Journal of Rational-Emotive & Cognitive-Behavior Therapy
Volume 14, Number 1, Spring 1996

THE NATURE OF IRRATIONAL AND RATIONAL BELIEFS: PROGRESS IN RATIONAL EMOTIVE BEHAVIOR THEORY

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ABSTRACT: This paper discusses some limitations of Ellis's Rational Emotive Behavior Therapy. It is suggested that the present definition of irrational and rational beliefs is inadequate. The present theory is unclear whether irrational beliefs are exaggerated negative evaluations or empirical distortions of reality. It is proposed that irrational beliefs are core schemes, and that the concept of schema replace the present definition of beliefs. Ellis's position that demandingness is at the center of irrational thinking and emotional disturbance is examined. Research has failed to support this theory. It is proposed that demandingness and self-downing may be separate types of core irrational schemes. Research strategies are suggested that could test Ellis's position on the centrality of demandingness and on the nature of irrational beliefs in general.

It is also suggested that irrational beliefs differ on their level of abstraction. The present REBT theory fails to identify which level of abstraction is necessary to cause disturbance, at which level of abstraction therapists should seek change, and whether a therapist should intervene first at higher or lower levels of abstract beliefs. It is suggested that a therapist only seek change to the level of abstraction that matches the client's concerns and that therapists begin to intervene at lower levels of abstraction and move up to more abstract cognitions as therapy progresses.

Rational Emotive Behavior Therapy (REBT) has experienced substantial growth and change in the last three decades (Dryden, 1994). This growth has been facilitated by its commitment to self criticism,

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logical debate, and philosophical discourse. I once heard a workshop participant ask Albert Ellis what he would do if REBT became a religion with all of its dogmatic trappings. Al immediately pounded his fist on the table and responded, "Oppose it!" Following this tradition of openness to criticism, I will give my impressions of the present weaknesses of REBT theory and propose some refinements. These criticisms represent an attempt to improve REBT, not to abandon it. My attitude toward REBT reminded me of the famous saying about democracy. "It's the worst form of government ever developed. But it is better than all the others." Well REBT has many faults and limitations. But I believe that it is the best system of psychotherapy ever developed. I will focus my comments on the need for empirical research, the nature and definition of irrational beliefs, Ellis's notion of the central role of musts, and the many levels of elegant disputing.

ANTI-EMPIRICAL BIAS?

Most criticisms of REBT concern its failures to present empirical support for its predictions. Most founders and promoters of systems of psychotherapy have held university faculty appointments. This encouraged them to do empirical research that fostered the acceptance of their views. The disadvantage of having systems of psychotherapy developed by academics is that the systems often lack external validity. Al Ellis has always been a practitioner and a theoretician and not a professor or researcher. As a result he has produced little empirical research and mentored few researchers. The strength of REBT lies in the fact that Albert Ellis, and other proponents of REBT, actually practice psychotherapy, and do not theorize, research or teach psychotherapy. They enhance and expand the theory based on problems that result from failures with real clients. The flip side of this strength is that too many of us rely on case study, theoretical and clinical writings. The majority of REBT advocates are known for such theoretical and clinical writings—not their research. REBT has benefited greatly from the rich clinical literature its advocates have created. However, we have grown in this way as much as we can. The culture of REBT needs to change or we will be discussing the same criticisms in the next decade.

Despite the commonly held belief that REBT has failed to marshal empirical evidence (e.g., Haaga & Davison, 1993), there have been seven reviews of REBT outcome research, discussing more than 240

individual studies (DiGiuseppe & Goodman, 1995). This represents a greater reservoir of empirical studies than I had expected. However, examining these studies indicates some disappointing patterns. Few investigators engaged in ongoing, programmatic REBT research. Many researchers have a single foray into empirical science. Most studies have failed to build on the research that preceded it, have failed to test specific hypotheses on the process of REBT, or have failed to compare REBT to alternative treatments. Rather, they are limited to comparing REBT to a control group. Talking about the lack of REBT research is like waiting for Godot. He is not coming. Each of us needs to take responsibility to produce an empirical literature.

DEFINING IRRATIONAL BELIEFS

The important question facing REBT concerns the type of cognition we refer to when we talk about irrational beliefs (IBs). Are IBs facts, predictions, theories, schema, attributions, or evaluations? Both Wessler and Wessler (1980) and Walen, DiGiuseppe and Wessler (1980) took the position that exaggerated, rigidly held negative evaluations lead to emotional disturbance. In fact, we have often taught at IRET training programs that REBT targets evaluative beliefs while Beck's (1976) cognitive therapy challenges distortions of empirical reality. Therapists' attempts to target clients' views of empirical reality were labeled as inelegant interventions since they did not help clients deal with the philosophical evaluation concerning the bad thing that could happen.

However, Ellis often describes "musts" as "commands on the universe to be the way you want it to be." This sounds like a cognitive distortion of reality. Is a "must" a philosophical evaluative belief about what is good and what ought to be in a moral sense? Does emotional disturbance result when people believe the world, or empirical reality, "must" be the way they would like it to be?

REBT has been unclear as to what type of cognition irrational beliefs are. If we maintain that they are evaluative cognitions, does that mean that we ignore anti-empirical aspects of what people are thinking? If we focus on the empirical veracity of a belief does that mean that there are no differences between automatic thoughts (that Beck defines as distortions of reality) and irrational beliefs? Rorer (1989) argued that the definitions of irrational beliefs are inconsistent. He noted that some irrational beliefs are evaluative beliefs and that all

evaluations are arbitrary assignments of values to events. This definition of IB's follows from the often quoted Shakespearean line that REBT enthusiasts use to explain the theory: "Things are neither good nor bad but thinking makes them so." The constructivistic approach to psychotherapy has gained great popularity (Mahoney, 1991) and Ellis (1990) seems eager to convince his critics that REBT is as constructivistic as any therapy. It presently appears unfashionable to talk of reality and view dysfunctional thinking as anti-empirical in nature. I, for one, believe that constructivistic approaches have gone too far. Yes, we create images of reality, and these are often fictions. However, there is a reality. As science fiction writer Dick noted, "Reality is that which, when you stop believing in it, doesn't go away." Demanding that reality go away appears to represent the irrational commands that reality be consistent with a person's preferences. These "musts" are distortions of reality since the person continues to perceive and expect reality to be the way they want it regardless of the amount or type of disconfirming evidence. Thus, some references to irrational beliefs are evaluative and others are empirical distortions.

REBT teaches that some cognitive distortions are not worth challenging, for example, "My spouse acted angrily and unaffectionately last night." This represents an automatic thought and is not targeted for intervention. However, in REBT we believe that other cognitive distortions are targets for intervention such as, "My spouse must show me love and affection!" Such statements about reality are more global in nature since they include a class of events over a longer period of time. However, a more generalized form of the automatic thought would be, "My wife does not love me anymore." This is a more global automatic thought, but it is still not an irrational belief. Thus, level of generalization is not the only criterion for distinguishing an automatic thought/inference from an irrational belief. The irrational belief, "My spouse must show me love and affection!" is not only a statement about "what is" but it is also a statement about "what should be," and "what will be." It includes an evaluative component concerning its desirability and correctness and a prediction about what to expect. The part of the statement concerning what is to be expected is based on what is desiredl rather than the preceding empirical reality. Thus, when holding an IB people expect reality to reflect a desired state rather than what was previously experienced. IBs appear to be cognitions that include an evaluative component and a reality component simultaneously.

Maultsby (1984) defined a belief as irrational if it is logically incor-

I propose that the type of cognitions that Ellis has been defining as irrational beliefs are a type of schema that merges "what is" with "what is desirable, moral, or correct." Viewing irrational beliefs as schemes recognizes that irrational beliefs are more than exaggerated evaluations, and/or distortions of reality and/or moral rules. Irrational beliefs are the core or central schema concerning the relationship between ourselves, our preferences, and the existence of our preferences in reality. Thus, a schema has reality-based aspects, evaluative aspects, and explanatory aspects, and moral aspects. Challenging and replacing an irrational schema involves disputing the adequacies of the schema in all aspects, and involves replacing the irrational schema with a new complex rational schema that can be used to guide our picture of reality, our explanation of reality, our evaluations of events, and our view of what is correct.

Ellis has described irrational beliefs as rigid and dogmatic. In schema theory, rigid and dogmatic beliefs could be translated into a person adapting to disequilibrium through assimilation only or predominantly. The person continues to force the demands of the environment and information about the world into already existing schema and fails to create new concepts to construe the world and plan more effective responses. Viewing irrationality as the domination of assimilation over accommodation is more consistent with Ellis's definition of irrationality as rigid and dogmatic thinking. Since assimilation and accommodation are cognitive processes rooted in the biology of brain function, the dominance of assimilation over accommodation may represent the exact mechanism in Ellis's (1976) theory that irrationality has a biological basis.

According to a schema model, irrational demands include distortions of reality. I would propose that people hold schema that describe what is good or bad for them as well as maps of the world concerning whether and where such preferences exist. Irrational beliefs are those core schema where the individual does not accept the empirical feedback that the world does not match what is desired. The person continues to hold that his or her preference will be reality. Rather than change their view of the world, disturbed people rigidly hold onto their schema about the way the world is based on what should be. Emotional disturbance involves the rigid, absolutistic belief about the way the world is. Irrational schema appear not to change when confronted with disconfirming reality. The disturbed person somehow fails to accommodate and develop a new schema when confronted with negative information.

This schema model appears superior to our present thinking about

irrational beliefs for numerous reasons. First, it resolves the conflict of whether IBs are evaluative cognitions or cognitive distortions. They are both. Second, it ties the construct of IBs to mainstream cognitive psychology. We are better able to improve our understanding of IBs, change them, and test our theory by seeing IBs as core schema than as a separate undefined cognitive construct. Fourth, other psychologists are more likely to accept REBT if it is more firmly based in mainstream scientific psychology. Fifth, the definition of rational or irrational beliefs makes more sense for schema than for isolated beliefs. A schema's validity could be evaluated as irrational or rational based on any of Maultsby's (1984) criteria as noted above. Sixth, since schema are construed by the individual, the adoption of a schema model of irrational beliefs recognizes the constructivistic aspects of IBs and REBT that Ellis (1990) has proposed. Seventh, a schema model suggests that challenging irrational change schema would involve assessing their heuristic value, logical consistency, empirical veracity, explanatory power, and predictive accuracy. Therapists would also demonstrate that alternative rational schema are superior in each of these areas. Eighth, the schema model appears consistent with the definition of irrational beliefs that Ellis (1962; 1973; 1976) has proposed. The description of rigidly, dogmatically held views of the world in the face of empirical disconfirming evidence and/or lack of utility in reaching one's goals could be used easily as a definition for dysfunctional schema in addition to irrational beliefs.

The question that a schema model of IBs fails to answer is, why people would hold an irrational schema as opposed to rational ones? However, a schema model may help us explore this issue better than our current models of irrational beliefs. The question now becomes, why do people assimilate and fail to accommodate? Whatever psychological and neurological factors which lead people to assimilate or accommodate their schema when they confront new information will apply to IBs. It is quite possible that research in schema adoption will confirm Ellis's (1976) idea that IBs are biologically based. People may be unable to accommodate and develop a new schema because of their lack of intelligence or biological limitations in their ability to adapt to new information.

THE CENTRAL ROLE OF "MUSTS"

In the beginning, Al gave us the eleven irrational beliefs. He specifically stated that these represented common examples of IBs that he

observed in his clinical practice. With time, the theory has changed to stress the irrational beliefs of demandingness (DEM), awfulizing (AWF), global evaluations of human worth or self downing (SD), and frustration intolerance (FI) (Walen, DiGiuseppe, & Wessler, 1980). Campbell (1985) helped promote this condensation with testable hypotheses that different irrational beliefs related to different disorders. Finally, Ellis proposed that demandingness was a core irrational belief and all other irrational beliefs are psychologically deduced from it. All emotional disturbance could be reduced to demands on the self, others or the world.

One problem with the present theory is its inability to account for different emotional reactions. If "musts" are core to all emotional disturbance why do some people become depressed, others become anxious, and others become angry, jealous, guilty, etc. Beck (1976) tried to account for the cognitive mediation of different emotions by suggesting that different emotional disorders are mediated by different cognitions (e.g., Beck & Emery, 1985; Beck, Freeman, & Associates, 1992). Much research has been undertaken to demonstrate that different types of thoughts lead to different emotional states (e.g., Beck, 1976) and even different personality disorders (e.g., Nelson, Gray, 1976). The fact that REBT suggests that "musts" are the core element to all psychopathology may not be a serious problem. It has been established that measures of emotional disturbance factor together to form one factor labeled "negative affectivity." Perhaps, "musts" lead to negative affectivity and other more peripheral cognitions determine whether negative affectivity is experienced as anxiety, depression or whatever. However, REBT presently fails to explicate what mediating factor influences whether the "must" leads to different emotional reactions.

Ellis's present theory is based on clinical observation and lacks an explanation for why "musts" must be the core cognition central to emotional disturbance. Empirical evidence to support the theory is also absent. In fact Bernard (1988) and myself (DiGiuseppe, et al., 1988) attempted to construct irrational belief measures with items reflecting separate subscales of DEM, AWF, FI, SD. All of these studies failed to confirm the primacy of "musts." These studies indicated that SD or FI correlated most strongly with disturbance rather than DEM. Also, exploratory factor analyses in all of these studies have failed to find a separate factor of DEM. In each study SD emerged as a separate factor. Thus, SD has consistently emerged as a separate factor independent of DEM in all of the recent psychometric studies.

Since some scholars question the use of exploratory factor analysis for the validation of psychometric scales and propose that confirma-

tory factor analysis is a more appropriate test, we recently ran a confirmatory factor analysis of the same data set that we have not yet published. Two factors emerged: DEM, AWF, and FI loaded on one factor, and SD emerged as a second. The fact that DEM, AWF, and FI factor together, suggests that these three constructs may be psychologically equivalent.

This idea actually occurred to me while doing case supervision. I have always been careful to dispute the irrational belief that clients indicate that they endorse. I pay particular attention to whether supervisees do the same. During the therapeutic dialogue I have observed that both therapist and client can use the terms for DEM, AWF, and FI interchangeably without confusion. For example, a new trainee elicited from a client that her irrational belief was that she must be loved by her mate. Immediately the therapist disputed the client's "must." During the remainder of the session the therapist responded with a disputation such as, "Why can't you stand it if he does not love you," and "Why would it be awful if he did not love you." Although the client never agreed, stated or implied that she endorsed awfulizing or frustration intolerance over the loss of the lover's affection, she identified with these disputes and indicated that she thought the therapist understood the beliefs behind her problem. However, when the therapist asked, "Why would you be a worthless person if he stopped loving you." The client hesitated, and responded that she would not be worthless and that she had never thought that. This client appeared to endorse irrational beliefs of demandingness, awfulizing, and frustration intolerance but not self downing. One could handle this problem within REBT theory by suggesting that the client had discomfort disturbance and not ego disturbance. She endorsed demandingness and the derivative irrational belief of AWF and FI but not SD.

However, work with another client lead me to entertain the notion that SD was separate from DEM. A client with a similar problem revealed to his therapist that he believed he was a worthless person since his wife left him. The therapist assumed the psychological equivalence of the SD with DEM and retorted with the dispute, "Why must you be loved by your wife or anyone else?" The client stopped, pondered the query and responded, "I don't have to be loved by anyone, but it says something about me if I am not, I'm a SH#@."

My observation of the use of language to express irrational beliefs suggests that DEM, AWF and FI share equivalent meaning, at least in American English, and they have different meaning from statements of self-worth. Perhaps, experiments with "mentally healthy" individ-

uals and psychotherapy clients could be conducted where the therapists purposely and systematically use the terms for DEM, AWF, FI, and SD regardless of what terms the client uses to describe his or her thoughts. The subjects' reactions could be coded for comprehension. Such studies would benefit our understanding of the meaning structure of irrational beliefs. Another research strategy would require therapists to dispute only one IB construct regardless of which IB form clients reported they experienced. The dependent measure would be the change in endorsement of all four IB constructs. If disputing one IB construct resulted in reduced endorsement of other IB constructs one could conclude that their meanings were equivalent. Preliminary results of research underway at the IRET by myself, Kathryn Hutchinson, Jennifer Naidicht, Mark Terjison, and Rick Holmes suggest that when therapists dispute DEM statements there is a corresponding change in AWF and FI beliefs but not SD beliefs.

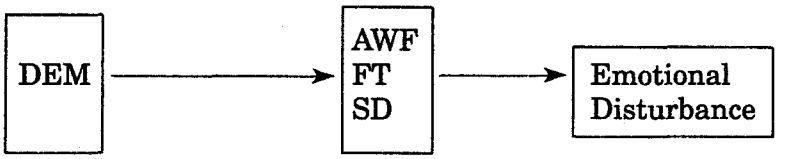
Perhaps, DEM is a more subtle, tacit IB that drives the others and the fact that it is tacit means people are less aware of thinking it. If DEM beliefs represent subtle schema they are more likely to be out of awareness and, therefore, less likely to be endorsed. Another research strategy to test Ellis's notion that DEM is the core belief would be the use of path analysis and structural latent modeling. Several hypothetical paths relating IBs to emotional disturbance could be identified and submitted to path analysis to identify which has the best support. Table 1 suggests examples of how Ellis's theory and my hypotheses could be represented. In path one, DEM leads to all other evaluative irrational beliefs (AWF, FI, & SD) which then lead to emotional disturbance. In path two, DEM leads directly to emotional disturbance and leads to SD, AWF, and FI which then lead to emotional disturbance. In path three, DEM leads directly to emotional disturbance, and leads to AWF and FI which then lead to emotional disturbance. Self-downing leads to emotional disturbance independent of the other irrational beliefs.

An important practical question concerns the primacy of disputing clients' "musts." Is REBT more effective if therapists dispute clients' DEM than if therapists dispute AWF, FI, or SD? Would it be more effective to dispute the irrational belief that each client indicates is closest to what he or she actually experiences during an emotional episode? Or is it irrelevant which irrational belief form therapists dispute? Perhaps, if the meanings of all or several irrational concepts are equivalent, as I have proposed above, it does not matter which form of irrational belief the therapist targets. Research on which disputing

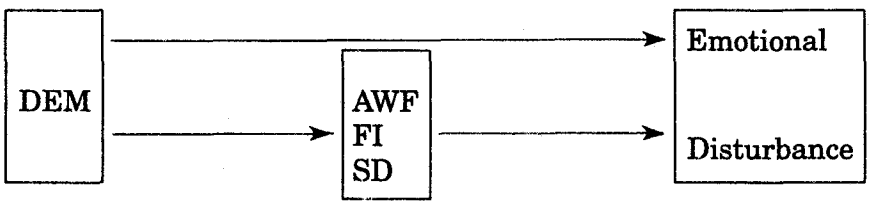
Table 1

Three Models of Possible Paths of Irrational Beliefs Which Could be Tested with Path Analysis

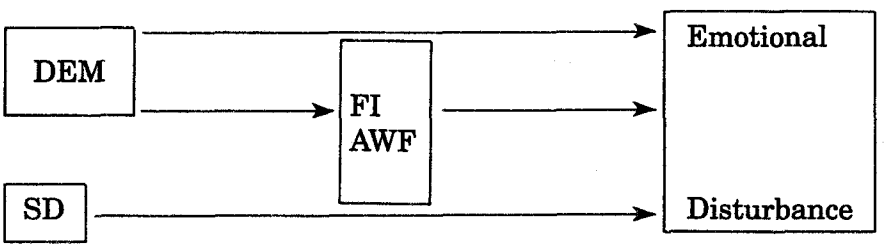
Model 1. Demandingness leads to other evaluative irrational beliefs which then lead to emotional disturbance.



Model 2. Demandingness leads directly to emotional disturbance and leads to AWF and FI which then lead to emotional disturbance.



Model 3. Demandingness leads directly to emotional disturbance and leads to AWF and FI which then lead to emotional disturbance. Self-downing leads to emotional disturbance independent of the other irrational beliefs.



strategy results in the most change in emotional disturbance is important if the field is to progress.

The schema model of irrational beliefs may resolve the issue of whether "Musts" are the central or core irrational belief. I would propose the following explanation. Muran (1991) has pointed out that schema are compound or conditional sentences. Also, as I have suggested elsewhere (DiGiuseppe, 1991) it is unlikely that a person's core schema are constructed and stored in one's native language or in the verbal control areas of the cortex. Schema would be more diffusely represented in the brain, and any attempt to discuss schema in therapy would involve a process of translating one's core schema into one's native language. Our confirmatory factor analysis results suggest that there are two main factors: DEM, FI, and AWF statements load on one factor, and SD on the other. This suggests that people may distinguish between core schema that refer to the outside world and core schema which involve the self. Core schema that represent irrational demands on the outside world may take the compound sentence form of a must combined with either an AWF statement or an FI statement. For example, an irrational belief about one's mate might be expressed as, "My mate must do what I want, and if he or she does not do what I want, it is awful." Or "My mate must do what I want, and if she or he does not do what I want, I cannot stand it." An irrational schema that includes evaluation of self-worth might be expressed as follows: "I must have my mate's affection, or I am a worthless person. My mate is unaffectionate to me, therefore, I am worthless." Note that both of the examples have characteristics of demandingness. However, in the first example the demand is about the way the world must be. The AWF and FI statements follow logically (or psychologically) from the demand being unmet. In the last example the demand is about conditions which must be met for self-worth. When the conditions are unmet, it logically (or psychologically) follows that one is worthless.

When we construct measures of irrational beliefs, it is likely that subjects read the items and focus on salient discriminative features of the test items. The tacit assumptions leading up to the IB items which are not in consciousness may not be tapped by the way IB items are worded in our present scales. Subjects can differentiate items which include self-downing from those which do not since reference to the self is a very salient feature of the scale items. Thus, irrational beliefs will separate into factors which involve self-evaluation and those which do not.

These two types of core irrational beliefs both involve musts but are

still two different types of thoughts. The first type is clearly an empirical distortion of reality. The client demands that some aspect of reality be as they desire, and if it is not, they will not accept reality as it is. They either believe they cannot tolerate the situation or believe that it is awful. The second type, concerning self-evaluation, are conditional syllogisms. The client has set a standard to evaluate one's self-worth. This belief reflects a conclusion of a negative evaluative because the condition for it was made. The first type of belief is no inference, rather it is a failure of categorization. One fails to differentiate what one desires from what is. The second type requires deductive inference based on a standard and observed fact. The irrationality in the first is the distortion of reality—expecting reality to match the desire. The irrationality in the second does not involve the inference. It involves the absolutistic, arbitrary conditions of the standard. The first type of irrational belief appears more primitive. The second involves more complex cognitive processes.

I would suggest here that we need to explore different methodologies to test REBT theory. The construction of tests of irrational beliefs is a superficial way to test our theory. Single sentence items fail to encompass the demandingness assumptions of reality, the denial of empirical reality, and evaluations of the disconfirmation of the expected reality. Unless our methodologies to assess irrational schema tap the tacit assumptions in the thinking and evaluative process, we will not be able to support our theory. Items that reflect SD might need to be represented by a syllogism that includes the demanding standard, the fact that the standard is unmet, and the self-downing conclusion. Perhaps it would be best for REBT aficionados to collaborate with neuropsychologists and psycholinguists to help us understand where schema associated with emotional disturbance are stored in the brain and how humans access these types of cognitive structures into their native language. Future methodologies need to look at the more tacit assumptions to test our theories. We need to test them and not wait for GODOT.

Anxiety and "Musts"

One area where I believe that the concept of "musts" is most questionable is anxiety. It is generally believed in the psychological community that anxiety is a reaction to threat and danger. It is also generally accepted that anxiety disorders involve the perception of a threat where there is none. REBT would propose that the anxious patients

thinks that they must have something that they will not get, or that they must not be exposed to some stimuli. The only thing necessary for anxiety is for the person to identify some stimuli as dangerous. The English words terrible, awful, and horrible may be common labels for dangerousness. However, the REBT definition of awful as, "more than 100% bad" is clearly not found in any dictionary, and is not a definition that has a consensus among most English speaking people. I strongly suggest that we stop using this definition of the "awful." I, personally, have never found it persuasive to clients and have found other professionals perplexed by the idea. Some clients have felt offended that their feelings and situations were not understood. Instead, we could ask clients what danger they are in. What damage will occur to them if the awful thing happens? Rorer (1989) suggested that awfulizing beliefs are just arbitrary evaluations. By pursuing questions about dangerous and damage I believe that we will get the clients to see that they are in no real danger, and no damage will occur to them.

Perhaps people conclude that things are dangerous for two reasons. First, they have some history of classical conditioning that is not related to a tacit assumption. The client does not know why something is dangerous, awful, or terrible, it just is. Second, clients have set some arbitrary conditions of security, comfort or self-worth and they wrongly concluded that their self-worth, comfort, or security can only be maintained if such conditions are met. Here again the irrational belief may be both a demand on reality that one must get what one wants, and an absolutistic, rigid, narrow, and arbitrary definition of what one *needs* for comfort, security, or self-worth. Thus, anxious persons define what they need. Needs may be how "musts" are expressed by anxious clients.

The criticism of REBT that I confront most often is that we place "musts" in people's mouths when they are not there. This is sometimes a valid criticism, and appears to occur most often in cases of anxiety. An anxious person appears to have thoughts that stimuli are dangerous when they are not, such as simple phobias, or they have an exaggerated false belief about what they need, such as a socially phobic client who "needs" the approval of certain people. The REBT practitioner would state the social phobic's irrational belief as, "I must have the approval of certain people." This "must" requires the logical extension, "and if I don't have that person's approval it is awful." The "must" here is a statement concerning what the person believes she or he must have to function or survive. The evaluative statement is the

awfulness that results when the must is unmet. Although this is a minor point, I predict many anxious clients would more likely experience their belief as "I need to be approved of by certain people." Although there appears to be great similarity of meaning between must and need, I would propose that it is more important to assess the belief in the form that clients actually experience them. I would also propose the hypothesis that it is best to dispute the beliefs in the terms that are closest to what clients experience.

My experience suggests that there is a tendency among us to force the clients' statements concerning what they are thinking into a "must" sentence even if they do not use such words. A "need" statement may propose no real threat to the integrity of REBT theory yet might be more sensitive to the way the IB is experienced by clients. As a result it may be easier to help clients identify, challenge and replace the IB if they believe we understand them and we identify with what they are thinking. To this end as REBT therapists, we need to keep "musts" in our mind to guide our conceptual map of the client, but we need to be careful to allow clients to express the concepts in their language.

HOW ELEGANT THE DISPUTE?

Ellis has referred to the challenging of irrational beliefs as "elegant" or "philosophical" disputation and the challenging of automatic thoughts as "inelegant." Elegant of course is better than inelegant. The elegant strategy involves asking clients to imagine that their automatic thoughts are true. Therapists then challenge the irrational beliefs about it happening. On numerous occasions Ellis has stated that many clients fail to get the elegant solution. I have had concerns regarding how elegant and philosophical we expect our clients to get. How elegant do we want clients to be and how effective are our strategies to achieve elegance?

Many REBT therapists misconstrue the elegant solution. Rather than ask their clients to imagine that their automatic thoughts are true they ask them to imagine the worst thing that could happen, to assume that it does happen. This stretches clients to cope beyond what they fear. It may be logically consistent in REBT theory to teach clients the most elegant solution to their problems to help prevent future disturbance. One could teach clients that nothing is awful and they can stand almost anything, however, there may be pragmatic limits to

the degree of elegance clients are willing to reach. The question in each case is, how elegant do we go with this client?

Suppose a client, who is a competent professional, reports that he must be successful at his present job. If he does not perform in an outstanding manner, his colleagues will perceive him as only average. The well-trained REBT practitioner would ask the client, "What if they do perceive you as only average?' The client answers that he will make a mistake and be regarded as average by his peers. The REBT practitioner would ask, "Suppose they do think this about you, what would that mean?" Suppose the client responds, "I could not stand it if they thought that of me, I must be perceived as competent by all my peers." The inelegant dispute would challenge the belief that the client was perceived by his peers as performing poorly or that they negatively evaluated him because he performed poorly. The elegant intervention would be to challenge the belief that he needed or must be evaluated positively by his peers on this occasion. The dispute would be, "Why must you be viewed as competent at all times by your colleagues?"

Many REBT practitioners could take our hypothetical client several additional steps down the road of catastrophes. They could ask the client to imagine that he is totally incompetent. Suppose he could do nothing right? Suppose that he was demoted? Suppose he was no longer viewed as competent, lost his professional license, and had to work as a clerk? A more elegant intervention than the one mentioned above would be to attempt to convince him that he did not have to be evaluated positively by his peers and could survive if only seen as an average professional who sometimes made mistakes. An even more elegant solution would be to convince the client that he could stand his peers viewing him as a below average professional. The most elegant intervention would be to convince him that he could tolerate being viewed as so incompetent that he is drummed out of the profession. The therapist could go still further and could help the client to accept the most horrible possibility that he is perceived as totally incompetent and cannot even get a job flipping burgers at a fast food chain. The question the theory fails to address is how far down the chain of elegance do we go?

My concern is how far do we proceed down the inference chain? Does therapy need to progress to a level of elegance that the client never worried about in the first place? Our hypothetical client may never have feared his peers evaluating him as below average, or that he could fail at a burger stand. Perhaps our client only truly worried

about being thought of as fallible, or as just average. Therapy could focus on teaching him he is a worthwhile person even if his peers believe he is average at work. Or we could offer a more abstract philosophical rule that he is a worthwhile person because he exists even if he failed at any or every job. Because of the philosophical nature of REBT therapists may focus on the general principle rather than the clients' underlying belief about the activating event that brought them to treatment.

Teaching the most elegant step goes beyond the client's presenting problem. Is the goal of therapy to help the client cope with future negative activating events which might occur? The answer depends on the probability that these negative events will occur. However, the theory fails to specify how elegant a solution it is best to seek.

Irrational beliefs appear to exist on a continuum of abstraction. I have suggested that it is best to dispute concrete irrational beliefs about the specific activating event that elicited the client's upset (DiGiuseppe, 1991; Dryden & DiGiuseppe, 1990; Walen, DiGiuseppe, & Dryden, 1992). Then, one can work up to more abstract variations on the belief. Over the years I have observed that it is common for REBT therapists to identify a concrete irrational belief and immediately jump to an exaggerated elegant solution. I recently supervised a therapist who helped a client identify the irrational belief that he could not stand to be rejected by a prospective date. The therapist's first dispute was, "Why do you need people's approval? Suppose no one liked you, why would that be terrible?" Such a statement is logically consistent with REBT theory. However, it is poor clinical practice. It may be an unpersuasive way to introduce the client to REBT concepts and may drive the client out of therapy. The glibness with which some of us purport to de-catastrophize clients' traumatic events discredits and trivializes the theory.

This behavior by therapists may occur because REBT theory fails to specify which level of abstraction of irrational beliefs causes disturbance or on which level of abstraction the therapist should intervene. Although it is advantageous and rational to believe that one does not have to be competent at any job, or that one does not have to be liked by everyone, how do we get clients to believe such things?

As noted above, I believe that it is efficient to start lower on the ladder of elegance and move up gradually, rather than directly go to the most elegant solution. This hypothesis follows from the social judgement model of attitude change proposed by Sherif and Sherif (1967; Sherif, Sherif, & Nebergall, 1965). This model proposes that all

attitudes exist on a continuum of attitudes that a person could believe. Along the continuum of attitudes there are always three regions or clusters of attitudes. The latitude of acceptance includes all the statements a person endorses. The latitude of rejection includes a range of attitudes that a person clearly rejects. The latitude of non-commitment includes a range of attitudes between the latitude of acceptance and the latitude of rejection that the person neither rejects nor accepts. The research on social judgement theory indicated that attempts at attitude change were most effective if they were aimed at attitudes in the latitude of non-commitment. This resulted in expanding the latitude of acceptance, narrowing the latitude of rejection and shifting the latitude of non-commitment into the latitude of rejection. Successive communications targeted at the latitude of non-commitment resulted in significant attitude change. Research on the model also found that the more ego-involved a person was in an issue, the narrower the latitude of non-commitment, and therefore the fewer attitudes along the continuum that maybe targeted for successful interventions. Another research result indicates that the further into the latitude of rejection a communication is targeted, the less likely it is to result in attitude change.

The Social Judgement Model has implications for clinical practice. Since psychotherapy concerns ego-involved issues, the theory suggests there are only a few places along the continuum where persuasion is likely to occur and it may be effective to challenge attitudes well into the latitude of rejection. Psychotherapy is likely to succeed if it is targeted at a narrow latitude of noncommitment. Finding this latitude and targeting one's disputes at it could be the art of REBT.

Table 2 presents a hierarchical list of rational alternative beliefs that could apply to the hypothetical male professional client discussed above who feared that his peers evaluated him as average. The beliefs are presented for three points in time: the beginning, the middle, and the end of therapy. All of the rational statements could be considered elegant according to REBT. Clearly statement number 8 is the most elegant since it is the most philosophical generalizable statement and would help our client cope in the widest range of situations. Statement 1 is in the client's latitude of acceptance, statements 2 and 3 are neither strongly held nor rejected. They are in the latitude of non-commitment. Statements number 4 through 10 are in the latitude of rejection. The model suggests that the most effective intervention would be targeted at statements 2 or 3. Interventions aimed at statement 5 through 8 would fail to produce change. After several sessions of suc-

Table 2

Hypothetical Model of a Client's Beliefs According to the Social Judgment Model of Attitudes Change

Beliefs	*Latitude*	*Result of Intervention*
	Time 1 Beginning of Therapy	
1) I can stand it if only a few of my peers do not admire and respect me.	Latitude of Acceptance	No Change
2) I can stand it if some of my peers respect me, but they know I make some mistakes.	Latitude of Non-Commitment	Change
3) I can stand it if many of my peers know I make some mistakes.	Latitude of Non-Commitment	Change
4) I can stand it if a few of my peers do not like or respect me.	Latitude of Rejection	No Change
5) I can stand it if some of my peers do not like or respect me.	Latitude of Rejection	No Change
6) I can stand it if most of my peers do not like or respect me.	Latitude of Rejection	No Change
7) I can stand it if all of my peers do not like or respect me.	Latitude of Rejection	No Change
8) I can stand it if all of my peers know I do all jobs poorly.	Latitude of Rejection	No Change
	Time 2 Middle of Therapy	
1) I can stand it if only a few of my peers do not admire and respect me.	Latitude of Acceptance	Original Position

2) I can stand it if some of my peers respect me, but they know I make some mistakes.	Latitude of Acceptance	Change
3) I can stand it if many of my peers know I make some mistakes.	Latitude of Non-Commitment	Change
4) I can stand it if a few of my peers do not like or respect me.	Latitude of Non-Commitment	Change
5) I can stand it if some of my peers do not like or respect me.	Latitude of Rejection	No Change
6) I can stand it if most of my peers do not like or respect me.	Latitude of Rejection	No Change
7) I can stand it if all of my peers do not like or respect me.	Latitude of Rejection	No Change
8) I can stand it if all of my peers know I do all jobs poorly.	Latitude of Rejection	No Change
Time 3 End of Therapy		
1) I can stand it if only a few of my peers do not admire and respect me.	Latitude of Acceptance	Original Position
2) I can stand it if some of my peers respect me, but they know I make some mistakes.	Latitude of Acceptance	Change
3) I can stand it if many of my peers know I make some mistakes.	Latitude of Acceptance	Change
4) I can stand it if a few of my peers do not like or respect me.	Latitude of Acceptance	Change
5) I can stand it if some of my peers do not like or respect me.	Latitude of Non-Commitment	Change
6) I can stand it if most of my peers do not like or respect me.	Latitude of Non-Commitment	Change
7) I can stand it if all of my peers do not like or respect me.	Latitude of Rejection	No Change
8) I can stand it if all of my peers know I do all jobs poorly.	Latitude of Rejection	No Change

cessful interventions aimed at statement 2, the client's ranges would change to those represented at time 2, the middle of therapy.

At time two, the middle of therapy, the model would predict that the best places for intervention would be statements 3 or 4. Disputing statements targeted at statements 5 through 8 would most likely fail. As the client improves in therapy the latitude of acceptance should expand, the latitude of non-commitment should move downward, and the latitude of rejection would shrink. This is represented at time three, the end of therapy.

I originally became familiar with Sherif & Sherif's model from an undergraduate professor, John Aboud, who was a doctoral student of C. Sherif. This model has guided much of my clinical work in REBT, and I have found it most helpful in choosing interventions. As a general rule, I think REBT is enhanced if we attempt to incorporate into it concepts from mainstream psychology such as the Social Judgement Model of attitude change. Specifically, I think that the theoretical and clinical writing in REBT has paid too little attention to which IBs we should target. Presenting clients with the most elegant solution to the most horrible thing that they can imagine is philosophically consistent with the ultimate goal of REBT. However, there is no reason to believe that such arguments are always effective. We need to focus more on additions to our theory that will help us recognize the most effective strategies to reach the ultimate philosophical solutions for our clients.

SUMMARY

In this paper I have outlined some theoretical amendments to REBT that will help it advance as a comprehensive and scientifically accepted therapy. First more REBT proponents need to collect data and rely less on clinical case study and theoretical arguments. To foster this aim theoretical statements in REBT need to be stated in falsifiable terms. Theoretical positions should include specific empirical predictions that can be tested that follow from the proposition.

Irrational beliefs appear to be poorly defined and they may be best understood as rigidly held schemes that are resistant to change. Anchoring irrational beliefs into the concept of schemes builds on a well accepted construct in developmental and cognitive psychology and ties REBT to mainstream psychology. Nothing appears to be lost in explanatory power by such a definition.

It is also suggested that not all irrational beliefs must be "musts." It

is suggested that negative self-evaluations appear to represent a different type of cognition that involve different cognitive processes than demandingness.

REBT needs to address the pragmatics of its philosophical positions. REBT proponents often pursue logically consistent positions that are likely to be rejected by clients and professional alike. The social judgement model of Sherif & Sherif (1967) is suggested as a means of determining which level of elegance is best to target in therapy.

Specific research hypotheses are presented for each of these suggested refinements in REBT theory.

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