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Rational-Emotive Therapy and Cognitive Behavior Therapy: Similarities and Differences

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*General or nonpreferential rational-emotive therapy (RET) is synonymous with cognitive behavior therapy (CBT). Specialized or preferential RET, however, differs from CBT in several ways. Cognitively, it has a pronounced philosophic emphasis, includes a humanistic-existentialist outlook, strives for pervasive and long-lasting rather than symptomatic change, tries to eliminate all self-ratings, stresses anti*musturbatory *rather than antiempirical disputing methods, recognizes the palliative aspects of cognitive distraction, discourages problem solving that is not accompanied by changes in clients' basic belief system, and emphasizes secondary as well as primary symptoms of emotional disturbance. Emotively, it stresses the discrimination of appropriate from inappropriate emotions, emphasizes methods of working directly with and on emotions, encourages forceful emotive interventions, and uses relationship procedures that heavily stress unconditional rather than conditional positive regard. Behaviorally, it favors penalization as well as reinforcement, is partial to in vivo desensitization and flooding, and makes sure that skill training is done within a philosophic framework of trying to help clients make basic changes in their irrational beliefs.*

Rational-emotive therapy (RET) and cognitive behavior therapy (CBT) are both similar and different; and to dispel some of the existing confusion in this regard (Lazarus, 1979; Mahoney, 1979; Meichenbaum, 1979), I shall try to present in this article something of a systematic outline of their main similarities and differences. Let me first say what I have tried to make clear before (Ellis & Whiteley, 1979): that what I call general or unpreferential RET is synonymous with CBT, while what I have called elegant RET, but what may be more objectively be called preferential RET, differs significantly from CBT in several important respects.

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Preferential RET I shall define as that kind of rational-emotive therapy that RET practitioners usually prefer to use, particularly with relatively bright, neurotic, and reasonably well-motivated clients because, they hypothesize, it is more efficient, thoroughgoing, self-maintaining, and productive of "deep" or "pervasive" personality change than is general RET. It is their therapy *of choice,* and it is a kind of RET that they will often choose *not* to use when restricted conditions of therapy and/or the limited resources of clients make it unfeasible or impractical. Preferential RET is always a form of general RET or CBT, but the latter may, and often does, include few aspects of the former. When, in this paper, I refer to RET without any modifier, I only mean *preferential* RET; when I refer to CBT and *general* RET (which, again, I view as synonymous), I mean them as more generic terms that potentially but not necessarily include preferential RET. Let me now outline some significant differences between CBT and (preferential) RET under three major headings: cognitive, emotive, and behavioral differences.

COGNITIVE DIFFERENCES BETWEEN RET AND CBT

Some of the main cognitive differences between RET and CBT include the following.

Philosophic Emphasis. CBT of course emphasizes cognitive processes, but it does not have a specific philosophic emphasis, as RET does. Meichenbaum (1977), one of the leading proponents of CBT, covers many techniques, but he significantly omits any stress on a distinctly philosophic outlook. RET, on the other hand, emphasizes that humans are born (as well as reared) as philosophers (Ellis, 1962, 1973a) and that they are natural scientists (Kelly, 1955), creators of meaning (Frankl, 1966), and users of rational means to predict the future (Friedman, 1975). One of its main goals, therefore, is to help clients make a *profound philosophic change* that will affect their future as well as their present emotions and behaviors.

To this end, RET tries to help people comprehend and accept several ideas that are still revolutionary in our culture: (1) They largely (though not exclusively) *create* their own emotional disturbances by strongly believing in absolutistic, irrational beliefs. (2) Having a distinct measure of self-determination or "free will," they can actively *choose* to disturb or undisturb themselves. (3) To change, they had better actively *work* at modifying their thoughts, feelings, and behaviors. (4) If they decide to profoundly change one major philosophy, they may help modify many of their own emotional and behavioral reactions. (5) They will usually find a philosophy of

long-range hedonism more healthful and productive of happiness than one of short-range hedonism. (6) A scientific rather than than an unscientific, devoutly religious, or mystical outlook is likely to bring them greater emotional health and satisfaction.

As I have shown (Ellis, 1962, 1971a, 1971b, 1973a, 1973c, 1974a) and as Raimy (1975) has emphasized, all therapy techniques, when they are effective, probably work because clients, wittingly or unwittingly, change their underlying congitions, ideas, assumptions, or philosophies. RET tries to help them specifically to see what are their self-defeating views, to question and challenge these, and to surrender them for more self-helping or happiness-producing outlooks. CBT may also include this RET philosophic approach, but it may not. In RET, it is central rather than optional or peripheral to personality change.

Humanistic Outlook. Not only is RET philosophical but it includes the specific existential-humanistic outlook of some other therapeutic schools (Ellis, 1962, 1973a). To some degree, it incorporates the views of Alfred Adler, Kurt Goldstein, Karen Horney, Viktor Frankl, Carl Rogers, and other humanistic theorists. This view sees people as holistic, goal-directed individuals who have importance in the world just because they are human and alive; it unconditionally accepts them with their limitations; and it particularly focuses upon their experiences and values, including their self-actualizing potentialities. At the same time, RET favors ethical humanism, the philosophy of the American Humanist Association, which encourages people to live by rules emphasizing human interests over the interests of inanimate nature, of lower animals, or of any assumed natural order or deity. This outlook acknowledges people only as human, and in no way as superhuman or subhuman. It hypothesizes that devout faith in suprahuman entities and powers almost always leads to poor emotional health and to decreased long-range happiness. Although CBT (like behavior therapy or BT) is usually humanistically oriented, it does not have to be, while a humanistic outlook is intrinsic to RET.

Goals and Purposes. While RET, like CBT, is often interested in, or at least will settle for, symptom removal, it primarily strives for deep-seated emotional and behavioral change. It works for—but, of course, does not always achieve—a remarkably new psychological *set* on the part of its clients that will enable them not only to feel better and be relieved of their presenting symptoms but also to bring a radically revised outlook to all *new,* present and future, situations that will semiautomatically help them to stop disturbing themselves, in the first place, or to quickly undisturb themselves, in the second place.

This new outlook or *set* for which RET strives includes clients' acquiring philosophies of self-interest, self-direction, tolerance of self and

others, acceptance of uncertainty, flexibility, scientific thinking, risk-taking, and commitment to vital interests (Ellis, 1973a, 1979a). RET hypothesizes that if clients achieve this kind of a changed perspective, they will minimally create present and future "emotional" problems.

Lack of Self-Rating or of Ego. RET differs significantly from behavior therapy, from cognitive behavior modification, and from almost all other humanistic-existential therapies in that it does *not* espouse positive self-rating: of clients acquiring what is often called "self-confidence" or "self-esteem." Like these other therapies, it emphasizes the harm of self-downing or self-disesteem, but it takes the somewhat special position that all ratings or evaluations of the self tend to be mistaken and illegitimate. It holds, instead, that although people biologically and socially strongly tend to rate themselves as well as their acts and peformances, they can learn to omit the first and to stick only with the second rating. That is, they can set up goals and values and then only rate what they do in terms of whether it helps them to achieve these goals, without giving any global rating to their "selves" for the achievement or nonachievement of such goals (Ellis, 1976a; Ellis & Abrahms, 1978; Ellis & Grieger, 1977; Ellis & Harper, 1975).

Various kinds of CBT—including the techniques of Goldfried and Davison (1976), Maultsby (1975), Meichenbaum (1977), and Rimm and Masters 1974/1979)—teach rational coping statements, such as, "I am good because I exist" or "Even though I fail, I am still a good person." But the philosophical rationale for holding the belief "I am neither good nor bad, nor can I legitimately rate myself as a total person at all, even though some of my traits are good (efficient) or bad (inefficient) for some of my main purposes" can probably not be shown to clients without a fairly sophisticated analysis and socratic-type dialogue that is indigenous to RET.

Use of Humor. CBT, as well as certain other forms of therapy—such as Farrelly and Brandsma's (1974) provocative therapy—may include humor, or reducing irrational ideas to absurdity, as a therapeutic method. In principle, however, RET hypothesizes that almost all neurotic disturbance stems from taking things too seriously—from demanding, commanding, or *must*urbating about one's goals—and states that one of the main antidotes to this kind of irrational thinking is the strong therapeutic use of a sense of humor. Consequently, RET stresses (though does not mandate) the use of humor, including paradoxical intention, evocative language, irony, wit, cartoons, and rational humorous songs (Ellis, 1977a, 1977b).

Antimusturbatory Techniques. CBT practitioners—e.g., Beck (1976), Maultsby (1975), and Goldfried and Davison (1976)—often employ empirical arguments to show clients how to surrender their misperceptions

of reality, and even Wolpe (1978) advocates helping clients to change their unrealistic, antiempirical perceptions. Going beyond this, however, RET hypothesizes that most antiempirical statements by which people disturb themselves stem from overt or implicit *musts:* from absolutistic premises that humans *bring to* many situations and that then almost compel them to misperceive these events.

Thus, if you begin with the irrational premise "I *must* not die dramatically in an airplane accident," you will easily tend to make several antiempirical conclusions, such as: (1) "There is a *good chance* that the plane I fly in will get into an accident," (2) "If I do get in an air crash, it will be awful (that is, more than 100% inconvenient)!" (3) "I *can't stand* even the thought of flying!" (4) "Everything connected with airplanes—even a photo of a plane—is exceptionally dangerous and horrible!" If, on the contrary, you start with the rational premise "I definitely don't want to die in an airplane crash, but if I do, I do!" you will most probably not make such antiempirical conclusions and will easily see that there is little chance of your getting killed in a commercial flight (Ellis & Harper, 1975; Ellis & Whiteley, 1979).

Because it hypothesizes the existence of underlying *musts* and of what Horney (1965) called "the tyranny of the shoulds," RET not only tries to rip up clients' antiempirical, unrealistic statements but also reveals and disputes the underlying *must*urbatory premises out of which these statements usually arise. In this respect, RET may be said to be "deeper" or more "radical" than related CBT procedures.

Disputing Techniques. RET, like CBT, employs many cognitive methods, including the teaching of rational or coping self-statements, cognitive distraction, thought stopping, bibliotherapy, semantic analysis, modeling, imagery, and problem solving (Ellis, 1969, 1976b, 1978b; Ellis & Abrahms, 1978; Ellis & Grieger, 1977; Ellis & Knaus, 1977). Considerably more than CBT, however, it specializes in two active forms of disputing: (1) the therapist's vigorously disputing or debating clients' irrational thinking and (2) the therapist's teaching clients how to do their own self-disputing and self-debating, so that they internalize the questioning, challenging, skeptical method of science and use it to surrender their present and future absolutistic cognitions (Phadke, 1976).

This is not to say that RET primarily or exclusively consists of arguing with clients and showing them how to rationally argue with themselves—which has been wrongly implied by critics such as Lazarus (1979), Mahoney (1974, 1979), and Meichenbaum (1977, 1979). Often, REP practitioners hardly use disputation—as when they see young children, mentally retarded individuals, or severely psychotic individuals who are hardly amenable to Socratic-type dialogues and who can be more efficiently reached by

teaching them rational coping statements. Whenever feasible, however, RET favors active disputation for several reasons: (1) This is a highly democratic procedure that avoids indoctrinating clients with the therapist's "rational" beliefs. (2) It helps clients make their own generalizations, which may lead to many and more profound emotional and behavioral changes. (3) It appears to help clients not only achieve but also sustain their improvement (though this hypothesis is yet to be clearly tested). (4) It shows clients how to dispute the irrationalities of their relatives, friends, and associates, and frequently to help these people and the clients' relationships with them (Ellis, 1957/1975, 1973a).

Recognition of Cognitive Palliative Methods. Like CBT, RET employs many cognitive distraction methods, such as teaching clients to use Jacobsen's (1958) progressive muscle relaxation technique or Benson's (1975) relaxation response. All these methods work at times, help clients to temporarily stop worrying, and thereby facilitate behavioral change. RET, because it focuses on the philosophies that often underlie cognitive-behavioral methods, recognizes however that cognitive distraction methods are almost always palliative, for they sidetrack people momentarily from their self-defeating views instead of helping them truly to surrender these views. Moreover, there is the danger that, in feeling "good" or "relaxed" as a result of employing cognitive distraction, many clients may stop working at their underlying irrational beliefs and may therefore prevent themselves from making the thoroughgoing changes of which they are capable. RET practitioners, therefore, use distraction methods with caution, sometimes deliberately omit them, and encourage clients to employ them *in addition to* more penetrating and profound methods of cognitive behavior therapy.

Problem-Solving Methods. CBT importantly employs problem-solving methods of treatment (Haley, 1977; Spivack, Platt, & Shure, 1976; D'Zurilla & Goldfried, 1971), while RET discourages such problem-solving at what it calls A (activating experiences in clients' lives) until *after* or at least *along with* clients' work to undermine and change B (their irrational beliefs about what is happening at A). Thus, if at point A (activating experience) your partner is giving you a hard time, and you are indecisive at point C (emotional and behavioral consequence) about whether or not to leave him or her, a typical CBT solution to this problem will be to have the therapist figure out with you how you can change your partner, reorganize the conditions under which you work with him or her, form a new partnership with someone else, etc. Instead, RET will first explore what you are telling yourself—at B, your belief system—to make yourself indecisive, and will turn up such irrational beliefs as "I *must* make a perfect decision, else I am contemptible!" "I can't stand making a disadvantageous decision!" and "It's *awful* if I lose my partner completely!"

Once it helps you to clearly see and then to dispute and surrender these basic irrationalities, RET then will try to help you work out a better solution to the difficulties with your partner that exist at point A. For disturbed people almost always have, first, practical problems (e.g., "How can I get along better with my partner?") and emotional problems, or problems *about* problems (e.g., "How can I refuse to seriously depress or anger myself even if the problem with may partner never goes away?"). Where CBT frequently concentrates on practical problem solving, RET much more frequently focuses on solving the emotional problem about the practical problem—and then (if required) helping the client with the original difficulty.

The Concept of Discomfort Anxiety. Most psychotherapies, including CBT and RET, deal largely with clients' ego anxiety: on their downing themselves as total humans when they act incompetently and/or are disapproved of by significant others. RET, in addition, makes a special effort to work with clients' discomfort anxiety or low frustration tolerance. Discomfort anxiety is emotional hypertension that arises when people feel (1) that their life or comfort is threatened, (2) that they *must* not feel uncomfortable and *have to* feel at ease and (3) that it is awful or catastrophic (rather than merely inconvenient or disadvantageous) when they don't get what they supposedly must (Ellis, 1978b).

While active-directively dealing with ego anxiety, RET deliberately looks for manifestations of discomfort anxeity and reveals and disputes the irrationalities that lie behind it. Because of its basic philosophy of long-range rather than short-range of hedonism, it tends to be more specific and stronger foe of low frustration tolerance than are more general forms of CBT.

Secondary Symptoms of Disturbance. The theory of RET says that not only do people tell themselves basic irrational beliefs (B) about the activating experiences (A) in their lives and thereby bring on disturbed emotional and behavioral consequences (C), but because humans have a pronounced biosocial tendency to observe and evaluate virtually everything in their lives, including their emotional reactions, they also see, think about, and appraise their disturbed feelings and behaviors—and in the process of *must*urbating about their primary symptoms they often create secondary symptoms, or disturbance about disturbance! Thus, by telling yourself, "I *must* succeed at this task!" you can make yourself anxious, and by convincing yourself, "I *should* not make myself anxious," you can produce the secondary symptom of anxiety about anxiety. You may also, at times, proceed to a third level: make yourself anxious about being anxious about being anxious!

RET, moreso than CBT, specifically looks for secondary and tertiary symptoms of disturbance, shows clients how they create these symptoms,

and indicates what they can do to eliminate primary, secondary, and tertiary symptoms. Especially in the case of serious phobias, such as agoraphobia, RET works with original fear and, especially, the fear of fear: the horror *about* the original fear (Ellis, 1979a).

Selectivity of Techniques. Like CBT, RET is exceptionally electic in its methods of treatment, and although it favors cognition, it also tries to encourage personality change through emotive and behavioral methods: recognizing that if people force themselves to act and/or feel differently, they frequently will bring about cognitive modification (Ellis, 1968, 1970a, 1979b; Wolfe & Brand, 1977). RET, however, hypothesizes that *efficiency* is an important aspect of therapy and that, to achieve maximum efficacy and minimum harm with their clients, therapists had better employ a highly selective rather than an indiscriminatively eclectic use of various methodologies.

Following its philosophy of therapeutic efficiency, RET favors in vivo desensitization and flooding homework assignments, and hypothesizes that they will usually result in more profound and lasting philosohic changes than will, say, imaginal and/or gradual desensitization. It also minimizes the use of catharsis and abreaction of anger because it assumes that these techniques help people immediately feel better but ultimately get worse by encouraging them to cognitively reaffirm a philosophy of outrage while they are "releasing" their anger.

RET also avoids the use of transpersonal, mystical, and religious techniques because, again, these methods may sometimes help some clients to live "better" with their disturbed thinking but at the same time interfere with the full development of flexible, open, and scientific attitudes—which, according to RET, are core characteristics of optimum and sustained mental health (Ellis, 1970b, 1972). RET, then, because of its basic assumptions about what really constitutes emotional health and disturbance, is more selective in choosing therapeutic methods than is general CBT. (Let me note, in passing, that one of the main differences between RET and Lazarus's (1976) multimodal therapy is that the latter somewhat compulsively uses all the main techniques in the BASIC ID model with virtually all clients all of the time, while RET more selectively uses some of these CBT techniques with some of the clients some of the time.)

EMOTIVE DIFFERENCES BETWEEN RET AND CBT

In principle, RET almost invariably employs emotive and behavioral methods of psychotherapy, and has always done so. Because it unusually emphasizes cognitive-rational methods, and is somewhat different in this

respect from most other forms of therapy, I originally called it RT or rational therapy (Ellis, 1957, 1957/1975, 1958), but I soon changed this to RET or rational-*emotive* therapy when I realized that the original name was leading critics to see it only (rather than in great measure) in rational terms (Ellis & Harper, 1961).

As I noted in the previous section of this paper, RET is not merely a pragmatic approach to therapy that employs any and all techniques that "work" or that give good, tested results; it is also a philosophic system or theory of human nature and of personality change—and as long as this theory seems valid, RET practitioners largely (though, I hope, not rigidly) follow it in their work with clients. Some of the main tenets of this theory follow. (1) Humans disturb themselves for biological as well as social or environmental reasons: because they are naturally and easily predisposed to think crookedly, emote inappropriately, and behave dysfunctionally in regard to their own goals and values. (2) Once they acquire or invent irrational thinking, they strongly and forcefully hold onto it, and have great difficulty in giving it up. (3) Because their cognitions, affects, and actions significantly interact and transact with each other, only a multifaceted cognitive-emotive-behavioral approach to therapy is likely to help them overcome their neurotic symptoms, to maintain emotional health, and to significantly prevent them from disturbing themselves again in the future. (4) Emotional maturity and behavioral efficacy largely consist of wishing, wanting, and preferring self-chosen, individualistic goals rather than absolutistically needing, necessitating, or *must*urbating about those goals. (5) Efficient—meaning quicker, simpler, longer-lasting, and more thoroughgoing—methods of personality change are usually preferable to less efficient means. Because of its being based on such theories as these—most or all of which, of course, may subsequently be revised or abandoned—RET favors certain emotive techniques and disfavors other emotive methods of therapy while CBT is less selective in this respect. For example:

Discriminating Appropriate from Inappropriate Emotions. RET especially discriminates between negative emotions like sorrow, regret, frustration, and annonyance, which follow from people's not getting what they *desire* and which motivate them to try to change for the better an undesired or obnoxious situation, and negative emotions like depression, panic, rage, and feelings of inadequacy, which (it hypothesizes) follow from people's not getting what they irrationally think they *need* or *must have* and which interfere with their constructive motivation and action and usually sabotage their desires. Unlike many CBT and experiential practitioners, rational-emotive therapists do not accept an emotion as "good" merely because it exists, is genuine, and has a certain degree of intensity. Instead, RET specifically defines "healthy" emotions in terms of

clients' goals and values, and not abstractly in their own right. Thus many followers of CBT—e.g., Beck (1976)—think of depression as extreme sadness, and view both intense sadness and depression as harmful symptoms. But RET sees depressed people as commanding that their extreme sadness (which may be based on a real loss, and therefore quite legitimate) *must* not exist and as thereby illegitimately making themselves depressed. It consequently tries to help such individuals remain appropriately sad but surrender their inappropriate, self-defeating feelings of depression.

Directly Working with and on Emotions. Like CBT, RET uses many evocative-emotive exercises that give clients an opportunity to acknowledge, get in touch with, work on, and change their feelings from inappropriate to appropriate ones. It particularly employs my version of Maultsby's rational-emotive imagery (Maultsby, 1971, 1975; Maultsby & Ellis, 1974), where clients are asked to intensely imagine one of the worst possible things that could happen, to let themselves strongly feel anxious, depressed, or angry, and to directly work on changing these feelings to those of sorrow, disappointment, or annoyance. It also, much more than does CBT, creates and uses some encounter and marathon techniques (Ellis, 1977c; Ellis & Whiteley, 1979; Wolfe & Brand, 1977).

At the same time, RET avoids many emotive procedures, such as Reichian, gestalt, bioenergetic, and primal technique, that some CBT practitioners—e.g., Palmer (1973)—use because these procedures often help exacerbate rather than ameliorate feelings that RET views as inapproprate—such as anger and "self-esteem."

Relationship Procedures. RET, CBT, and almost all other forms of psychotherapy involve some kind of relationship between the therapist and clients, but RET tends to be more selective than CBT in this respect and emphasizes the therapist's *accepting* rather than *giving warmth or approval* to clients and stresses teaching them the philosophy of self-acceptance. Although RET practitioners can, if they wish, give their clients empathy, sympathy, warmth, and even love, they tend to do so with extreme caution: recognizing that the therapist's expression of these feelings can easily backfire and help clients think that they are "good people" *because* the therapist approves of or loves them. Clients thereby tend to acquire conditional rather than *un*conditional self-acceptance that RET favors.

Forceful Emotive Interventions. Because it theorizes that humans are for the most part biologically predisposed to disturb themselves and to perpetuate their own dysfunctional thinking, emoting, and behaving, and that they have enormous difficulty in changing and keeping changed their self-defeating emotional reactions, RET holds that it is often important for therapists to use a great deal of force or vigor in interrupting their clients' philosophies and behaviors (Ellis, 1979b). Consequently, RET employs

unusually strong rational coping statements that have a powerful emotive quality, and it uses dramatic exercises, such as its famous shame-attacking exercises, to induce many clients to flood themselves with positive or negative feelings that may be therapeutically useful (Ellis, 1974b; Ellis & Abrahms, 1978). CBT may, of course, employ the same kind of forceful emotive procedures used in RET, but it tends to do so less often and to do so on pragmatic rather than theoretical grounds.

BEHAVIORAL DIFFERENCES BETWEEN RET AND CBT

Both CBT and RET include a wide range of behavioral procedures—in fact, almost all the common methods that are used in general behavior therapy (BT). Because, however, of the same kind of theoretical and philosophic assumptions mentioned in the previous sections of this article, RET is once again more selective than CBT in this connection. Thus it emphasizes relatively few behavioral methods while ignoring or de-emphasizing some of the others:

Reservations About Operant Conditioning. Although RET often utilizes operant conditioning (Ellis, 1969, 1973b; Ellis & Abrahms, 1978), it takes a somewhat skeptical view of the effectiveness of social reinforcement, and especially of kind and encouraging words from the therapist when clients do the "right" thing. For if I, as your therapist, keep telling you, "That's great!" or "I like that!" when you carry out your RET homework assignments, you may start to do them mainly for me and the praise I give you rather than for their intrinsic rewards. Moreover, you may falsely conclude, "Because I am doing so well at this therapy and because Dr. Ellis likes me for carrying it out satisfactorily, I am a good person!" You may thereby give yourself conditional rather than unconditional positive regard or acceptance, and feel better but remain basically as disturbed as ever.

According to RET theory, most people—and, especially, most seriously disturbed people—are already, because of their biological nature and their social (reinforcement) upbringing, *too* reinforceable, *too* conditionable, and *too* suggestible. They much too easily do the "right" things for the wrong reasons. RET, therefore, is one of the few behavior therapies that consciously try to help clients acquire a basic philosophic outlook that makes them maximally nondependent, individualistic, and nonconformist. Although it often (for practical purposes) adopts Skinnerian methods, it also retains a fundamental individualistic-humanistic outlook that encourages clients to be less conditionable by outside (social) influences and more self-conditionable and self-controlling.

In this respect, it is again more selective in it use of techniques than some of the other modes of CBT tend to be.

Use of Penalization. Although considerable research tends to show that reinforcing people for their "good" behavior works better than penalizing them for their "poor" behavior (Skinner, 1971), I have not found this to be consistently true in clinical practice—especially with adult D. C.'s (difficult customers!) whose degree of emotional disturbance, and especially their abysmally low frustration tolerance, almost forces them to go for immediate pleasures rather than long-term gains. RET practice has discovered that these individuals often do not alter their dysfunctional behavior unless they give themselves an immediate and somewhat drastic penalty immediately after repeating this behavior. Thus inveterate smokers frequently won't stop smoking if, say, they reinforce themselves with delicious food every time they desist from smoking—for they find, for physical and psychological reasons, cigarettes so "rewarding" that the food doesn't prove that reinforceable. But if they severely penalize themselves every single time they smoke—say, by burning a $100 bill (and lighting up the cigarette with it!)—they usually stop smoking quite quickly!

On the basis of these and many similar observations concerning people's low frustration tolerance, RET theory states that humans frequently vigorously hold to and give in to irrational ideas, such as the idea that they can harmlessly get away with smoking, and that highly forceful emotive-behavioral intervention, such as their giving themselves stiff immediate penalties whenever they indulge in dysfunctional activities, is often required to help depropagandize them regarding these irrationalities. Whereas CBT and BT, therefore, tend to emphasize behavioral reinforcement methods, RET more often utilizes self-penalization.

In Vivo Desensitization. BT and CBT today often use in vivo desensitization rather than Wolpe's systematic desensitization, which is largely done imaginatively (Emmelkamp, Kuipers, & Eggeraat, 1978; Wolpe, 1958, 1973). RET, however, has always favored in vivo desensitizing homework assignments and does so more than general CBT (Ellis, 1962, 1979b). The two main homework assignments utilized in RET follow. (1) People who needlessly fear to do certain things—such as ride in elevators or encounter members of the other sex—are urged to do so many times, and preferably in a short period of time. (2) Clients who have low frustration tolerance and who cop out of difficult situations in order to feel better—e.g., quit unpleasant jobs or refuse to visit difficult relatives—are encouraged to stay in these situations until they overcome much of their low frustration tolerance or discomfort anxiety—and then, perhaps, to leave these situations.

Flooding or Implosive Therapy. Because of its assumption that dramatic interruption of clients' irrational beliefs is often more effective

than gradual and less dramatic interruption of these beliefs, RET tends much more than CBT to favor flooding or implosive therapy. It encourages disturbed individuals to engage, suddenly, implosively, and repetitively, in "dangerous" or "phobic" behavior—not merely to desensitize themselves to the "pain" of undergoing this kind of action but also to impinge on their irrational ideas that they *can't* perform this behavior, that it will *destroy them* if they do, that it is *too* painful to bear, etc.

Skill Training Procedures. Both RET and CBT employ a good many skill training procedures, such as the teaching of assertion training, personal relating, and sex proficiency, but RET also emphasizes the limitations of skill training when it is used mainly in its own right and does not include a basic change in clients' irrational beliefs (Ellis, 1977d). RET practitioners, when using skill training, strongly emphasize people's first surrendering their basic irrationalities (especially, horror of failure and dire need for others' approval that blocks their acquiring assertion training, sex, and other skills) and then learning the skills themselves (Lange & Jakubowski, 1976; Wolfe & Fodor, 1975, 1977). The RET approach in this respect has a different emphasis from that used by most other CBT practitioners (Liberman, King, DeRisi, & McCann, 1977; Masters & Johnson, 1970).

CONCLUSION

I have tried to outline in this article some of the major differences between cognitive behavior therapy (CBT) or general RET, which I see as synonymous, and specialized or preferential RET, and to outline the somewhat distinct theory and practice of the latter form of psychotherapy. I have by no means covered all the possible differences between these two overlapping methods of therapy but have concentrated on the important ones that currently come to my mind. One of my main hypotheses is that the systematic use of CBT or general RET will be more effective for more clients more of the time than any form of treatment that exclusively stresses cognitive, emotive, or behavioral methods. But I also hypothesize that RET, when defined as it is in this paper and when used in its preferential form, will also prove more effective than CBT (or than general RET) for more clients more of the time. Virtually no studies have yet been done to test this hypothesis, and it will be interesting to see what the outcome of such studies will be.

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