psychophysiological instrumentation to measure anxiety. Regarding follow-up studies, this remains a problem with the current research, with only a small minority of studies performing follow-up.

Two other limitations noted by DiGiuseppe and Miller concern the short duration of therapy and the level of training of the therapist. The first of these, duration of treatment, surely remains a problem with the research in this thesis, with some studies using only a single session. Regarding the level of training of the therapist, this too remains a significant barrier to valid RET outcome assessment. In addition to the DiGiuseppe and Miller argument that researchers publish therapist manuals describing the techniques used in research, this author believes that, where feasible, taped audio sessions be included of treatment sessions, and that these be reviewed by seasoned, acknowledged practitioners of RET.

The final remarks of DiGiuseppe and Miller concern the lack of research isolating the critical components of RET. None of the outcome research reviewed in this thesis addresses this subject; however, this is not to suggest that such research is absent, but simply to note that this thesis did not seek out such research, since such studies do not measure outcome, as such.

Having discussed this thesis in reference to the conclusions drawn by DiGiuseppe and Miller, considerations will now be given to conclusions to be drawn from this updated review of the literature. In the research since the DiGiuseppe and Miller study, RET has been tested in a greater number of problem areas, thereby increasing its generalizability to a broader range of therapeutic situations. In addition to a wide array of anxiety situations, the current review shows research covering such topics as migraine headache, weight loss, alcohol abuse, personality change, dating skills, emotional disturbance, Type A behavior, school misconduct, self-concept, assertion, depression, and pretreatment. Though none of this research can be said to represent conclusive evidence of effectiveness, the body of this research as a whole supports the RET paradigm. Problem areas not covered to any extensive degree include obsessions, phobias, hysterias, and the whole scope of psychoses - but in fairness, few therapeutic paradigms have covered these areas in research.

Another advance in the research performed since 1977 is the number of other therapies to which RET has been compared. Though this is still

somewhat limited, this current review does include research which compares RET to psychodynamic insight therapy, eclectic therapy, in-house treatment programs, Relationships Oriented Counseling, relaxation training, Self-Instructional Coping Therapy, stress management training, behavioral assertion training, cognitive modification, systematic desensitization, Gestalt therapy, nutritive education, pharmacotherapy, and digit temperature and frontalis EMG biofeedback. Absent from comparisons, however, are psychoanalysis, existential therapy, transactional analysis, and reality therapy. On the whole, however, it may be fairly stated that RET has been tested against a wide range of therapies, with no major results significantly favoring another therapy.

One area of concern to outcome studies of any therapeutic paradigm is the implicit assumption that the given therapy being studied is a static entity with well-defined theory and techniques. It is, in fact, more accurate to say that therapies are in a state of evolvment, questioning and refinement. For example, Freud added to or changed psychoanalytic premises throughout his life; Skinner has done likewise in his study of behavior. RET is not an exception. Thus, in reviewing outcome studies, it is important to ask what particular set of theories and techniques is being represented as RET in any given study. For some researchers RET is only the introduction of the ABC's of emotional disturbance, and the instruction that thinking causes emotions. Other practitioners of RET include imagery, homework assignments, etc., as part and parcel of the therapy. In this sense, then, it is difficult to fully assess these outcome studies.

Absent in the research performed thus far are longitudinal studies to evaluate RET over a period of years. While it is true that the immediate effects of RET generally produce positive results, there is no rigorous research indicating the effectiveness of RET after termination of therapy. This is certainly not an indictment of RET alone, since the funds and personnel to support such research remain a problem for all paradigms; nonetheless, the presence of such research would be most valuable.

Summary and Recommendations

Even with the shortcomings noted above and those noted in reviewing the conclusions of DiGiuseppe and Miller, the overall conclusion may still be made that RET is largely supported by the literature, and in no case found ineffective. This leads to the following suggestions for future research: 1. Continued research comparing RET with other major therapies, especially the psychoanalytic and non-cognitive behavior therapies; 2. Longitudinal studies and research including better follow-up results; 3. Better enunciated descriptions of therapies being compared: that is, written description of the techniques being practiced as representing RET or another therapy; 4. The use of trained therapists and clinicians in the therapies being compared, rather than graduate students or academicians; 5. Research evaluating different therapeutic styles within the context of RET. Criticism is often directed based on the unique style of Ellis, and this style is regarded as typical of RET in practice. But as Johnson (1980) and others have discussed, a therapist

need not be like Ellis to effectively practice RET; 6. More studies with actual patient populations, as opposed to student "volunteers."; 7. Greater use of the technologies available, such as video taping treatment sessions, in evaluating research; 8. Research evaluating psychiatric uses of RET.

In conclusion, the results show that there exists little doubt that RET offers many valuable contributions to the field of psychology and the practice of psychotherapy; with continued research and refinement, RET promises even greater use by practitioners.

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Exhibits
&
Appendices

APPENDIX 1: Non-Comparative Studies from DiGiuseppe and Miller

<u>Name/Year</u>	<u>Comparisons</u>	<u>Problem</u>	<u>Subjects</u>	<u>Outcome</u>
Jacobs (1971)	RET vs. 2 control groups vs. placebo	anxiety	college students	RET sig.
Wine (1971)	RET + modeling vs. RET - modeling	test anxiety	college students	RET + mod sig.
Karst Trexler (1970)	RET vs. fixed role therapy	speech anxiety	college students	No sig. diff.
Trexler Karst (1972)	RET vs. placebo vs. control	public speaking anxiety	college students	RET sig.
Straatmeyer Watkins (1979)	RET vs. RET - disputing vs. placebo vs. control	public speaking anxiety	college students	RET sig on pre to post testing; not sig on post test comparisons
Keller Croake Brookings (1975)	RET vs. control	anxiety and irr. ideas	geriatric pop.	RET sig.
Bard (1973)	RET + proselytizing to friends vs. RET	irrational beliefs	college students	RET + proselytizing
Jarmon (1972)	RET vs. RET + bibliotherapy vs. placebo vs. control	speech anxiety	college students	RET + bibliotherapy sig.
Maultsby (1971)	RET + written homework	multi-symptomatic	psychiatric outpatients	85% of patients judged most improved rated written homework as valuable.

Appendix II: Comparative Studies from DiGiuseppe and Miller

<u>Name/Year</u>	<u>Comparisons</u>	<u>Problem</u>	<u>Subjects</u>	<u>Outcome</u>
Maes Heiman (1972)	RET vs. client centered vs. systematic desensitization vs. control	test anxiety	high school students	RET and Sys. Des. sig. over client- centered and control on GSR and heart rate; but, no sig between groups on State-Trait Anxiety
DiLoreto (1971)	RET vs. client centered vs. sys. desensitization vs. placebo vs. control.	interpersonal anxiety	college students	RET and Sys. Des. Sig.
Meicheubaum Gilmore Fedoravicius (1971)	Group RET vs. Group Sys. Desensitization vs. Group RET + Group Sys. DES. vs. placebo vs. control.	speech anxiety	college students	RET alone and Sys. Des. alone better
Meicheubaum (1972)	Cognitive modifi- cation vs. sys. desensitization vs. control.	test anxiety	college students	Cog. mod. sig.
Kauter (1975)	Systematic rational restructuring vs. systematic desensiti- zation vs. control.	anxiety	volunteer pop. from newspaper ad	All treatment sig. pre to post

<u>Name/Year</u>	<u>Comparisons</u>	<u>Problem</u>	<u>Subjects</u>	<u>Outcome</u>
Moleski Tosi (1976)	RET vs. systematic desensitization vs. RET + in-vivo practice vs. sys. des. + in-vivo practice vs. control.	stuttering	adult stutterers	RET groups sig. better
Wein Nelson Odom (1975)	Cognitive restruc- turing verbal extinction vs. systematic desensiti- zation vs. placebo vs. control.	snake phobia	college students	Cog. res. and sys. des. better
Holroyd (1976)	RET vs. systematic desensitization vs. RET + sys. des. vs. pseudotherapy/ meditation vs. control	test anxiety	college students	RET sig.
Wolfe (1975)	RET + modeling + behavioral rehearsals vs. modeling + beh. reh. vs. placebo vs. control	assertiveness and anxiety	women volunteers	Both treat- ment groups sig. for assert; only RET group sig. for anxiety
Tiegerman (1975)	RET vs. assertive training vs. RET + assertive training vs. placebo vs. control.	interpersonal anxiety	college students	All better but not sig. over controls; assertive training best followed by combined, than RET
Thorpe (1975)	RET vs. systematic desensitization vs. behavioral rehearsal vs. placebo	assertiveness	college students	RET better but not sig.
Maultsby Knipping Carpenter (1974)	RET vs. control	primary prevention	emotionally disturbed high school students	RET sig.

<u>Name/Year</u>	<u>Comparisons</u>	<u>Problem</u>	<u>Subjects</u>	<u>Outcome</u>
Maultsby Costello Carpenter (1974)	RET vs. control	preventive mental health	college students	RET better than control

Appendix 3: Studies Used in this Thesis

<u>Name/Year</u>	<u>Comparisons</u>	<u>Problem</u>	<u>Subjects</u>	<u>Outcome</u>
Hymen Warren (1978)	RET + imagery vs. RET - imagery	test anxiety	11 undergrad	no sign. diff.
Barabasz (1979)	psychophysiological arousal: RET vs. placebo vs. no tr.	test anxiety	148 students	RET sig better than placebo & no treatment
D'Angelo (1978)	RET vs. control	fear of neg. eval	78 ind.	RET sig.
Katz (1978)	RET vs. placebo vs. no treatment	test anxiety	30 students	RET sig.
Rosenheim Dunn (1977)	RBT alone	multi- symptomatic	5 M & 7 F in military health setting	improvement but not sig.
Roberts (1977)	RET vs. control	multi- symptomatic	48 students	RET sig.
Krenitsky (1978)	REE vs. placebo vs. control	relation of age/IQ to efficacy of REE	59 older (60-79) adults	age/IQ not a factor. REE sig. in rat. thinking and emot. adj; not sig. on neuroticism scale.
Ritchie (1978)	REE vs. control	irr. beliefs; assert.; locus of control	200 5th grade students	REE sig in irr beliefs; improved in assert./lc
Patton (1978)	RBT vs. control	emotional disturbance	34 emot. disturbed adolescents	RBT sig for RBT concept test/Common Perc. Inv./ IN-EX scale/ Time comp sc of POI; impr but not sig In-directed supp sc and all sub scales of Obs Emot Inventory

<u>Name/Year</u>	<u>Comparisons</u>	<u>Problem</u>	<u>Subjects</u>	<u>Outcome</u>
Savitz (1979)	RET vs. control	emotional disturbance	35 out/pat.	no dependent measures but improvement noted for all by referring physician
Block (1978)	RET vs. In-house school trtmt pgm	school failure & misconduct	40 11th & 12th grade minority students	RET better, bot not sig.
Kujoth	RET vs. Psychodynamic Insight therapy	irr. ideas & neg. emotions	115 community college students	RET sig. wrt irr ideas, better but not sig wrt neg. emotions
Kujoth Topetztes (1977)	RET vs. Psychodynamic Insight therapy vs. eclectic therapy	irr. ideas & neg. emotions	115 community college students	RET sig. wrt irr ideas, anxiety, & depression
Warren (1979)	RET vs. RET + imagery vs. Relationships Oriented Counseling	interpers. anxiety	60 junior high sch. students	Both RET grps sig. from pre to post & also wrt control.
Smith (1980)	RET vs. Relationships Oriented Counseling	test anxiety	60 junior high sch. students	NO sig. diff. wrt ROC; but, RET sig from pre to post wrt to self report & sig. compared to control on sociometric measures.
Baither Godsey (1979)	RET vs. Relaxation Training	test anxiety	150 under-achieving students	RET better, but not sig.
Lipsky Kassinove Miller (1980)	RET vs. Relaxation Training	emotional adjustment	50 adults (20-60 yrs) actual patient population.	RET sig.

<u>Name/Year</u>	<u>Comparisons</u>	<u>Problem</u>	<u>Subjects</u>	<u>Outcome</u>
Jackson (1980)	RET vs. Self- Instr. Coping Therapy	assertiveness	43 females	Both RET & SI sig. from pre to post. RET better, but not sig wrt to SI.
Jenni Wollersheim	RET vs. Stress Management Trng.	Type A behaviour	42 indiv.	Both sig. wrt control. RET sig for high degree of Type A charac- teristics wrt SMT.
Bigney (1979)	RET vs. control	person- ality/ tempermt changes	12 couples in mar. counseling	improved but not sig.
Rainwater (1979)	RET case study	obsessive	male obsessive	sig. imp.
Stevens (1979)	RBT alone	stress	individuals in Security Service of U.S. Air Force	sig. imp.
Cox (1979)	RBT alone	alcohol abuse	15 criminal offenders	improved - only 2 of 15 had parole revoked after treatment
Plachetta (1979)	RBT vs. control	dating skills	17 volunteers	RBT sig. on Dating Fear Scale & Social Avoid. & Distress Scale improved on Fear of Neg Eval. Scale
Zelie Stone Lehr (1980)	RBT vs. control	school discipline	60 students	RBT sig for 2 behaviour ratings and recidivism

<u>Name/Year</u>	<u>Comparisons</u>	<u>Problem</u>	<u>Subjects</u>	<u>Outcome</u>
Block (1980)	RET vs. placebo vs. control	weight loss	40 overweight	RET sig.
Dye (1981)	REE vs. attention vs. no treatment	self concept	24 maternally deprived adolescents	improved but not sig.
Eades (1981)	RET vs. Behavioral Assertion Training	assertion and irr. beliefs	30 under- graduates	Both RET and BAT sig. pre to post; only RET sig comp. to control
Cohen (1977)	RET vs. Cognitive Modification	test anxiety	16 female undergrads.	RET better but not sig.
Foley (1977)	RET vs. Institutional Program	alcoholism	52 males	Both trtmt grps improved but not sig.
Beck (1980)	RET vs. Systematic Desensitization	Speech anxiety	24 indiv.	Both RET & SD better, but not sig.
Shackett (1980)	RET vs. Systematic Desensitization	anxiety	60 indiv.	RET & SD both sig wrt control but not wrt each other.
Uzoka (1977)	RET vs. Behavioral Rehearsal vs. Systematic Desen.	Test anxiety	69 male undergrad	For defensive locus of control all trmt grps sig wrt to control; for passive locus of control RET & Beh Reh better but not sig.
Carmody (1977)	RET vs. Self-Insr Coping therapy vs. Behaviour Assertion Training	assertion	63 adults	All trmt better only RET sig.

<u>Name/Year</u>	<u>Comparisons</u>	<u>Problem</u>	<u>Subjects</u>	<u>Outcome</u>
Manchester (1978)	RET vs. Behavior Modification vs. Gestalt vs. Nutritive Educ.	obesity/ nutrition	71 minority elem. sch. children	All improved, none sig wrt each other
Rush Beck Kovacs Hollan (1977)	Cognitive Therapy vs. Pharmacotherapy	depression	44 indiv.	Cog. Therapy sig better than Pharm.
Lake (1978)	RET & digit temp. biofeedback vs. digit temp. bio alone vs. EMG bio. vs. relax. trng.	migraine headache	24 indiv.	All improved, but none sig.
Miller (1977)	REE vs. REE & Beh. Reh. vs. REE & Beh. Re. & written home- work	content acquisition, neuroticism, anxiety.	96 child.	All trmt grps sig wrt con- trol, but not wrt each other
Saltberg (1980)	RET vs. RET & bibliotherapy vs. biblio. alone	self-concept	30 stud.	Improvement with all, not sig.
Taylor (1981)	RET & Sys. Des. & Relax. Trng.	test anxiety	143 H.S. students	Trmt grp sig. wrt placebo & control.
Kassinove Miller Kalin (1980)	Rational Emotive Biblio. vs. Rat. Emot. Audiotherapy	pre-trmt	34 adults	For neurot. & anxiety biblio. sig.; for irr ideas both sig.
Zane (1979)	RET & Beh. Reh. vs. Beh. Reh. & RET	assertion	12 Male 12 Fem.	Both sig pre to post
Costello Dougherty (1977)	RBT vs. control	RBT in classroom	63 indiv	RBT sig.
Miller Kassinove (1978)	REE vs. REE & Beh. Reh. vs REE & Beh. Reh. & ABC h.w. vs. control	emotional factors	96 4th graders of low/hi IQ	Improved, but not sig. IQ not factor

<u>Name/Year</u>	<u>Comparisons</u>	<u>Problem</u>	<u>Subjects</u>	<u>Outcome</u>
Miller (1977)	RET self-acceptance grp. vs. self esteem vs. control	social anxiety	60 under- graduates	RET sig on Fear of Neg Eval Scale; RET better, but not sig on Social Avoid. and Distress Scale
Hultgren (1977)	Rational Child Management vs. control	parent educ.	16 mothers	Only partial sig.



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May 14, 1982

Terrance E. McGovern
16W481 Lake Drive
Clarendon Heights, IL 60514

Dear Mr. McGovern:

Thank you for the kind sentiments expressed in your May 9 letter. I am delighted that news about multimodal therapy has spread to Illinois!

I do hope that you will read THE EFFECTS OF PSYCHOLOGICAL THERAPY (Second Edition) by Rachman and Wilson (Pergamon Press, 1980) especially pages 195-209 which deals with a review of outcome studies in RET.

As to the statement that in practice RET and multimodal therapy (MMT) are identical, this is incorrect. There are many practical (and theoretical) differences. While it is true that there is much overlap, let me mention a few significant differences.

- 1) To the RET practitioner, "imagery" and "cognition" are more or less the same. MMT believes that the left-brain/right-brain split makes it imperative to separate imagery from cognition. This results in many different imagery techniques in the hands of MMT practitioners, whereas RET employs little more than so-called "rational-emotive imagery" techniques.
- 2) There are many procedural differences. The MMT clinician works from a Modality Profile, constructs Second-Order BASIC I.D. Charts (when necessary), and employs techniques that are unique to MMT such as "bridging" and "tracking."
- 3) The use of Structural Profiles is also unique to MMT. In marriage therapy, we find them invaluable.

There are additional differences, but as you can see, MMT and RET are by no means identical in practice. I do hope this proves useful to you.

Sincerely,

Arnold A. Lazarus, Ph.D.
Director



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Terrence McGovern
16W481 Lake Dr.
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May 19, 1982

Dear Mr. McGovern:

In response to your letter of May 8, let me say that I agree with Richard and Ruth Wessler that in practice RET and multi-modal therapy are quite similar. As I have pointed out in several of my recent writings on RET and in most of the workshops on rational emotive therapy that I give, RET is always cognitive, emotive and behavioral, and invariably includes several techniques under each of these three main modalities. It does not always include all of the elements in Arnold Lazarus' basic ID, since occasionally one of them would be omitted in RET. For example, the element of sensation would be included in practically every case where the individual has a sex problem but it might not be included in or it might be only mildly included in cases where individuals have test anxiety. Very often, RET therapists would use all the techniques included in Lazarus' basic ID and would also emphasize philosophic discussions and a consideration of ethical questions which might be largely ignored in Lazarus multi modal therapy. The main difference between the practice of the two therapies would be that RET therapists would almost always use a great deal of active disputing and the teaching of the scientific method to clients while multi-modal therapy might minimize these particular methods. But many therapists who call themselves RETers could not easily be separated from many of those who call themselves practitioners of multi-modal therapy. I prefer to see cognitive behavior therapy of cognitive emotive behavior therapy as the generic term for what is done in both RET and multi-modal therapy and to see both of these methods as somewhat different aspects of this generic mode.

As I may have told you in my previous correspondence, I now have probably more than 200 outcome studies of RET and cognitive behavior therapy collected for a comprehensive book on RET and CBT that I am in the process of trying to get to press. Before you actually finish your thesis, you might do well to look over some of the material I have here in New York to see whether it goes beyond that which you have already collected. If you are going to be in New York at any time, especially on a Sunday when I will be in town, let me know and I can give you some of this material to look over.

Cordial regards,

A nonprofit community agency chartered by the Regents of the University of the State of New York

Albert Ellis, Ph.D. Executive Director AE:wd

APPROVAL SHEET

The thesis submitted by Terrance E. McGovern has been read and approved by the following committee:

Dr. Manuel Silverman, Director
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Assistant Professor, Guidance and Counseling, Loyola

The final copies have been examined by the director of the thesis and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the thesis is now given final approval by the Committee with reference to content and form.

The thesis is therefore accepted in partial fulfillment of the requirements for the degree of Master of Arts.

4-20-83

Date



Director's Signature