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REVIEW PAPER

# To (i)B or not to i(B), that is the question: on the differences between Ellis' REBT and Beck's CT

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**Abstract**
Far from being a monolithic approach to psychotherapy, cognitive behavioural therapy (CBT) is in fact an umbrella term to describe a family of psychological therapies that share many common features but also have nuanced differences. Of the CBTs, two are often conflated under the 'CBT' moniker, namely cognitive therapy (CT) and rational emotive behaviour therapy (REBT). In this article, we explore some of the key differences and similarities between CT and REBT, touching on philosophy, practical implementation, and literature. We provide a brief hypothetical case study to demonstrate the different ways a therapist using CT and REBT might tackle the same client problem. We do not declare either approach superior, but suggest each might have their advantages in certain contexts and acknowledge that skilful practitioners could, and often do, integrate both approaches. As CBT continues to evolve and move into new areas, it is important that psychology practitioners and researchers are clear about which specific approach to CBT they are delivering, measuring and/or reporting on.

**Keywords:** Cognitive distortion; Cognitive mediation; Disputation; Irrational beliefs; Therapy

## Introduction

Cognitive behavioural therapy (CBT) is an umbrella term to describe a group of psychological therapies that share a common focus, namely the interaction between an individual's thoughts, behaviours, physical sensations and emotions (Craske, 2010). In simple terms, CBT-based approaches are concerned with how maladaptive thinking processes underpin maladaptive behavioural and unhealthy emotional outcomes, and how these are maintained in the present (Craske, 2010). CBT has arguably the most robust literature of all the psychological therapy frameworks (Hofmann *et al.*, 2012). Thousands of studies across clinical, sub-clinical, and high-performance settings have used and reported the efficacy of CBT-based approaches since they were developed in the mid part of the twentieth century (David *et al.*, 2018a; Epp and Dobson, 2010). In this article, we focus specifically on two forms of CBT, namely cognitive therapy (CT) and rational emotive behaviour therapy (REBT). We explore some of the key differences and similarities between CT and REBT, touching on philosophy, practical implementation and literature. To aid this comparison, we provide a brief hypothetical case study to demonstrate the different ways a therapist using CT and REBT might tackle the same client problem.

## Against CBT monolithism

As previously stated, rather than being the monolithic approach to therapy it is often mistaken for, CBT is a family of therapies, and each therapy contains nuances that helps to distinguish it from other CBTs. As Kuo (2019) states, 'CBT should not be conceived of as one singular approach. Rather, CBT represents a large body of related interventions using a therapeutic approach with common elements' (p. 87). The notion that CBT is not just a single approach to therapy is important for at least four reasons. First, it is academically important. If we believe that therapeutic modality matters in our work with clients, then the accurate portrayal of those modalities is important. How can I assess the evidence related to rational emotive behaviour therapy (REBT), for example, if the papers that test this modality simply refer to it as 'CBT'? Allied to this point on accuracy, maintaining specificity in the discussion of theoretical concepts allows for consideration of the possible similarities and differences in the various sub-theories underpinning the different modalities. For example, whilst CT uses a unitary theory of emotion whereby emotional distress is experienced along a continuum from low to high, REBT in contrast uses a binary theory of emotion whereby emotional distress can be categorised as either healthy (adaptive) or unhealthy (maladaptive) (e.g. Ellis and DiGiuseppe, 1993; Hyland and Boduszek, 2012a; Turner *et al.*, 2018)

Second, recognising that CBT is not monolithic is accurate, and as scientists and evidence-based practitioners we should be interested in accuracy. By accurately reporting the precise CBT utilised in applied studies, for example, we can reduce confusion by encouraging authors who write about CBT to be specific in their labelling and description of the particular CBT they are referring to. For example, if one writes in a scientific paper that 'CBT was applied' then the reader is left wondering exactly which CBT was applied and understanding is lost. This point can also be extended to *within* specific modalities of CBT, not just between them. For example, two papers reporting on outcomes from REBT may have used differing approaches to REBT (e.g. 'elegant' versus 'inelegant' REBT; Dryden and David, 2008), and may be integrating behavioural methods in different ways (e.g. shame attacking versus graduated exposure), yet unless specific interventions are labelled and described in detail, we are none the wiser on these important subtleties.

A third reason why it is important to be precise about CBT is that it is instructive with regard to training and practice. By being specific in labelling training using specific CBT monikers, trainees can understand precisely what CBT they are trained in and can explore other training in additional CBTs. By training in various CBTs, we can encourage skilled practitioners to utilise the most suitable CBT to meet the specific case and context. Lastly, being precise about CBT maintains important separation between different CBTs that are theoretically and technically distinct, so that the practice of one CBT is not conflated with the practice of another. If the clinical evidence for one CBT with a particular condition is strong, then I would want to make sure I apply that specific CBT with a similar case, rather than a different and less well-supported CBT for that condition. Therefore, and in sum, there are many CBTs, each with important differences in origin, theoretical positions and technique, which should be maintained in the portrayal of CBT in scientific, pedagogical and vocational discourse at least until they are appropriately synthesised within the scientific literature.

## A tale of two CBTs

Of the CBTs, two are often conflated under the 'CBT' moniker, namely cognitive therapy (CT) and rational emotive behaviour therapy (REBT). CT and REBT reside within the 'second wave' of CBT, which saw the integration of cognitive and behavioural elements. They followed behaviour therapy which arose from the 'behaviourism' movement of the early to mid-twentieth century (Thoma *et al.*, 2015). In recent decades there has been a substantial increase in research and interest in 'third-wave' CBTs whereby ancient Eastern practices, such as mindfulness, have

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become integrated within 'second wave' CBT treatment models (Hayes *et al*., 1999; Linehan, 1993; Segal *et al*., 2002). CBT has evidentially evolved over time to become more integrative, eclectic, and thus trickier to define as a singular concept. Albert Ellis, who developed REBT, himself acknowledged this, stating that it is 'almost impossible to describe CBT accurately' (Ellis, 2003; p. 225). However, unquestionably, CT and REBT have been integral in driving cognitive and behavioural approaches to psychotherapy towards widespread global adoption. It is beyond the scope of the current paper to fully outline the depths of each CBT. Interested readers can access many resources that exhaustively cover REBT (e.g. DiGiuseppe *et al*., 2014) and CT (J.S. Beck, 2020) and are also directed to previous valuable scholarly contributions which have considered how CT and REBT may integrate (see Hyland and Boduszek, 2012b). We will instead provide a very brief introduction to each approach next, before moving on to compare CT and REBT around certain broad paradigms.

### *Rational emotive behaviour therapy (REBT)*

REBT is a cognitive behavioural approach to psychotherapy developed in the second half of the twentieth century by the American psychologist Albert Ellis (Ellis, 1957; Ellis, 1962). Ellis created REBT (which was initially called rational therapy, then later rational emotive therapy, before finally settling on REBT) having become disillusioned with practising psychoanalysis in the Freudian tradition – the most popular school of therapy at the time – which he saw as being untargeted and too slow to bring about positive change among clients (Ellis, 1995; Still and Dryden, 1998). REBT was the first model of psychotherapy to present emotional disturbance as chiefly resulting from dysfunctional thinking in response to adversity, and to specifically target irrational belief systems held in the present as a mechanism for change (David *et al*., 2005). As such, REBT is considered by many to be the original form of CBT. Ellis has been called a 'trailblazer' (Thoma *et al*., 2015, p.429), and even the 'grandfather' of CBT (DiGiuseppe and David, 2015; p. 155).

### *Cognitive therapy (CT)*

CT was developed by the American psychiatrist Aaron T. Beck. Like Ellis, Beck began in the psychoanalytic school before gravitating towards a cognitive approach. Beck's early papers on cognitive factors in depression (A.T. Beck, 1963; A.T. Beck, 1964) kick-started a lifetime of work, spanning decades. Beck developed treatment models for a vast array of psychological disorders including depression, generalised anxiety disorder and obsessive-compulsive disorder, to name just a few (Beck, 1993). Chronologically, Beck developed CT after Ellis had presented REBT (or 'RT', as it was originally called) and thus cannot lay claim to being the first to formally outline a cognitive treatment model. However, the scale and impact of Beck's work means that he is considered by many to be the most influential figure in CBT (Thoma *et al*., 2015). As its central premise, CT holds that psychological problems are caused by faulty thinking processes (i.e. cognitions). Cognitive therapists set about helping patients to identify and then correct their various cognitive distortions, biases and misalignments through psychoeducation, reason-based discussion, and reality-testing (DeRubeis *et al*., 2010).

## Comparing REBT with CT

Given that REBT and CT emerged at similar times in history, with similar over-arching assumptions, how do CT and REBT differ theoretically, and is it possible or even appropriate to declare one approach better than the other? The rest of this paper will attempt to address these meaty questions briefly by covering the clearest points of comparison, pointing the reader to more detailed reviews comparing CT and REBT should they have the inclination to explore more deeply

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(e.g. Ellis, 2003; Padesky and Beck, 2003). We keep our presentation of similarities and differences at the broad fundamental level to provide a concise and edifying paper that can serve the CBT community, rather than an exhaustive analysis. We first explore the suggested similarities and differences between REBT and CT, and then present a hypothetical case study to bring the discussion to life.

### Over-arching similarities

REBT and CT have always shared several over-arching similarities and, arguably, have become more similar over time as each has evolved (Ellis, 2003). Crucially, both REBT and CT consider thinking, feeling and behaving as 'integrally and interactionally related' (Ellis, 2003; p. 227). They both believe that realistic, logical and healthy thinking processes are integral for emotional and behavioural flourishing and are concerned with addressing a client's disturbances, thinking processes, and experiences in the present, rather than spending time on early developmental experiences as with other approaches like psychoanalysis.

Both CT and REBT recognise the role and importance of cognitive mediation in emotional responding, an idea that emerged formally in the cognitive revolution of the 1950s (Ruggiero *et al.*, 2018). Cognitive mediators are defined as 'mental processes or activities that take place between the initial occurrence of a stimulus and the subsequent related response' (Alegria and Cameron, 2020; p. 496). The theory is that as cognition mediates between what we experience and how we respond, we can attempt to modify our cognitions in order to shape our emotions. Furthermore, in their practice both REBT and CT share common ground around being goal-oriented, structured and time-limited, as well as integrating homework tasks into the therapeutic process. Both also emphasise collaborative listening, mutual problem-solving and Socratic questioning – although REBT therapists are often considered more direct and didactic and traditionally have used humour more often than with CT – perhaps a reflection of Ellis' gregarious personality and Beck's more reserved character.

### Philosophy versus science

Whilst over time some of these differences have reduced, in terms of their origins it can be said that REBT has worn its philosophical influences on its sleeve, metaphorically speaking, more so than CT, and CT has traditionally placed a greater emphasis on empiricism and scientific rigour than REBT (Padesky and Beck, 2003). Ellis created REBT from a philosophic viewpoint, building a therapeutic approach which was directed at long-range hedonism and life improvement. Ellis was famously inspired by the works of ancient philosophers, particularly Ancient Stoics such as Marcus Aurelius, and Epictetus, the latter recorded in *Enchiridion* (translated from Latin: 'the handbook') as saying: '*Men are disturbed not by things, but by the views which they take of them*' (Long, 1991). Ellis aligned REBT closely with this dictum, creating an ABC model to emphasise how disturbances at 'C' are caused not by adversity at 'A' alone, but rather by the views, or beliefs ('B'), we hold about the adversities (Dryden, 2005). In addition to Stoicism, REBT also incorporates constructivism, humanism, existentialism, and even Buddhist themes, in various ways that CT either does not, or at least does far less so (Ellis, 2003).

Both REBT and CT aim for long-term improvement among clients but REBT is perhaps more ambitious in targeting profound philosophic change beyond symptom relief and disorder-focused treatment (Ellis, 2003). Comparatively, CT is perhaps more cautious in targeting, at least initially, a return to normal functioning and symptom treatment (Padesky and Beck, 2003). The term 'cautious' used here in comparison with 'ambitious' is not intended as pejorative. REBT is considered transdiagnostic, not because it ignores diagnostic manuals, but because it focuses on unhealthy negative emotions such as anxiety, depression, shame, anger, guilt, jealousy and hurt (Dryden, 2005). By contrast, CT has traditionally taken a more diagnosis-led and protocol-driven

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view to treating psychological disturbances, although it has moved in a more transdiagnostic direction in recent years (Barlow *et al*., 2011; Beck and Haigh, 2014; Norton and Barrera, 2012). Beck was highly significant not only in creating CT treatment models but also offering tools and inventories to allow for clearer and more effective psychiatric diagnoses (Beck *et al*., 1996). Whilst Ellis demonstrated a very scientific approach to psychotherapy, with empiricism being encouraged in his clients as a key component of REBT, he was not a scientist *per se*, and conducted very little research. In contrast, CT was born from a research-driven approach to understanding and treating psychopathology, and Beck was a prolific researcher, However, this does not mean Beck ignored the importance of Stoic works of ancient philosophy in CT's development.

Proponents of CT might reasonably point out that being less philosophical does not make it any less effective and that the opposite could be true. Indeed, they might also point out that over time CT has incorporated more philosophical themes, including the pursuit of a meaningful life (A. T. Beck *et al*., 2021) and mindfulness (J. S. Beck, 2020). Moreover, CT adapts according to disorder requirements as evidenced by robust real-world data and has demonstrated efficacy across a wide range of clinical settings in a body of literature that is substantial (Padesky and Beck, 2003). It could be that CT offers a more realistic or approachable starting point in treatment, especially for more clinically extreme presentations where irrational belief disputation may not be possible, or at the least is more difficult. REBT proponents might counter this by pointing out that REBT has demonstrated efficacy with serious psychiatric illnesses (Dryden and Bernard, 2019) and may suggest that CT misses its chance to enact long-lasting philosophical change. However, comparison studies reveal REBT to be *as effective* as other CBTs (Stefan *et al*., 2019), and there is little evidence that REBT is superior to other CBTs despite clear evidence that REBT is superior to placebo or no treatment controls (e.g. David *et al*., 2018b; Engels *et al*., 1993).

### Approach to cognitions

CT and REBT both agree that maladaptive thinking is at the heart of disturbance but tend to take different approaches when tackling it. This is a complex area, and we will cover some key distinctions within the confines of this article's scope and aims as outlined. REBT preferentially targets a specific set of deeply held irrational beliefs (i.e. demandingness, awfulizing, low frustration tolerance and global rating; DiGiuseppe *et al*., 2014) which it places at B in its ABC model. REBT does however also allow practitioners to return to and help clients explore their higher-order thinking (i.e. inferences and automatic thoughts) as necessary but it is typically not its preferred starting point (Ellis, 1994). Indeed, scholars of REBT refer to 'specific' (or elegant) and 'general' (inelegant) REBT (Dryden and David, 2008), whereby the former holds belief change as its chief focus, and the latter allows for change at various levels, not just at the belief level (Turner, 2022). For example, in specific REBT the practitioner would focus the work on helping the client to weaken their irrational beliefs (iB) and strengthen their rational beliefs (rB) at 'E' in relation to a critical adversity (A) using disputation techniques (at 'D' in the extended ABCDE model of REBT). In other words, B change is the necessary chief focus. However, in general REBT, the practitioner can help clients to explore G change (e.g. adjust their goals), A change (e.g. adjust the situation, or inference about the situation), and/or C change (e.g. modulate the physiological aspects of an emotion), as primary objectives of the work (Turner, 2022). Ellis used the terms 'elegant' and 'inelegant' within this context, noting that he was open to 'inelegant' approaches if these were better suited to an individual client (Ellis, 1977; Ellis, 1994).

Notwithstanding, REBT is distinct from CT in *typically* focusing on the four key irrational beliefs Ellis saw as being key to emotional and psychological disturbance (as outlined), in helping clients identify four alternative parallel rational beliefs (preferences, anti-awfulizing, high frustration tolerance and unconditional acceptance), and in incorporating an active process of belief disputation (based on empiricism, logic and pragmatism) designed to weaken irrational beliefs and strengthen rational alternatives. CT also looks at addressing deeper level cognitions

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under the terms schema, conditional assumptions, and core beliefs (Beck and Haigh, 2014; J.S. Beck, 2020), but is *typically* more tentative in approaching these deeper belief systems than REBT, instead recommending a focus on automatic thoughts and inferences in the early phases of therapy to acclimatise the client to the notion of cognitive mediation and the process of cognitive restructuring, before moving onto deeper belief work if and when necessary and/or possible. This was also recognised by Ellis who indicated that CT advocates the disputing of irrational or dysfunctional beliefs in a less direct and gentler manner than REBT (Ellis, 2003).

Another important and related distinction is that REBT therapists will tend to assume that their client's inferences *are true* to get to the underlying beliefs underpinning disturbance and begin disputation of these straight away (Ellis, 2003). By contrast, CT therapists would tend to work with clients to help them first explore through evidence seeking if their negatively skewed automatic inferences about themselves, others, and the world, are indeed true. For example, the inference 'my colleague does not like me' would initially be assumed to be true (whether it is factually true or not) by the REBT practitioner, who then seeks to understand the client's underlying beliefs about not being liked by colleagues. A CT therapist, on the other hand, would likely begin by seeking to help the client to challenge the initial negative automatic assumption or interpretation that they are indeed disliked by their colleague, before possibly – although not definitely – moving into deeper intermediate and core belief work down the line. As the eminent CT therapist and daughter of Aaron Beck, Judith Beck describes, CT practitioners can use a 'downward arrow technique' to explore intermediate and core beliefs which involves 'asking clients to assume their automatic thoughts are true and then questioning them about the meaning of their automatic thought'. However, Beck also describes how 'doing so can arouse increased negative emotion though, so you usually wouldn't use this technique in the first few therapy sessions' (J.S. Beck, 2020; pp. 291–292), perhaps demonstrating the more cautious approach advocated by CT to working on deeper level beliefs compared with REBT.

## Hypothetical case study

What follows is a simplified example to demonstrate some of the main differences in approach between REBT and CT. As previously acknowledged, REBT therapists can engage with client higher-order thinking and CT work can also include exploring and challenging deeper level beliefs. Indeed, both CT and REBT include behavioural techniques. It is typically the practical starting point and focus of therapy treatment where the differences lie, and this is the point we seek to illustrate in this example.

> *John seeks help for anxiety in relation to public speaking at work. He has a history of mild social anxiety. John fears that his blushing will be noticeable and that his colleagues will perceive that he is nervous, unaccomplished, and weak as a result. John avoids giving presentations at work. If unavoidable, he becomes very anxious prior to and during his presentations, sweating, feeling nauseous, and worrying constantly about people noticing that he is nervous. This is detrimentally impacting John's experience of work, and career aspirations. Otherwise, John is generally mentally and physically well.*

Working with the ABCDE model, an REBT therapist would initially assume that John's inferences (that people will notice that he is nervous) *are true* to get to John's underlying irrational beliefs at 'B' which can then be disputed on empirical, logical and pragmatic grounds. The therapist might ask, for example: 'let's assume that it is true that your blushing is noticeable, and people can see that you are nervous, what would be anxiety provoking about that?'. After working down a chain of inferences (Neenan and Dryden, 1996), John may arrive at one of several irrational beliefs which could be: 'I want to be seen as capable and in control at all times therefore my

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colleagues absolutely must see me this way' (demandingness), or 'I cannot bear being seen to be nervous by my colleagues' (frustration intolerance), or 'If I am seen to be nervous, that would make me a weak and useless person'. Therapy room work and homework would be targeted at helping John in systematically disputing his irrational beliefs (irrational because they are rigid, extreme, dogmatic, and illogical) and instantiating and strengthening alternative rational beliefs (that are flexible, non-extreme, nondogmatic, and logical). An REBT therapist would, over time, help John to develop an over-arching philosophy of rationality, flexibility and self, other and life acceptance, as well as disputation skills which can be applied to future disturbances no matter their content.

A therapist working within the traditional CT model would likely approach this case from a different starting point, namely John's biased inferences and higher-order thinking processes. Interested readers are directed to Clark and Wells' cognitive behavioural model of social phobia (Clark and Wells, 1995), for a detailed explanation of this evidence-based approach. Within a traditional CT framework, rather than assuming John's inferences *are true* (even if they are not) to get to his underlying irrational beliefs (as with REBT), CT would likely begin from the position of helping John to see that his inferences are biased and not in keeping with reality. John would likely be encouraged to *reality test* the evidence supporting or challenging his inferences that people will notice that he is nervous, and that if they did, that they would judge him negatively, which could include real-world experiments. John might, for example, be encouraged to conduct a survey of his colleagues (or a representative sample) to assess the extent to which he is noticeably nervous when speaking, and/or interpretations of his capability when delivering presentations. Videos of John delivering presentations might also be used. Whatever the specific techniques used – and there are many available (see Clark and Wells, 1995) – the goal is for John to realise that his assumptions are negatively biased and not in keeping with reality, and for positive change to begin from this point. Psychoeducation would be used alongside real-world evidence testing throughout. Longer-term work might include an investigation of John's core beliefs, or schemas, as CT also recognises these as being important, but the aforementioned process would be a starting point, and potentially the entirety of the work, within a CT framework dependent on the length of treatment.

## Is taking sides useful?

If both CT and REBT approaches to helping people like John are efficacious, it begs the ultimate question: which is better? CT has the larger evidence base, especially within clinical populations (Matweychuk *et al.*, 2019; Solomon and Haaga, 1995). REBT practitioners and researchers recognise and are seeking to address this imbalance (David *et al.*, 2018b; Turner, 2016). This difference may reflect Beck's diligent scientific data gathering and Ellis' apparent preference for delivering and teaching therapy data, rather than provide hard evidence in favour of CT theoretically. It is not as though REBT lacks evidence, far from it, just less than CT. In recent years, REBT has been applied with effect to non-clinical performance settings like sport and business, suggestive that it may have broader application among healthier individuals than CT (Criddle, 2007; Turner, 2019).

Would it not therefore be too simplistic, indeed unhelpful, to attempt to call it one way or the other? These authors argue yes. REBT may suit some scenarios, CT others. REBT may be better suited for a case like John's, which is largely characterised by social anxiety with undesired but not highly disturbed outcomes, and for a client who has the intellectual, emotional and psychological capacity to imbibe the profound philosophical teachings that REBT can deliver. CT may be better applied to more serious psychiatric illnesses, like psychosis, or severe depression, where accessing irrational beliefs or undergoing systematic belief disputation is harder, at least at the outset, and where CT methods have a stronger evidence base. Even this is far too generalised. Indeed, some REBT practitioners have disagreed with the notion that REBT

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is less suited to more seriously disturbed cases (see Dryden and Bernard, 2019). In reality, wise practitioners might, and indeed often do, skilfully integrate REBT, CT and behavioural methods to suit client needs and situations.

## Conclusion

In this paper we have sought to make two main contributions. Firstly, to call for more clarity around CBTs in reporting and discourse, and secondly to compare CT and REBT to give readers a high-level understanding of where they overlap and where they diverge.

Both CT and REBT have contributed enormously to the success of CBTs, in fact they have been its linchpins. Both have demonstrated efficacy across a wide range of settings. Both address maladaptive thinking to improve psychological, emotional and behavioural outcomes among clients. They diverge in some of their methods, however. REBT is a more philosophical, humanistic, and largely transdiagnostic approach. REBT focuses on disputing and weakening deeply held irrational beliefs which include demandingness, awfulizing, frustration intolerance and global rating. CT is in contrast rooted in empiricism and more closely aligned with psychiatric diagnoses. It typically addresses higher-order thinking, such as automatic thoughts and inferences, and indeed intermediate beliefs, before core beliefs. It does not incorporate philosophy like REBT does but is not wholly unphilosophical. Indeed, it is moving in more philosophical directions.

Readers should be aware that the volume of empirical evidence supporting CT is superior to the volume of evidence supporting REBT. But this does not necessarily mean its theory and approach is stronger. CT may be better suited to more serous psychiatric illness than REBT, for reasons touched on, but even this is uncertain. It is dogmatic to declare one theory and approach better than the other, and many CBTs teache us that dogmatic thinking is unhelpful. Skilful CBT practitioners would likely integrate both CT and REBT methods, and indeed, Turner (2022) argues for an integrated REBT framework that incorporates a broad range of CBT techniques. In addition, much of this research evidence for CBTs, particularly that which was conducted in the twentieth century, has been conducted within western cultures, and, although not always, often with largely white populations. Indeed, CBT's development itself was led by white, middle-class American men. This is not a criticism but merely an acknowledgment of the historical context in which CBT has been developed, worthy of more nuanced and detailed discussion than can be afforded by our article.

Putting the REBT versus CT discussion to one side altogether, in these final remarks, as with our introductory remarks, we will take the opportunity to advocate for practitioners and academics being as clear as possible in their reporting, practice and teaching of CBT, so that we can collectively drive towards greater clarity of understanding in what is undoubtedly a nuanced area. If CT us used, report it as 'CT', rather than 'CBT'. Ironically, this may become even more challenging as the lines between therapies such as CT and REBT become ever more blurred and as integrated CBT increases in popularity.

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