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Psychologists' Opinions As To The Effects of Holding Five of Ellis' "Irrational Ideas"[1]

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December 15, 1966

PR–66–7

Abstract

Five of Albert Ellis' "irrational ideas" were inserted in a psychological statement matrix of the form: "If a person believes *p*, holding this belief will tend to make him uncomfortable, or ineffective, or both." Three groups of psychologists or psychologists-in-training (graduate students in a clinical diagnosis class, second-year clinical doctoral candidates in a psychotherapy class, and an exhaustive sample of Psychology Department faculty) were asked to indicate whether the resulting statements concerning probable psychological effects-of-belief were true. Neither group of students had heard Ellis' views discussed in class. Very high consensus (96%, 93%, 86%) was found for three of these statements; almost maximal disagreement (45%, 51%) for the other two. Comments by no-responders suggest that the latter two were formulated too "ideologically" or "abstractly" to imply personal distress. No good evidence appeared to indicate that self-described theoretical orientation, field of psychology, stage of training, faculty status, institution granting one's doctorate, or years of clinical experience influenced responses. It is tentatively suggested that, given the present lack of scientific evidence, a practitioner's reliance upon the three high-consensus generalizations is at least as justifiable as is reliance upon most theoretical or tactical beliefs held by psychotherapists, on which much lower consensus than this exists.

[1]This research was supported in part by a grant from the National Institute of Mental Health, United States Public Health Service, Research Grant #M4465.

In attempting to gain a hearing among conventional psychotherapists for the theories and tactics of innovators like Ellis (1957, 1958, 1962) (Ellis & Harper 1961) one sometimes hears the quasi-ethical objection that approaches such as Ellis' rational-emotive psychotherapy are intrinsically wrong because they involve the therapist's "imposing his own values" upon the patient. Those who object along these lines to rational-emotive therapy (or, for that matter, to any of a larger group of therapies employing active cognitive restructuring, Socratic dialogue, task-setting, intellectual intervention, and the like) argue that apart from the presently unsettled question as to the therapeutic efficacy of these approaches— a question which, needless to say, can be raised equally forcefully with regard to more conventional techniques subsumed under the general heading of "dynamic psychiatry"—there is a purely moral or philosophical objection which has nothing to do with questions of efficacy or technique. The philosophical reasoning involved here is complicated, and what I believe to be its errors will therefore require more detailed treatment in another place. (But see McClosky and Meehl 1947, Meehl 1959) Suffice it to say for present purposes that these objections stem in large part from a confusion between *genuinely axiological statements* and what I shall, for convenience, call 'pseudoaxiological' statements, the latter being statements which do not actually assert or posit a value or ethical obligation but rather allege the existence of some kind of causal or statistical relationship between a person's *holding* a specified value and other aspects of his behavior or his social

impact. Thus, for example, the proposition: "Patriotism is one of the noblest virtues" is a genuinely axiological statement, a positing of a value (an expression of a sentiment, a formulation of an ethical principle.) Whereas the statement "*If* a person strongly holds that patriotism is one of the noblest virtues, *then* he is likely to favor harsh punishment for refusal to fight in wartime" is a pseudo-axiological statement, since it does not make any value claim but rather asserts a certain psychological connection between *one* psychological state or event, to wit, the holding of a value, and *another* psychological state, namely, having punitive attitudes toward non-combatants. Such statements, while containing axiological or deontological statements as components (i.e., as subordinate clauses following a verb of belief, acceptance, and the like) do not depend for their correctness upon the validity of their axiological portions. In the terminology of the logician, we say that pseudoaxiological statements are not truth-functional with respect to their axiological components. What this amounts to in the more usual language of psychotherapists is that psychological statements about value-behavior are not themselves value- statements, nor are they dependent upon value-statements. By the prefix 'pseudo' I intend nothing pejorative, as these are perfectly legitimate empirical assertions; the 'pseudo' merely points to the fact that they are sometimes misclassified as value-judgments.

Once this elementary semantic confusion is clarified, the ethicality of a rational-emotive therapist's active intellectual interventions is seen in a very different light, because now the question is not one of the therapist's imposing his "personal, private, subjective" value-orientation upon his patient. Rather it is an empirical one, namely, whether the pseudoaxiological (i.e., psychological-causation) statements which the therapist

presupposes are factually correct or not. The patient or client comes seeking help for a certain ego-dystonic symptom or character trait, and the explicit or implicit therapeutic contract between him and the professional helper is that the latter will attempt, employing all legal and otherwise licit means, to relieve him of this complaint. (It goes without saying that this therapeutic contract can always be renegotiated, and we know that it regularly is, in such technical forms as, for example, "If this is a problem for you, perhaps we should explore it further?") If it turns out that there is a close causal connection—or, as would more accurately be said, a reasonably close quasi-causal connection—between the patient's holding of certain axiological commitments and, as a direct or indirect psychological or social consequence, the difficulties under which he is laboring and from which he desires to be freed, then the therapist's attack upon these commitments can be philosophically predicated upon the premise that *the patient cannot continue to hold these commitments and at the same time bring about the other changes which he states he desires to bring about*. A judgment as to the compatibility of two or more axiological commitments is, of course, not itself a "value-judgment," but is either a meta-axiological or pseudo-axiological question belonging to the domains of logic, semantics, or behavior science. And, as such, it is genuinely *cognitive* (i.e., the patient can be mistaken about it, whereas many philosophers and psychologists would hold that one cannot be "mistaken" about his primary value-commitments.)

It goes without saying that there is at the present time no psychotherapeutic theory, nor is there any set of technical maneuvers, about which anyone can assert, "These are infallible, they always work, and furthermore we have a complete causal comprehension of how and why they work, scientifically documented to the fullest extent that any rational man could properly

demand about a matter involving his vital interests." If the utilization of a particular theory of mental mechanisms or the etiology of behavior disorder, or the application of specific interview tactics, or the employment of a diagnostic instrument, were to be considered professionally illegitimate absent such ironclad scientific documentation, it is obvious that practically all clinical psychologists would have to cease and desist forthwith from practically all of our professional activities. Dr. A. relies upon the Rorschach in selecting patients for uncovering therapy; Dr. B uses the MMPI to identify sociopaths, because he does not like to work with them therapeutically; Dr. C. rejects all psychometrics because he has a great faith in his unaided clinical intuition. Dr. X. has a couch in his office because he is convinced that the couch yields "better material"; Dr. Y. avoids thinking diagnostically because he is convinced that such thinking departs from the kind of unconditional positive regard which he believes is an essential condition for successful therapy; Dr. Z. is of the Jungian persuasion and is a great one for interpreting archetypes. Each of these clinical practitioners accepts his role as a professional helper, and collects a fee from the patient (or a salary check from the taxpayer) for operating within the framework of his beliefs. Not one of them could provide anything like adequate scientific documentation for the beliefs which he holds. If pressed each would appeal to his "clinical experience," the only trouble being that this appeal is equally available to the others who 'hold very different theories and favor very different instruments and techniques. It would be tedious to pile up further grounds for my assertion, so I shall assume from this point forward that all rational readers who have not been completely brainwashed by membership in some diagnostic or therapeutic sect will admit that this is an accurate description of the state of affairs.

Now one possible conclusion from this is that there ought not to be any such activity as clinical psychology and that all of these practitioners should discard their shingles forthwith

and begin to make an honest living selling soap. For purposes of the present paper, I shall assume that this (while a live option theoretically) is not our conclusion, but that instead we conclude the following: Lacking adequate scientific evidence in areas where there is a great human need for a certain kind of help, it is ethically proper and professionally legitimate to rely in one's clinical practice upon a doctrine or a technique which one believes to be supported by some combination of (a) armchair considerations, ranging from common sense to extrapolated scientific theory, (b) one's personal experience of living, (c) one's personal experience in clinical work, making the best effort to be open-minded about what others report from a different point of view, and (d) the best available professional consensus. I do not wish to maintain controversially that these four grounds, even in the aggregate, are ethically adequate. I merely say that if they are *not* collectively adequate to justify clinical work, we would all

have to shut up shop and go home. The present study explores (d).

As a result of some recent discussions among professionals concerning rational-emotive and allied types of psychotherapy, I was struck by the fact that the psychological connection between what Albert Ellis calls "neurotic postulates" or "irrational ideas" and behavior maladjustment seemed, to me at least, to be very obvious and direct, and at least as well supported by my observations of life and my 23 years of diagnostic and therapeutic work with patients, as most of the *other* psychological generalizations upon which clinicians (myself included) typically rely in our daily work. Example: Ellis' Irrational Idea Number One, that "It is a dire necessity to be loved

or approved by almost everyone in my environment" is a notion which I have found present in many of my patients, as well as quite a few students, colleagues, and acquaintances. I estimate that I have known at least 100 persons well enough to conclude that this idea was strongly operative in them. I have never known anyone to hold this idea who was not made uncomfortable or ineffective as a result of his efforts to guarantee that everyone will love or approve him, which is hardly surprising, for the reasons Ellis elaborates (Ellis 1962, pp. 61-62). Unpublished data on the theoretical and tactical opinions of a sample of some 150 psychotherapists of a great variety of orientations (collected in collaboration with B. C. Glueck, Jr., and William Schofield) had made it quite clear that there are very few statements about the theory of neurosis or the techniques of treatment which can command even near-universal assent among practitioners. (E.g., only 4 out of 132 statements show a 90% consensus, and these few are rather trivial platitudes such as "A person who is basically cold and unsympathetic would not make a suitable therapist for most cases" and "The client should feel free to say anything he wants to about the therapist.") Would Ellis' "irrational ideas" fare this badly?

Pending a large-scale investigation of a similar national sample, I have in the present study attempted a preliminary exploration of this question on psychologists available to me locally. Taking the first consecutive five "irrational ideas" listed by Ellis and making slight reformulations (he himself has employed different language in the books and papers he has written on the subject) I then recast each of them into a properly stated pseudo-axiological proposition. That is to say, I first expressed the irrational idea in question as a proposition *p*, and then inserted this proposition in a standard matrix of the form: "If a person

believes *p*, holding this belief will tend to make him uncomfortable, or ineffective, or both." (I "watered down" some of Ellis' formulations which were stated categorically by introducing the verb 'tend,' since in inquiring among behavior scientists or students of behavior science whether one psychological state or event produces another, one should surely take into consideration the fact that many such scientifically-trained respondents will routinely refuse to accede to *any* proposition of flat categorical form, on the ground that practically all "laws" about complex human behavior are only quasi-laws of a probabilistic nature, even though the probabilities may in some cases be very high indeed.) The psychological consequence of holding the irrational belief *p* was stated as a non-exclusive disjunction between being "uncomfortable" and being "ineffective," operating on the principle that, broadly speaking, *subjective distress* or *objective inefficiency* are almost completely exhaustive of the domain of problems or complaints for which an individual seeks psycho therapeutic help or society insists that he have it.

Respondents were reminded that the statements were not value-judgments but were statements asserting alleged empirical (causal) connections between the psychological fact of a person's holding a certain value-judgment or attitude and the probable psychological effects of his holding it. The word 'uncomfortable' was explicated as including roughly such feeling- states as being anxious, tense, angry, resentful, frustrated, distressed, dissatisfied, ashamed, guilty, unhappy. The word 'ineffective' was explained as including three main components, to wit, perceiving inaccurately, reasoning fallaciously, or acting inappropriately. The respondents were asked to check whether they agreed that such a psychological connection exists between the belief in question and the discomfort or inefficiency allegedly resulting, and were

told that we were not interested in whether they could prove this connection "scientifically," but that we merely wanted their opinions, based on whatever grounds they personally found persuasive.

A copy of the questionnaire employed is found in the appendix.

Samples

Three samples of professional psychologists or psychologists-in-training were studied, representing three levels of theoretical training and professional experience.

Sample I: *Students in Clinical Psychology class* (N = 74). These were students in a first-year graduate course in introductory clinical psychology (assessment) taught by myself and Dr. William Schofield. The course is required of all first-year trainees in clinical psychology (child or adult), but is regularly or frequently taken by students in several other training programs at the University of Minnesota, such as counseling psychology (Psychology or Educational Psychology), school psychology, industrial psychology, personality theory, and so forth. Actually, less than half of the class in any year are formally enrolled as trainees in clinical psychology. Characteristics of the class are summarized in Table 1. The questionnaire having been administered in the first week (prior to any reference to psychotherapy), it may safely be assumed that most students were as yet unaware of the lecturer's predilections (eclectic, mainly neo-Freudian and rational), and that most of them were relatively naive as regards advanced professional problems in theory and techniques of therapy. Asked to record their prorated approximate full-time years of clinical experience, the great majority (n = 61) indicated that they had as yet had no clinical experience. Among the 13 who reported having some experience, the median was one year.

Table I

Composition of Clinical Psychology (Diagnosis) Class (N = 74)

Field			Orientation			Degree Earned		
	F	%		F	%		F	%
Clinical	31	42	None adopted yet	32	43	None	9	12
Counseling	17	23	Eclectic	18	24	BA, BS	53	72
Applied, other*	11	15	Rogers	5	7	MA, MS	9	12
Non-applied	12	16	Neo-Freud	4	5	MSW	2	3
Unknown	3	4	Skinner	4	5	MD	1	1
	74	100	Freud	3	4		74	100
			Jung	3	4			
			Existential	2	3			
			Horney	1	1			
			Sullivan	1	1			
			Szasz	1	1			
				74	100			

Me 11 *The 11 “Applied, other” include 6 school, 2 industrial, 2 differential, and 1 consumer psychology. The 12 “Non-applied” include 6 experimental (learning, mathematical, perception), 3 personality, and 3 social psychology.

It is worth noting that after the questionnaire was administered, we asked for a show of hands as to how many recognized the source of the item content, and only one hand was raised. Oddly enough, it turned out that 27 students had nevertheless at least heard of Albert Ellis, although only 21 had ever heard of rational psychotherapy.

Sample II: *Second-year clinicians beginning a didactic class in psychotherapy* (N = 20). This sample consists of all students enrolled in a required two-year course surveying theories and techniques of psychotherapy, taken by all second- and- third-year doctoral candidates in clinical psychology (child or adult.) Students in the first year of this class vary in amount of clinical experience from 0 hours to 5 years (median < 1 year) and they also vary considerably in how much formal and informal exposure they have had here or elsewhere to various theoretical orientations in psychotherapy. The questionnaire was administered during the first week of the quarter and prior to any didactic presentation by the fall quarter lecturer. A bare majority (n = 11) of these students state that they have as yet adopted no theoretical orientation, although an additional 5 characterize their position as "eclectic." The distribution of characteristics for this sample is shown in Table 2.

Sample III: *Psychology Department Faculty* (N = 58). This is an exhaustive sample (100% return!) of all persons having the status called "full department membership" in the University of Minnesota Department of Psychology (57 psychologists and one psychiatrist). Full department membership involves the right of attendance and voting at meetings of

the psychology faculty. A considerable number of persons holding such full department membership are not full-time in the Psychology Department, but mainly function in other teaching, research, or service positions on the University campus, e.g.,

Table 2

Composition of Psychotherapy Class (N=20)

Orientation			Earned Degree			Years Experience		
	F	%		F	%		F	%
None adopted yet	11	55	BA	18	90	5	1	5
Eclectic	4	20	MA	1	5	4	1	5
Freud	2	10	PhD*	1	5	3	1	5
Neo-Freud	1	5		20	100	2	2	10
Sullivan	1	5				<1	4	20
Skinner	1	5				0	11	55
	20	100					20	100

*PhD in History

University Hospital, Student Counseling Bureau, Department of Child Psychology (College of Education), Dean of Students Office, Psychiatric Research Unit, special training programs, e.g., psychopharmacology, and, in a couple of instances, mainly private practice. All individuals holding full department membership teach one or more formal courses offered by the Department of Psychology, and in the great majority of instances they receive some portion of their income from the Psychology Department budget. The distribution of self-described fields of concentration, institution granting the doctorate, years of clinical or counseling experience, and theoretical orientation toward neurosis and therapy, is shown in Table 3. What may appear to be an unusually large "applied" faculty is due in considerable part to these part-time appointments of psychologists in the Medical School or in campus service positions. Among the *full*-time Psychology Department Faculty, only 7 are in the applied fields.

The 6 "Applied, other" include 3 in differential, 2 industrial, and 1 advertising. The 19 "Non-applied" include 11 experimental (learning, physiological, comparative, perception, psycholinguistics), 5 social, 1 motivation, 1 personality, and 1 child psychologist.

The single psychiatrist has been tabulated under the "clinical" rubric in all analyses.

Results

It would be tedious and pointless to present raw data tables for all of the various statistical analyses that were made, so that I shall present only the summary statistics in Table 4.

In the small psychotherapy class, the incidence of item-endorsements for each item was contrasted for the 11 students who had as yet no clinical

Table 3

Composition of Psychology Department Faculty (N = 58)

Field	F	%	Orientation	F	%	Doctorate	F	%	Years Full-Time Clinical Experience	F	%
Clinical	22	38	Eclectic	24	41	Minnesota	30	52	16	5	9
Counseling	11	19	None adopted yet	13	22	Stanford	5	9	13-15	4	7
Applied, other	6	10	Skinner	5	9	Iowa	3	5	10-12	9	16
Non-applied	19	33	Sullivan	4	7	Yale	2	3	7-9	7	12
	58	100	Freud	3	5	North Carolina	2	3	4-6	6	10
			Neo-Freud	2	3	Denver	2	3	1-3	6	10
			Existential	1	2	Other*	13	22	None	21	36
			Horney	1	2	MD**	1	2		58	100
			Ellis	1	2		58	100			
			Kelly	1	2						
			Miller	1	2						
			Rotter	1	2						
			“Some undetermined’	1	2						
				58	100						

*One each from Chicago, Clark, Columbia (T.C.), Cornell, Harvard, Indiana, Northwestern, Ohio State, Pennsylvania, Radcliffe, Tulane, Washington, Wisconsin

**MD and residency at Minnesota; psychoanalytic training at Columbia Psychoanalytic Institute.

Table 4

Item endorsement by the three groups (N = 152)

		Diagnosis Class (N = 74)		Psychotherapy Class (N = 20)		Psychology Faculty (N = 58)		Pooled Group (N = 152)	
		f	%	f	%	f	%	f	%
Item	1	71	96	18	90	57	98	146	96
	2	68	92	20	100	54	93	143	93
	3	36	49	11	55	30	52	77	51
	4	63	85	19	95	49	85	131	86
	5	35	47	11	55	22	38	68	45

experience and the 9 who had some. In the faculty sample Chi-square comparisons were run on frequency of item-endorsement over four fields labelled clinical, counseling, other "applied," and non-applied, the latter covering all fields with the exception of clinical, counseling, industrial, and mental measurement. A comparison was also made between faculty who had received the doctorate at Minnesota and those who had received it elsewhere. Finally, a comparison was made between faculty who had (whatever their current self-described specialty) some amount of clinical or counseling experience with patients or clients, and those who had not. None of these contrasts approached statistical significance. In the larger class in introductory clinical psychology, after eliminating the three cases who did not specify any field of psychology, a comparison was made as to the frequency of item-endorsement for those in the fields of clinical, counseling, other "applied," and non-applied fields such as social, experimental, or mathematical psychology.

Again no differences were found.

Of some 27 significance tests run, only 1, that between the students in the psychotherapy class with and without some clinical experience in responding to item no. 3, was significant at the 5% level of confidence, and most of the tests were nowhere near statistical significance. Although this fourfold table is significant at the 5% level (exact test), the somewhat experienced psychotherapy students endorsing the item by a ratio 8:1 while those without experience endorse it in the ratio 3:8, the utter failure of any such tendency to emerge among the 58 members of the psychology faculty makes one suspicious that this one significant result found among the several contingency tables examined is probably the to-be-expected error in random sampling. At any rate, I am not prepared to offer any plausible interpretation of why clinical psychology trainees with slight or moderate

experience should have a greater tendency to think that the belief that certain people are bad, wicked, or villainous will tend to make patients uncomfortable or ineffective than would be true of trainees who are as yet clinically naive.

The summary data suggest that professional psychologists regardless of field, age, experience, or orientation display a remarkably high consensus with regard to items 1, 2, and 4. It is equally clear that with respect to items 3 and 5, there is almost no consensus, the endorsement frequency being close to the rejection frequency for these two items. Informal exploration with some of the subjects suggests a rather easy explanation for these differences. Several respondents pointed out that, with regard to item no. 3, respondents were conflicted by virtue of the double-barrelled character of the alleged psychological consequence, namely, "that holding this belief will tend to make him uncomfortable, or ineffective, or both." They reasoned that patients (and, for that matter, many normal persons) are able to handle their own conflicts, frustrations, and anxieties by adopting projective and extrapunitive mechanisms, as a result of which they are able to function fairly satisfactorily. It was also suggested that the belief that certain people are bad, wicked, or villainous may be held in a kind of abstract ideological way which does not really mobilize much rage affect in the holder, and that this kind of "official" ideology about moral badness does not necessarily play a critical role in the individual's psychological economy. Ellis' published clinical examples of this attitude regularly concern significant persons in the patient's immediate and daily surround (e.g., spouse, colleague, employer). It seems likely that a re-phrasing of the item along these lines would elicit quite different results, in the direction of increased endorsement. With regard to item no. 5,

a similar point was made about a kind of "philosophical determinism" commonly held by psychologists, and again it was pointed out to me that the item format does not sufficiently clearly indicate whether the patient concretizes these attitudes with respect to significant persons in his own immediate interpersonal environment.

Since the strongest objection to therapeutic innovators, especially those who emphasize cognitive and intellectual approaches to treatment, comes from the "establishment," i.e., the dominant tradition generally subsumed under the rubric of "dynamic psychiatry," a valid criticism of the present study would be that the general professional milieu from which these professionals and students were drawn is one characterized by scientific criticality and eclecticism, an orientation which (whatever its intrinsic merits) is quantitatively weak in its representation of the establishment's theoretical orientation. It is my intention to collect data on the same questionnaire from other sources which will be chosen so as to include more of this type of psychotherapist or theorist. (I may mention that the few clinical students or faculty in the present study who had undergone a psychoanalysis or other intensive "uncovering-interpretative" therapy did not show any tendency to deviate from the group results, but the N here was not sufficient to justify statistical analysis.) However, pending further investigation, I have attempted a preliminary approach to this question within the present data. Confining attention to students or faculty in the specialties of clinical or counseling psychology, I divided them into those labeling their own orientation as any of the following: Freud, neo-Freud, existential, Sullivan, Horney, Rogers, Jung, or Rotter. It seemed appropriate to designate any of these orientations
as being (broadly) in the "dynamic psychiatry" tradition. Contrasted with these were those

labeling their orientation as "eclectic," or indicating that they had not as yet adopted any theoretical orientation. Respondents describing themselves as followers of Skinner, Ellis (one case!) or George Kelly were omitted from this analysis. This dichotomy left me with a set of 27 respondents classifiable as being in the "dynamic psychiatry" tradition versus 65 who were as yet uncommitted or who called themselves eclectic. It goes without saying that some of the self-described "eclectics" would actually be fairly strongly in the dynamic psychiatry tradition, e.g., one respondent calls himself eclectic and then, in addition, checks his orientation as "Freud," existential'' and "Sullivan." Others (especially among the eclectics) would definitely not be in that tradition. For whatever it's worth, the percentages of item-endorsements over the 5 items between the "dynamic" and eclectic or uncommitted" professionals were practically identical, as shown in Table 5.

Needless to say, none of these data bear directly on the scientific question whether the 5 Ellis-type generalizations are valid or not. The present study was intended purely as an investigation of the existence or absence of professional consensus concerning 5 pseudo-axiological statements which I for one believe to be essentially correct. Lacking adequate research on the matter, I am encouraged in my daily utilization of pseudo-axiological generalizations 1, 2, and 4 by finding that around 95% of my professional colleagues and students in the clinical and counseling areas, aside from their theoretical orientation, place of obtaining the doctorate, or years of experience, share my view that the holding of these particular "irrational ideas" has a tendency to make a person uncomfortable, or ineffective, or both.

Table 5

Item endorsement by orientation

		"Dynamic" Orientation Named (N = 28)		"Eclectic" or No Orientation Adopted Yet (N = 65)	
		f	%	f	%
Items	1	28	100	62	95
	2	28	100	62	95
	3	13	46	32	49
	4	26	93	61	94
	5	13	46	31	48

References

Ellis, A. Outcome of employing three techniques of psychotherapy. *Journal of Clinical Psychology*, 1957, *13,* 344-350.

Ellis, A. Rational psychotherapy. *Journal of General Psychology*, 1958, *59*, 35-49.

Ellis, A. *Reason and emotion in psychotherapy*. New York: Lyle Stuart, 1962.

Ellis, A. and Harper, R.J.R. *A guide to rational living*, Englewood Cliffs Prentice-Hall, 1961.

McClosky, H. and Meehl, P.E. Ethical and political aspects of applied psychology, *Journal of abnormal and social psychology*, 1947, *42,* 91-98.

Meehl, P.E. Some technical and axiological problems in the therapeutic handling of religious and valuational material. *Journal of counseling psychology*, 1959, *6*, 255-250,

Appendix

Please indicate which *one* of the following best describes your theoretical orientation as to neurosis and its treatment:

_____ Adler	_____ Horney	_____ Reich
_____ Eclectic	_____ Jung	_____ Rogers
_____ Existential	_____ Meyer	_____ Skinner
_____ Freud	_____ Rado	_____ Sullivan
_____ Neo-Freud	_____ Rank	_____
		Other (identify)

_____ I have as yet adopted no orientation

If you are a psychologist or a psychology student, what is your main field of interest (e.g., clinical, counseling, learning, social)?

_____
Psychological field

Your degree: BA _____
MD _____
PhD _____
MSW _____

Years clinical experience (pro-rate to approximate full-time equivalent) _____

Following are five psychological statements concerning the probable influence of a person's beliefs upon his happiness or effectiveness. Note that the statements are *not* value-judgments; rather, they assert alleged empirical (causal) connections *between* the psychological fact of a person's holding a certain value-judgment or attitude *and* the probable psychological effects of his holding it. Each statement asserts that if an individual holds a certain value-belief, this will *tend* to disturb his comfort, or impair his efficiency, or both. 'Uncomfortable' includes, roughly, such feeling-states as being anxious, tense, angry, resentful, frustrated, distressed, dissatisfied, ashamed, guilty, unhappy. 'Ineffective' includes perceiving inaccurately, reasoning fallaciously, or acting inappropriately.

Please indicate by checking (✓) under "Yes" or "No" whether or not you agree that there is, in fact, such a psychological connection. Never mind whether you could prove it scientifically; we merely want your opinion, based on whatever grounds you personally find persuasive.

Yes No

___ ___ If a person believes that it is a dire necessity that he be loved or approved by almost everyone in his environment, holding this belief will tend to make him uncomfortable, or ineffective, or both.

___ ___ If a person believes that he is not worthwhile unless he is thoroughly competent, adequate, and achieving in everything he may have occasion to do, holding this belief will tend to make him uncomfortable, or ineffective, or both.

___ ___ If a person believes that certain people are bad, wicked, or villainous and should be severely blamed and punished, holding this belief will tend to make him uncomfortable, or ineffective, or both.

___ ___ If a person believes that it is awful and catastrophic when things are not the way he would very much like them to be, holding this belief will tend to make him uncomfortable, or ineffective, or both.

___ ___ If a person believes that human unhappiness is externally caused to such an extent that people nave little or no ability to control their sorrows and disturbances, holding this belief will tend to make him uncomfortable, or ineffective, or both.

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