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TWO CONCEPTS OF MENTAL HEALTH: RATIONALITY VERSUS ASSERTIVENESS

ABSTRACT: Two concepts of some importance to mental health are rationality and assertiveness. Both of these are implicit in the therapeutic approaches of two major schools of counselling. This study attempted to discover which of the two concepts is more central to good mental health. For this purpose, measures of both rationality and assertiveness were obtained from two samples: (1) a random sample of non-institutionalized (normal) subjects, and (2) a sample of psychiatric inpatients. Results indicate that there was a proportionately greater shift toward irrationality from the normal to the inpatient sample than there was toward lack of assertiveness (p less than .00001). Hence, it was concluded that rationality is a more central concept to good mental health than assertiveness. However, these results are not to be interpreted as being indicative of the relative merits of the above mentioned schools of therapy because the degree to which the instruments used here measure the aspired goal states of these therapeutic approaches is unknown. More research is needed before such conclusions are warranted.

INTRODUCTION

Throughout the ages, men have wondered about what constitutes mental health and its obverse, mental disorder. Yet, even at the present stage of scientific development, there are few attempts to define mental health. Generally speaking, an individual is labelled "weird," "insane," or "crazy" if he deviates too far from the commonly accepted rules, values, and mores of society. Since the innovations of Sigmund Freud, such people are usually led to seek help or are forced to receive it in the form of a variety of treatment techniques all of which are known as "psychotherapy."

All forms of psychotherapy involve at least two elements: change and direction. The first is obvious: someone has decided that the patient or client or counselee should be different from what he is. However, change in itself is not enough, for, as has been shown (Truax & Carkhuff, 1967; Carkhuff & Berenson, 1967), the client can change for "better or for worse." The direction of the change may

come from various sources, such as the patient, or the therapist, or societal institutions and standards. However, it is generally assumed that the therapist, if he does not prescribe the direction, at least supervises it to lend some assurance that the therapy is moving the patient toward improved mental health.

It follows, then, that the therapist should have some conceptualization of good mental health. This is usually founded on the therapist's rationale of what constitutes the behaviour of a mentally healthy person. To put it another way, a therapist generally works within a framework of theories of personality which either explicitly or implicitly describe the essential characteristics of a healthy personality, and likewise postulate the types of behaviour considered unhealthy, or abnormal. Unfortunately for most practitioners of psychotherapy, a healthy personality is all too often defined as one that does not display any of the maladaptive behaviours described as unhealthy. Such a definition of mental health creates problems for the practitioner because the direction of therapy is toward *removal* of the unhealthy symptoms, rather than toward a positively identified state of better mental health.

Not only does the lack of an adequate definition of "mental health" tend to inhibit purposive direction of therapy, but it also hinders the empirical study and comparison of the effectiveness of various systems of psychotherapy. The researcher who wishes to compare two systems must often abstract the underlying concepts of "mental health" which are implicitly or explicitly embedded in every system of psychotherapy. Such comparative studies are essential for the discovery of those constructs which appear to be most important, or most central, to good mental health. Knowledge about the relative importance of the "components" of good mental health would permit those therapists who prefer an eclectic approach to base their choice on empirical factors, rather than on claims of "success-rate," or, in the worst case, on the "appeal" of a proposed system of therapy. In the following sections of this paper, two systems of psychotherapy are examined for their embedded concepts of mental health, and the relative importance of these concepts are then compared by empirical methods.

TWO CONCEPTS OF MENTAL HEALTH

The specific concepts of mental health which were explored are those underlying the positions of (1) rational-emotive psychotherapy, advanced by Albert Ellis, and (2) systematic desensitization by reciprocal inhibition, formulated by Joseph Wolpe. These two therapeutic positions were chosen because the two approaches represent different major "schools" of psychotherapy. Wolpe's techniques clearly fall in the category of "behaviourism" while Ellis's principles are more like those applied by "cognitive psychology." Both have strong theoretical bases that have been subjected to fairly extensive empirical investigation. However, their theories appear to be at opposite ends of a continuum in terms of their conceptualization of mental health.

Wolpe, in the general medical tradition, considers mental health to be the absence of psychological disorder, while Ellis construes emotional health more as a way of life characterized by rational self-direction. Hence Ellis makes quite clear what he means by mental health and directs his therapy accordingly. Wolpe, on the other hand, does not talk about mental health at all; consequently, the kinds of behaviour that he would consider characteristic of psychological adjustment had to be deduced for the purpose of this study from his therapeutic approach.

Wolpe emphasizes the conditioning, or learning, aspect of neurosis. He views neurosis as learned, maladaptive behaviour patterns in which anxiety plays a central role. In his first book on reciprocal inhibition, he states, "Anxiety is usually the central constituent of this (neurotic) behaviour, being invariably present in the causal situations (Wolpe, 1958, p. 32)."

Wolpe considers therapy to involve the detachment of neurotic responses from objectively harmless stimuli; consequently mental health is the absence of emotional disorders. Because anxiety is central to all neuroses, the psychologically healthy person should employ more anxiety-inhibiting responses than would the emotionally maladjusted person. Furthermore, if, as Wolpe maintains, the most common inhibitor of anxiety in daily life is assertive behaviour (Wolpe & Lazarus, 1966), then we can expect the mentally healthy individual to exhibit more assertiveness than the psychologically disturbed individual.

The other position explored was the rational-emotive approach of Albert Ellis. Rational-emotive personality theory, although more formalized than conditioning personality theory, does not take a firm stand on what constitutes personality, falling somewhere between behaviourism and dynamic psychology. However, Ellis is quite explicit about what he means by mental health.

Although rational-emotive therapists accept the learning theorists' position that human beings become neurotic or psychotic largely as a result of conditioning, they do not believe that symptom-removal is extensive enough in scope. Ellis maintains that what is required is the restructuring of the client's basic philosophy of life into a conceptual framework that will provide him with techniques for resolving not only his present problems but future difficulties as well. Mental health, according to the rational-emotive therapist, is characterized by a rational approach to life and its accompanying dilemmas. Consequently, an emotionally stable person will possess fewer irrational ideas about the world than an emotionally disturbed person.

Ellis would agree with Wolpe that a mentally healthy person displays assertive behaviour but he would argue that assertiveness is not sufficient to guarantee mental health. For Ellis, the emotionally adjusted individual is the rational individual. And although the rational person is assertive, the assertive person is not necessarily rational. This relationship between rationality and assertiveness can best be illustrated by means of a Venn diagram such as the one shown in part a of Figure 1, in which R refers to the set of rational persons,

to the constructs of rationality and assertiveness: (1) those who are both rational and assertive, (2) those who are assertive but irrational, and (3) those who are irrational and non-assertive.

Wolpe's system also contains three categories, but differs from that of Ellis inasmuch as the second category contains rational but non-assertive people instead.

The following rationale was developed to test the relative importance of the constructs. Suppose responses to measure both assertiveness and rationality were obtained from a random sample of the population. These could be used to estimate the means of assertiveness and rationality required for norming the instruments. Due to the expected positive correlation between assertiveness and rationality, the scattergram of the scores would approximate that depicted in part a of Figure 2.

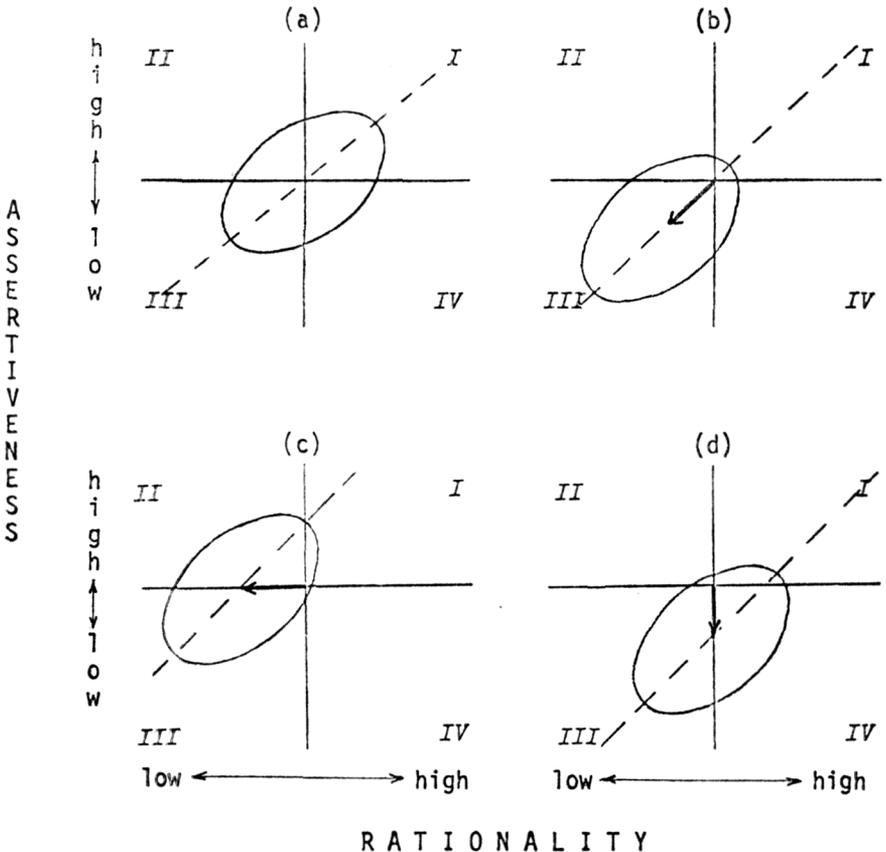


FIGURE 2: EXPECTED SCATTERGRAMS OF RATIONALITY AND ASSERTIVENESS FOR (A) THE NORMING SAMPLE, AND (B) THE PSYCHIATRIC SAMPLE IF THE NULL HYPOTHESIS IS TRUE, (C) IF RATIONALITY IS MORE CENTRAL TO MENTAL HEALTH, (D) IF ASSERTIVENESS IS MORE CENTRAL TO MENTAL HEALTH.

Suppose further, that responses were obtained from a sample of subjects who are inpatients in a psychiatric ward or clinic. The fact that they are hospitalized for psychotherapeutic treatment places them at least theoretically outside of the inner circles of the Venn diagrams in Figure 1.

Now, if the null hypothesis were true, that is, if both assertiveness and rationality contribute equally to mental health, then one would expect the scattergram of the scores of this sample to be located downward along the major axis of the ellipse of the norming sample, as illustrated in part b of Figure 2. In other words, assertiveness and rationality are lacking in equal proportion, and the areas of the Venn diagrams of Figure 1a and 1b labelled A and R respectively are probably null sets.

If, on the other hand, rationality is more central to mental health, and the diagram of Figure 1a is correct, then one would expect a scattergram as illustrated in Figure 2c. This figure depicts a proportionately greater displacement in the rationality component than in the assertiveness component.

By contrast, if assertiveness were the more central of the two (Figure 1b is correct), one would expect a scattergram as shown in Figure 2d from the inpatient sample where a relatively greater displacement occurred along the assertiveness dimension.

This can be tested statistically by examining the frequencies in the quadrants labelled II and IV. If the null hypothesis is correct, the proportion of cases falling into these quadrants will remain equal. Unequal proportions in these quadrants will support either rationality or assertiveness as more central to mental health.

PROCEDURES

The experimental procedure was to collect scores of both assertiveness and rationality on a norming sample, as well as a sample of psychiatric inpatients, and to examine the trend of the inpatient data with respect to the norms found from the norming sample.

The Instruments

A separate paper and pencil inventory was used for measuring the two constructs. Rationality was measured by the 60-item Adult Irrational Ideas Inventory (AII) (Davies, 1970; Fox & Davies, 1971) which is based on the Irrational Ideas Inventory originally constructed by Zingle (1965) to measure the extent to which students exhibit the eleven irrational beliefs outlined by Ellis (1962, pp. 60-68). The statements of the AII are scored on a five-point scale ranging from "strongly agree" to "strongly disagree." Davies (1970) reported test-retest correlations of .77 over a three-week interval, and KR20's of .74 and .78 for pre- and posttests, respectively.

For measuring assertiveness, the Social Acquiescence Scale (SA) of the Famous Sayings Test (Bass, 1958) was used. It is comprised of 56 statements requiring responses of "yes," "no," or "cannot decide." According to Bass (1958), "persons high in Social Acquiescence tend

to accept *any* generalizations about human behaviour. . . . Such people appear to be outward-oriented, insensitive, non-intellectual, socially uncritical individuals — unquestioning conformists to social demands (Bass, 1958, pp. 481-482)." Consequently, the more contradictory statements that a person agrees with, the higher his degree of social acquiescence or conformity. Conversely, it can be argued that a low SA score reflects non-conformity, independence, or assertiveness. Bass (1958) reports KR21's ranging from .8 to .9.

The Samples

To obtain an adult norming sample, 300 persons were randomly selected from *Henderson's Greater Edmonton Directory*, a list of all Edmonton residents 18 years of age and over. Since the directory lists approximately 300,000 names and addresses, the sample to population ratio was about 1 to 1000.

The psychiatric inpatient sample was drawn from the population of inpatients at the psychiatric wards of the Calgary and Edmonton general hospitals, and the Misericordia Hospital (Edmonton). The staff at these hospitals were asked to administer the inventories only to those inpatients who were judged capable of understanding the questions. The inventories were to be completed on a voluntary basis while the patient was *not* under the influence of chemotherapy, ECT, or the like.

Data Collection

Through the cooperation of the above mentioned hospital staff, responses were collected from 65 psychiatric inpatients (43 females and 22 males) with a mean age of 36.1 years. The diagnostic classifications of these patients were: 57 classified as neurotic, 6 as psychotic, and 2 as character disorders.

To obtain responses from the norming sample, copies of the inventory together with instructions and a cover letter were mailed to each of the 300 persons in the sample. Complete scorable responses were returned by 86 subjects (47 females, 30 males) with a mean age of 37.5 years. These were used for norming purposes.

Statistical Analyses

The two samples were compared on age, and on distribution of sexes. It was found that they did not differ in terms of age, or distribution of sex.

Means and standard deviations for rationality and assertiveness were calculated for both samples. These are given in Table 1. Parenthetically, in his study Davies (1970) reported means nearly identical to those reported here for his sample of 82 mental hospital patients (mean AII score = 185.63), and a representative sample of Edmontonians (mean AII score = 157.66). This lends credence to the usefulness of the AII as a consistent research instrument.

Table 1
 MEANS AND STANDARD DEVIATIONS OF ALL INVENTORY AND
 SA SCALE SCORES

Sample	N	AII Inventory		SA Scale	
		Mean	SD	Mean	SD
Normal	86	159.45	23.68	29.42	11.16
Inpatient	65	185.37	20.85	28.60	8.53

To obtain a standardized scattergram of the responses from the inpatient sample, all scores of this sample were transformed to standard scores (*z* scores) using the means and standard deviations obtained from the norming sample. The scattergram of these *z* scores is given in Figure 3. The frequencies in quadrants II and IV were obtained, and tested for equality using a test of the difference between two independent proportions (Ferguson, 1966, pp. 176-178). The resulting *z* score of 5.39 indicated the difference to be significant beyond the .00001 level.

Since quadrant II had the lower frequency, the test supports the theory that all rational persons are assertive, but not all assertive persons are rational.

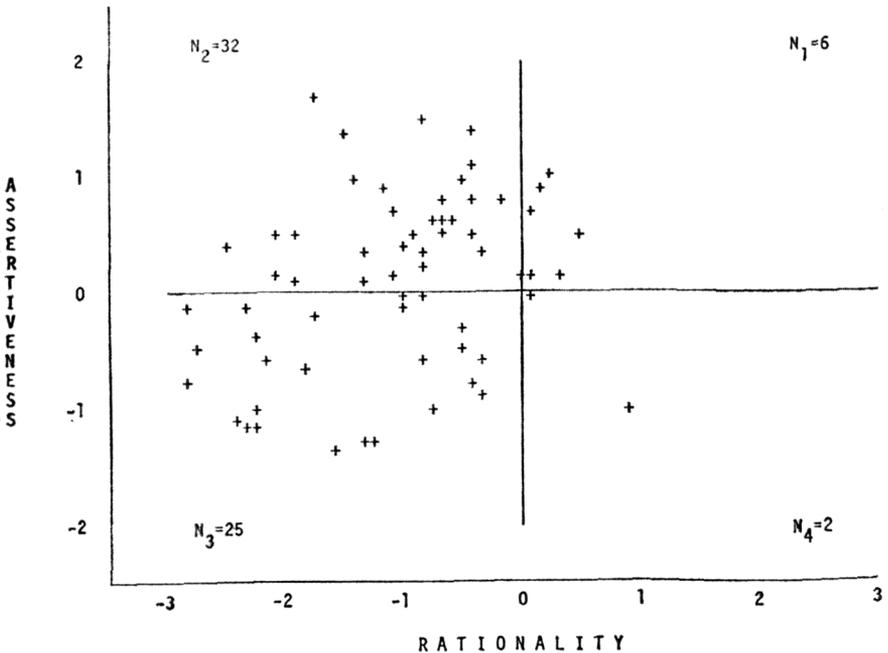


FIGURE 3: SCATTERGRAM OF RATIONALITY AND ASSERTIVENESS SCORES OF 65 PSYCHIATRIC INPATIENTS.

SUMMARY AND DISCUSSION

This study explored the following questions relating to the systems of psychotherapy known as rational-emotive therapy (Albert Ellis), and systematic desensitization by reciprocal inhibition (Joseph Wolpe): (1) Is Ellis's concept of mental health valid to the extent that all rational persons are assertive? (2) Is Wolpe's concept of mental health valid to the extent that all assertive persons are rational?

To explore these questions, the concepts of rationality and assertiveness were deduced from the kinds of changes effected by Ellis's and Wolpe's systems of psychotherapy. Rationality was measured by the Adult Irrational Ideas Inventory (AII) of Davis (1970), and assertiveness by the Social Acquiescence (SA) Scale (Bass, 1958). Both instruments were administered to a sample of 65 psychiatric inpatients and a random sample of 86 non-institutionalized (normal) subjects.

The results indicated support for the statement "All rational persons are assertive, but not all assertive persons are rational." Consequently, it may be concluded that rationality serves as a more central component of mental health than does assertiveness.

This result must, of course, be tempered by several qualifications. The most important of these is the question regarding the degree to which the instruments used here measure the objectives embedded in the therapeutic treatment approaches of Ellis and Wolpe, respectively. For example, it is important to recognize that although rationality is a paramount feature of rational-emotive therapy, it is not rationality in the philosophic seventeenth-century sense of the term (Brinton, 1950). Ellis (1962) is adamant on this point: "I am definitely not a rationalist, in any orthodox sense of this word (p. 121)." And later he states: "RT is not to be construed as a form of rationalism — and certainly not of any orthodox or classical kind of philosophic rationalism (p. 123)." Seventeenth-century rationalism addressed such questions as the nature of man, God, and the universe. Ellis does not consider these questions because he feels they are unanswerable. His brand of "rationalism" is empirical. For example, in response to a client's statement of worthlessness, he will often respond "What evidence do you have of that?" If the client finds no valid rationale to support his feelings of worthlessness, Ellis will point out that these feelings are not based on factual evidence, and hence should be re-considered.

This approach may be viewed as a re-formation of cognitive structures. Since it relies heavily on verbal behaviour, it may be possible to measure current states and changes by means of such paper and pencil inventories as the AII.

By contrast, Wolpe's therapy relies on behaviour modification only. In fact, he does not talk about mental health at all. The goal of his therapy is to inhibit undesirable behaviours. Since most of these behaviours can be classified as anxiety responses, the goal of the therapy was inferred to be increased assertiveness. Since the success of the therapy is measured in terms of behaviouristic outcomes (e.g.,

a former claustrophobic patient now rides in elevators), one may be justified to have some doubts about the degree to which a cognitive measure such as a score on the Social Acquiescence Scale represents a person's assertive behaviour. The SA scores may, therefore, not be a fair or adequate representation of a person's assertiveness in the sense implied by the therapeutic goals of Wolpe's system.

These qualifications, then, put a severe constraint on the generalizability of the findings. Note, however, that the results are strongly in favour of rationality as a more useful concept of mental health. Hence, inasmuch as the instruments assess the constructs of rationality and assertiveness, it may be said that of the two, rationality is more central to mental health.

It is hoped that this paper may stimulate similar comparative research leading to a better understanding of the relative importance of a variety of constructs such as components of good mental health.

RESUME: Les concepts de rationalité et d'affirmation de soi sont importants dans le domaine de la santé mentale. Chacun se retrouve de façon implicite dans l'approche thérapeutique de deux grandes écoles du counseling. Cette étude a tenté de découvrir lequel de ces deux concepts est le plus central pour la santé mentale. Conformément à cet objectif, des mesures de rationalité et d'affirmation de soi furent obtenues à partir de deux échantillons: (1) un échantillon pris au hasard, et (2) un échantillon de patients psychiatriques en institution. Les résultats indiquent que, de façon proportionnelle, il y a une plus grande tendance vers l'irrationalité allant de l'échantillon des normaux à l'échantillon psychiatrique qu'il y en a par rapport au manque d'affirmation de soi (p moins que .00001). Conséquemment, on a conclu que la rationalité est un concept plus central en santé mentale que celui de l'affirmation de soi. Cependant, ces résultats ne doivent pas être interprétés comme pouvant être indicatifs des mérites des écoles de thérapie mentionnées ci-haut, parce qu'on ne sait pas jusqu'à quel point les instruments utilisés dans cette étude mesurent bien l'état mental visé par ces approches thérapeutiques. Il faudra effectuer plus de recherches sur cette question avant de tirer de telles conclusions.

REFERENCES

- Bass, B. M. Famous sayings test: General manual. *Psychological Reports*, 1958, 4, 479-497.
- Brinton, C. *Ideas and men: The story of western thought*. New York: Prentice-Hall, 1950.
- Carkhuff, R. R., & Berenson, B. G. *Beyond counseling and therapy*. New York: Holt, Rinehart and Winston, 1967.
- Davies, R. L. Relationship of irrational ideas to emotional disturbance. Unpublished M.Ed. thesis, University of Alberta, 1970.
- Ellis, A. *Reason and emotion in psychotherapy*. New York: Lyle Stuart, 1962.
- Ferguson, G. A. *Statistical analysis in psychotherapy and education*. (2nd ed.) New York: McGraw-Hill, 1966.

- Fox, E. E., & Davies, R. L. Test your rationality. *Rational Living*, 1971, 5(2), 23-25.
- Truax, C. B., & Carkhuff, R. R. *Toward effective counseling and psychotherapy*. Toronto: Aldine Press, 1967.
- Wolpe, J. *Psychotherapy by reciprocal inhibition*. Stanford, California: Stanford University Press, 1958.
- Wolpe, J., & Lazarus, A. A. *Behaviour therapy techniques: A guide to the treatment of neuroses*. London: Pergamon Press, 1966.
- Zingle, H. W. A rational therapy approach to counseling under-achievers. Unpublished doctoral dissertation, University of Alberta, 1965.