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Science and Philosophy: Comparison of Cognitive Therapy and Rational Emotive Behavior Therapy

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Aaron T. Beck's Cognitive Therapy (CT) and Albert Ellis' Rational Emotive Behavior Therapy (REBT) are compared. A major difference between these therapies is that CT is an empirically based therapy and REBT is philosophically based. The origins and subsequent development of the therapies are reviewed with this difference highlighted. Comparisons between CT and REBT practice are made regarding attitudes toward client beliefs, use of guided discovery, types of cognition addressed, and the nature of the client-therapist relationship. The scientific foundations of CT are summarized in terms of the specificity of its conceptual models, the construction of targeted treatment protocols, and empirical findings that support both CT conceptualizations and treatments.

This article highlights similarities and important differences between Aaron T. Beck's Cognitive Therapy (CT) and Albert Ellis' Rational Emotive Behavior Therapy (REBT). Although CT and REBT have many characteristics in common, such as an emphasis on patient beliefs as a central focus in case conceptualization and treatment planning, they are actually quite different in origin, development, and practice as modeled by their founders. A fundamental difference between the two is that REBT is a philosophically based psychotherapy and CT is an empirically based psychotherapy. This basic difference has led to divergence between the "pure" therapies over time.

These differences are often obscured at the level of the therapist practitioner because many therapists are taught interventions that derive from a blend of both traditions. CT has spread more rapidly in recent decades than REBT. This is, in part, due

to greater demand for "empirically validated psychological treatments" (Task Force on Promotion and Dissemination of Psychological Procedures, 1995; Task Force on Psychological Intervention Guidelines, 1995). The CT literature offers empirically validated treatments for many different diagnoses, often with hundreds of research studies to validate the treatment. On the other hand, research on REBT has not been as extensive (Solomon & Haaga, 1995) and only a small number of outcome studies are published, most of these using waitlist controls (cf., Engels, Garnefski, & Diekstra, 1993) rather than the active treatment controls typically used in CT outcome research. In addition, Beck and his colleagues elaborate a rich theoretical conceptualization for each of the disorders. The basic tenets of these theoretical conceptualizations have also been subjected to rigorous empirical testing. For example, Clark and Beck (1999) specified nine major bases for the cognitive model of depression:

1. negativity,
2. exclusivity,
3. content specificity,
4. primacy,
5. universality,
6. severity/persistence,
7. selective processing,
8. schema activation, and
9. primal processing.

Each of these hypotheses has received strong empirical support. Over 800 studies have tested them with the vast majority supportive of the hypotheses (Clark & Beck, 1999).

THERAPY ORIGINS

Both REBT and CT developed from work begun in the 1950s. By the end of the 1950s Ellis had identified the philosophical roots of REBT. In contrast, Beck spent this decade conducting research aimed at deriving a scientific model to explain depression. Thus, even in these two therapies' early development, their founders followed different paths: science (CT) and philosophy (REBT).

Rational Emotive Behavior Therapy

Ellis developed a "rational psychotherapy" in the 1950s (Ellis, 1958) based on philosophical principles elaborated and eloquently presented in hundreds of articles and books over the subsequent decades. The accompanying article by Ellis outlines these principles, so they are not reiterated here. The REBT philosophy asserts that certain types of thoughts ("irrational" shoulds, musts, and other imperatives) inherently lead to problems and are always present when humans are troubled no matter what type of trouble is experienced. As a philosophically based therapy, similar treatment methods (e.g., disputation of imperative level beliefs) are employed with a wide variety of patient problems.

Cognitive Therapy

In the 1950s Beck completed psychiatric fellowships and training in psychoanalysis. In the latter half of the decade, he began research on the dreams of depressed patients to test the psychoanalytic theory that depression was anger turned inward. When data collected did not support psychoanalytic theory, he continued to collect data to construct a more empirically derived model of depression.

Early cognitive psychologists such as Allport, Piaget, and particularly George Kelly were the biggest influences on Beck. He also carefully reviewed the work of Karen Horney and Alfred Adler. He was not aware of the work of Ellis, which had been published primarily in papers in a psychology journal and volumes that Beck had not seen. After Beck's early papers on cognitive factors in depression (Beck, 1963, 1964) were published, Ellis wrote to Beck and noted the similarity in many of their ideas. Subsequently, Beck (1976) incorporated and cited several of Ellis' techniques and acknowledged Ellis' pioneering role in recognizing the importance of dysfunctional beliefs in producing psychic distress.

While the earliest forms of both therapies focused on client thoughts as central to problems experienced, REBT was already a philosophically based psychotherapy and CT was already becoming an empirically based psychotherapy. Thus, while Ellis was applying REBT to many human problems in the 1960s, Beck doggedly studied depression to develop a clear, data-based understanding of that problem and a system of psychotherapy that was ideally suited to treating its central features (Beck, 1964, 1976; Beck, Rush, Shaw, & Emery, 1979). Readers who wish to have a more complete review of the development of Beck's ideas are referred to the concise, yet eloquent, biography of his career (Weishaar, 1993) as well as a recent updated review of his career achievements (Padesky, in press).

DEVELOPMENT OF COGNITIVE THEORY AND THERAPY

Originally developed as a conceptual model and therapy for depression, cognitive theory led to compelling explanatory models for many additional disorders over the past several decades including anxiety disorders (Beck & Emery, 1985), addictions (Beck, Wright, Newman, & Liese, 1993), personality disorders (Beck, Freeman, et al., 1990; Beck, Freeman, et al., 2003), eating disorders (Vitousek, 1996), relationship difficulties (Beck, 1988), bipolar disorder (Newman, Leahy, Beck, Reilly-Harrington, & Gyulai, 2001), schizophrenia (Kingdon & Turkington, 1994; Morrison, 2002), and hostility and violence (Beck, 1999). Each of these new CT applications began with a cognitive conceptualization of the problem and evolved according to findings from empirical research.

The empirical foundation of CT is undoubtedly one of the reasons it is such a highly regarded therapy approach. There are five stages of development that lead to an empirically based system of psychotherapy. Some CT applications (e.g., depression, panic disorder) have achieved more thorough completion of these tasks than others (e.g., personality disorders, schizophrenia). Within each area of application, CT researchers examine conceptual models and psychotherapy approaches until all

five of the stages below have been thoroughly completed with empirical rigor and sufficient replication of results to lead to confidence in empirical findings. The five stages in the development of an empirically based system of psychotherapy are:

1. A broad conceptualization of a disorder is derived from clinical observations of a clinical phenomenon as well as empirical data.
2. This initial conceptualization, as well as its components, is empirically tested to evaluate the "fit" between conceptualization and the experience of people diagnosed with the disorder. There are often major modifications made to the conceptualization during this phase.
3. Once a conceptualization has been empirically validated, treatment methods are designed to address the key components of the disorder. An effort is made to tailor methods to parsimoniously address core issues.
4. Over time, these treatment methods are tested for efficacy by a variety of clinicians working with a variety of patients diagnosed with the particular disorder. Clinical steps that seem effective are specified and refined; there is an attempt to pare interventions that are superfluous to the outcome. The most useful methods are combined to form a "treatment protocol," step-by-step procedures shown to be effective in alleviating a particular problem.
5. Treatment protocols are tested via outcome studies including examination of relapse and post-treatment course. Treatments are modified subsequent to these studies and then published in treatment manuals that summarize the phenomenology, theory, treatment processes, and empirical support (cf., Beck, Rush, Shaw, & Emery, 1979).

Once these five stages are complete for a particular diagnosis, therapists learn the cognitive model and treatment protocol in order to apply these in individually tailored ways with particular patients. Because most patients arrive in therapy with multiple problems, a cognitive therapist is expected to learn a variety of conceptual models and treatment protocols as well as an empirical model of practice.

By "empirical model of practice" we mean each cognitive therapist is expected to duplicate the empirical basis of CT with individual patients. Therapists accomplish this by: (a) constructing a formulation of that person's experiences that draws on data from the individual patient's life, (b) comparing individual experience with empirically validated conceptual models, (c) applying treatment methods from published protocols based on their applicability to core aspects of the conceptualization, (d) evaluating the effectiveness of the individualized treatment by collecting data relevant to patient goals and comparing progress to published outcome data, and (e) modifying treatment methods based on patient reactions and newly published empirical findings.

This painstaking process of submitting conceptual models and therapy practices to empirical evaluation is the hallmark of CT. The resulting therapy protocols are recognized as state-of-the-art clinical practice (Task Force on Promotion and Dissemination of Psychological Procedures, 1995; Task Force on Psychological Intervention Guidelines, 1995). CT continues to evolve based on new research. While the development of REBT also is responsive to research, including research findings from CT studies, the REBT model has not been as vigorously tested and is not permeated so thoroughly by empiricism. In fact, Beck and Brown (1989) evaluated the assertion by Ellis (1987) that necessitous thinking or "musturbation" plays a central

role in depression. They found that this kind of thinking was present in depression but also in other forms of psychopathology. Whether it played a *central role* was not amenable to testing in the available data.

PRACTICE COMPARISONS

Several aspects of practice are highlighted with an emphasis on differences between CT as practiced by Beck and REBT as practiced by Ellis. Although these differences are sometimes subtle in nature, they may help the reader distinguish between the two types of therapy. The areas chosen are: (a) therapist attitude toward patient beliefs, (b) use of guided discovery, (c) links among thoughts and other aspects of human experience, (d) types of cognitions addressed and (e) the patient-therapist relationship.

Attitudes Toward Patient Beliefs

Ellis asserts that particular beliefs are healthy (e.g., unconditional other-acceptance, unconditional self-acceptance, unconditional life-acceptance) and other beliefs are patently unhealthy (e.g., absolutistic and unconditional shoulds, musts). At times Ellis restates an idiosyncratic patient belief in terms of REBT's list of irrational beliefs (Ellis, 1958, 1962, 1994). For example, a patient who reports, "I'm not happy with anything I do," might be told this is because they hold the belief, "I *must* do everything perfectly."

Beck is more concerned with how dysfunctional a belief is than with its alleged "irrationality." Cognitive therapists encourage patients to evaluate the functionality of beliefs within their own value system and life experience. Thus, for one patient the belief, "God will protect me from harm," may be quite functional (e.g., enhance spiritual joy) and for another person quite dysfunctional (e.g., lead to reckless risk-taking).

As shown in the following case example, Beck takes an empirical approach and encourages the patient to test his or her own beliefs, remaining open to the possibility that data collected may confirm a patient's belief. Thus, in CT the goal is to teach patients skills that enable them to investigate their own beliefs.

Case Example. A depressed woman reported that she is a "bad mother." Beck asked the patient how she came to this conclusion. She reported that her teenage children constantly fought with each other, were frequently late for school and had poor grades in several school subjects. She thought, "This is happening because I'm a terrible mother. I can't handle my kids. They are always going to have problems."

To help her investigate these conclusions, Beck discussed several areas of her own experience that were relevant: her own teen years and relationship with her brother, conversations she had with other parents of teenage children, and the context of her children's problems. (For example, the family had recently moved, disrupting her children's friendships, there was increased financial pressure, and she had been depressed and withdrawn in her parenting for several months.)

Review of information in these various realms of her life helped this woman see that although her children were showing signs of problems, these problems were not unusual in their scope or severity. She was able to recognize how her depressive thinking distorted her view of these experiences through processes of overgeneralization,

arbitrary inference, and self-blame. More important, she experienced in therapy how a more balanced view of her children's problems made it easier for her to consider options and feel motivated to solve the problems she faced.

As this woman progressed through therapy she learned to identify her thoughts and test them through review of life experiences, discussions with others, and behavioral experiments. At the end of each session, Beck helped her make a written summary of key points and asked the woman what she had learned that could help her that week. He also assigned homework each week so she became more adept at thought identification and testing, the ability to generate more balanced thoughts, and active problem solving. Beck emphasized development of skills that helped the woman learn to directly examine her beliefs as well as take action to test her beliefs and directly improve her life.

As this example illustrates, Beck advocates formulating patient beliefs in the patient's own words. This is part of the individualized approach in CT; Beck eschews putting words in the patient's mouth. This is because use of a patient's own words connects more directly with emotional aspects of a patient's experience than the use of stock phrases. Beck believes beliefs are best investigated in the presence of the emotions, memories, imagery, and behaviors associated with them. Thus, a cognitive therapist is encouraged to use a patient's idiosyncratic phrasing when investigating beliefs.

The therapy processes described above take somewhat longer than a direct challenge of her belief, "I'm a bad mother (because my children are having problems)." However, these processes help her achieve the ultimate goal of CT: mastery of skills that can prevent recurrence of problems. This woman not only felt better in the present, she developed a better understanding of depressive thinking processes and learned skills to help reduce the high risk of depression relapse.

Guided Discovery

Beck emphasizes methods of guided discovery that help patients identify and test their own beliefs through personal observations and experiments. Ellis emphasizes the direct disputation of beliefs. From a cognitive therapist's perspective, the advantages of guided discovery over direct disputation of beliefs are threefold:

1. guided discovery encourages patient activity so that the patient moves from a conviction mode to a questioning mode,
2. gathering relevant information from the patient's life strengthens alternative beliefs derived, and
3. the patient learns processes that can be used post therapy to evaluate troublesome beliefs and solve future problems, even if these are different from the presenting problem.

CT includes a wide range of guided discovery methods including Socratic dialogues (Beck et al., 1979; Padesky, 1993), automatic thought records (Beck et al., 1979; Greenberger & Padesky, 1995), behavioral experiments, psychodrama, and core belief logs (Padesky, 1994, 1995). Teaching patients to question and examine their own beliefs allows them to acquire skills that may help account for lowered relapse rates relative to other therapies (cf., Neimeyer & Feixas, 1990).

Practically speaking, patients can easily think of different ways to evaluate life experiences, but these alternatives often have low credibility to the patient. Frequently in CT, discussions of client beliefs lead to "behavioral experiments" to test beliefs directly by gathering evidence based on real-life experiments. Such experiments lead to experiential learning that can have much greater impact than the intellectual agreement reached during a verbal discussion. Thus, the experiential learning (both in and outside of the therapy session) that results from guided discovery bolsters patient conviction in alternative beliefs more than might be obtained by verbal disputation alone.

Links Among Thoughts and Other Aspects of Human Experience

Originally, Ellis proposed a model in which thoughts precede emotions and behaviors. Beck proposed an information processing model that accounts for mutual interacion among cognitions, emotions, behaviors, and physiological responses. While thoughts frequently do precede emotions, this CT model (and current REBT model) is consistent with data that show emotions also activate particular cognitions. For example, the negative cognitive triad (negative thoughts about the self, world, and future) is central to depression (Beck, 1967). In addition to these types of thoughts fueling depression, the patient may also interpret negative affect as, "I feel bad so things are probably terrible and I will never be able to feel better again."

Types of Cognition Addressed

REBT emphasizes the underlying assumption level of thought. Even when clients express automatic thoughts (e.g., "I'm really mad I didn't get the recognition I deserved") or core beliefs (e.g., "Those people are fools") an REBT therapist is likely to restate these as underlying assumptions linked to musts and shoulds (e.g., "If everyone doesn't admire me, then it is awful *because* I must be admired by everyone all the time or my work has no value").

CT emphasizes the level of thought consistent with empirical findings regarding particular problems. For example, CT for depression shows patients how to identify and test automatic thoughts (with a focus on underlying assumptions for relapse prevention or to treat recurrent depression); in addition to automatic thoughts, CT for anxiety examines the underlying assumptions ("if . . . then . . .") that characterize catastrophic predictions central to anxiety; CT for personality issues focuses primarily on the underlying assumptions and core beliefs that maintain rigid interpersonal strategies.

In addition to beliefs stated in words, both CT and REBT (Dryden, 1999) are attentive to imagery as an important form of cognition, particularly for anxiety disorders. Anxiety is often accompanied by images, and these images are often priming cognitions for anxiety reactions (Beck & Emery, 1985; Beck, Laude, & Bohnert, 1974; Grey, Young, & Holmes, 2002; Hackmann, 1999).

Patient-Therapist Relationship

In CT, the therapist and patient are collaborative partners. The therapist is supportive, educative and may also be directive in proportion to patient needs and the requirements of therapy protocol. The patient is encouraged to be active in CT. In fact, many

of CT's features are designed to increase the patient's active engagement in therapy. Patient and therapist set an agenda at the beginning of each session. The patient is encouraged to set clear, specific goals and to evaluate progress toward those goals on a regular basis. The patient and therapist coconstruct homework assignments each session that help the patient try out and practice ideas discussed in therapy. As stated above, the patient is the ultimate arbiter of which thoughts are functional.

Although many REBT therapists are also quite collaborative with patients, the REBT therapist often plays the role as arbiter of functional thoughts. In this sense, the therapist is the expert rather than a codiscoverer of meaning with the patient. Whereas cognitive therapists strive to use guided discovery to evaluate beliefs, REBT therapists are often confrontational. As Ellis states in the adjacent article, ideas are often expressed [by the therapist] "forcefully with strong determination."

EMPIRICAL TESTS OF THE THERAPIES

Although many REBT concepts are consistent with empirically derived findings, there have been relatively fewer empirical tests of REBT's concepts and methods as practiced. Most studies of REBT have been conducted with subclinical populations and most of these compare REBT outcomes with no treatment, rather than the more empirically rigorous comparisons with alternative active treatments (Solomon & Haaga, 1995).

In contrast, CT has been evaluated by thousands of studies that examine its conceptual models, treatment methods, protocols, and outcomes (Butler & Beck, 2000). This large empirical base is made possible by CT's specificity of conceptual models, specificity of treatment protocols, and innovations in measurement of clinical phenomena (moods, cognitions, physical symptoms, behavioral patterns). The following sections offer a concise summary of the scientific foundations of CT.

Conceptualization Specificity

All CT conceptualizations include two key assumptions. The first is that people actively construct meaning and derive rules that guide their behavior. This construction process involves information processing which frequently includes selective filtering and even distortion of what is perceived (Beck, 1967). The second is an assumption that cognitions, emotions, behaviors, physical responses and life events are interactively linked to one another (Beck, 1967; Padesky & Mooney, 1991). Although cognitions are not always causally linked to emotional or behavioral disorders, cognitive theory proposes that cognitions mediate all change efforts. For example, regardless of the original causes, someone with a substance abuse disorder may need to change beliefs about the problem before developing a motivation to participate in treatment. There is empirical support for each of these assumptions (Beck, 1991; Clark & Steer, 1996).

While these basic tenets unify cognitive conceptualizations, Beck and colleagues have derived specific and differentiated cognitive conceptualizations for most disorders on Axis I and Axis II in the *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition* (American Psychiatric Association, 1994), commonly known as *DSM-IV*. Each of these conceptualizations links key features of the disorder with cognitions that either cause or maintain the symptom picture. For

example, the cognitive conceptualization for depression emphasizes how the person's negative views of self, world, and future (the negative cognitive triad) maintain depression (Beck, 1967).

In contrast, all anxiety disorders are characterized by overestimations of danger and underestimations of coping and resources (Beck & Emery, 1985). In addition, each anxiety disorder has more specifically defined cognitions that either cause or maintain the disorder. For example, panic disorder is marked by catastrophic fears elicited by normal physical or mental sensations (Beck & Emery, 1985; D. M. Clark, 1996). Posttraumatic stress disorder is characterized by beliefs in the permanence of danger and trauma symptoms as well as a disorganized memory of the trauma that is more likely to be evoked by perceptual cues than intentional recall (Ehlers & Clark, 2000). Obsessive-compulsive disorder is marked by an exaggerated sense of responsibility for the occurrence and perceived consequences of intrusive negative thoughts (Salkovskis, 1996).

The cognitive theory of personality disorders links overdeveloped and underdeveloped interpersonal strategies to underlying assumptions and core beliefs (Beck et al., 1990). For example, someone diagnosed with avoidant personality disorder has characteristic core beliefs about self ("I'm inadequate and worthless") and others ("Others will criticize and demean me") that help explain the persistent pattern of interpersonal avoidance. Underlying assumptions and core beliefs common to each of the personality disorders have been identified that explain the overt patterns observed in each (Beck et al., in press).

Even schizophrenia, long considered a purely biological disorder, has recently been shown to have cognitive components that contribute to its maintenance and course. Delusions are associated with a tendency to jump to conclusions more readily (Linney, Peters, & Ayton, 1998). Auditory hallucinations may result from a cognitive bias toward externalization of thoughts; beliefs about these hallucinations may increase or decrease their occurrence (Beck & Rector, 2003; Morrison, 1998). The ability to cope with auditory hallucinations depends on one's perceptions of personal strength relative to strength of the voices (Romme, Honig, Noordhoorn, & Escher, 1992). Beliefs about symptoms and the diagnosis of schizophrenia can actually exacerbate or relieve symptoms (Brabban & Turkington, 2002).

Empirical Support for Cognitive Conceptualizations

The empirical research conducted to validate these cognitive conceptualizations has, at times, led to shifts in our fundamental understanding of disorders (D. A. Clark & Beck, 1999). For example, Beck and Emery (1985) proposed, and D. M. Clark (1986) later elaborated a cognitive model for panic disorder that suggested panic does not come "out of the blue" as defined in *DSM-IV* but rather is sparked by "catastrophic misinterpretation"of physical or mental sensations. D. M. Clark (1996) pointed out that although this simple theory can explain the clinical features of panic disorder, "this does not necessarily mean the theory is correct. In order to evaluate the theory, it is necessary to subject its predictions to appropriate investigation."

D. M. Clark (1986, 1988) made four specific predictions based on his cognitive theory of panic disorder. A decade of research conducted by investigators in five countries found strong evidence in favor of each of his predictions. As confidence in the cognitive model of panic gained support, this theory led to a cognitive therapy for

panic disorder that is highly effective: 74% to 94% of patients in outcome studies are panic-free at end of treatment with 76% to 89% panic-free at follow-up as long as 1 year later (Clark, 1996).

Cognitive conceptualizations for the following disorders also have received empirical support: depression (Beck, 1991; Hollon, DeRubeis, & Evans, 1996); anxiety disorders (D. M. Clark, 1999) including post-traumatic stress disorder (Ehlers & Clark, 2000), social phobia (Chambless & Hope, 1996; Clark & Wells, 1995; Harvey, Clark, Ehlers, & Rapee, 2000), obsessive-compulsive disorder (Rachman, 1997; Salkovskis, 1989, 1996), health anxiety (Asmundson, Taylor, & Cox, 2001) and generalized anxiety disorder (Riskind, Williams, Gessner, Chrosniak, & Cortina, 2000); eating disorders (Vitousek, 1996); and sexual arousal disorders (Sbrocco & Barlow, 1996). Empirical support is growing for the cognitive theories of the development and course of bipolar disorder (Lam et al., 2003; Newman, Leahy, Beck, Reilly-Harrington, & Gyulai, 2002), schizophrenia (Kingdon & Turkington, 2002; Morrison, 2002) and personality disorders (Beck et al., 2003).

Treatment Specificity

CT treatment methods vary substantially from disorder to disorder and usually are summarized by treatment protocols. The protocols derived for each application (cf., Leahy & Holland, 2000; Padesky, 1995) are based on the specific conceptualization and research for that disorder. CT of depression begins with behavioral activation because research shows such activation lifts mood. A patient rates moods as assigned activities are completed to directly test a common pessimistic belief that mood change cannot be achieved through patient effort. The central CT treatment component for depression, however, is teaching the patient to identify and test the negative automatic thoughts that maintain and deepen depressed mood (J. S. Beck, 1995; Beck et al., 1979; Greenberger & Padesky, 1995).

There is a unique treatment protocol for each of the anxiety disorders following the pertinent conceptualization. For example, CT for panic disorder involves helping the patient identify catastrophic misinterpretations of sensations and then develop alternative benign explanations for the same sensations. Patients then weigh the believability of catastrophic and benign explanations in the context of sensations induced within and outside the therapy session (D. M. Clark, 1996). Treatment of posttraumatic stress disorder involves identification of beliefs regarding the trauma and symptom sequellae, generation of normalizing explanations for the same phenomenon, restructuring beliefs about the trauma and subsequent symptoms, and organizing and completing the trauma memory itself (Ehlers & Clark, 2000).

Treatment of personality disorders involves construction of new underlying assumptions and core beliefs that allow the patient to develop new interpersonal strategies along with the flexibility to employ different strategies in different interpersonal contexts (Beck et al., 1990; Beck et al., 2003). The still evolving treatment of schizophrenia entails helping the patient identify and test beliefs regarding the diagnosis and symptoms in addition to use of cognitive-behavioral methods to solve problems and achieve patient goals (Beck & Rector, 2000; Kingdon & Turkington, 1994, 2002; Morrison, 2002).

Outcome Research

These and other CT treatment protocols have been subjected to the same empirical scrutiny as the conceptualizations on which they are based. Treatment protocols that have been in existence for some time, such as those for depression and panic disorder, have been examined extensively. More recently developed treatment protocols have fewer studies completed. However, there are consistent trends in the empirical findings that warrant support for the efficacy and enduring nature of CT treatments studied to date.

Generally, CT does as well or better than other active treatments for depression (Hollon et al., 1996; Strunk & DeRubeis, 2001), panic disorder (Clark, 1996), posttraumatic stress disorder (Ehlers & Clark, 2000; Gillespie, Duffy, Hackmann, & Clark, 2002; Resick, 2001), social phobia (Clark, 1997; Eng, Roth, & Heimberg, 2001), obsessive-compulsive disorder (Freeston et al., 1997), generalized anxiety disorder (Butler, Fennell, Robson, & Gelder, 1991), and bulimia nervosa (Bowers, 2001; Vitousek, 1996). Even more encouraging, there are indications that CT leads to lower relapse rates than other active treatments; this finding lends the strongest support to date for the cognitive model of treatment (Clark, 1996; Eng et al., 2001; Hollon, Thase, & Markowitz, 2002; Strunk & DeRubeis, 2001).

SUMMARY

Although REBT and CT share many common assumptions, the two therapies have different origins and have evolved along different paths. REBT is a philosophically based psychotherapy and CT is an empirically based system of psychotherapy. CT has benefited from empirical scrutiny. There are specific cognitive conceptualizations for different disorders, empirical evidence to support these formulations, and treatment protocols that meet criteria for empirical effectiveness and maintenance of treatment gains over time. Given the commitment to empiricism by CT's proponents, this therapy is likely to continue to evolve and grow over time.

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